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YOU ARE REQUIRED TO NOTIFY THE ADMINISTRATIVE OFFICE WHENEVER:

1. You change your home address.
2. You get married or divorced (copy of marriage license required and a complete full copy of divorce decree required).
3. You have a new dependent (copy of marriage license, birth certificate or adoption record required).
4. You wish to change your beneficiary.
5. You are receiving Worker's Compensation Benefits.
6. You return to work after a disability ceases.
7. You enter the Armed Forces of the United States.

You have 60 days from the date of divorce to notify the Administrative Office and provide a full copy of the divorce decree. If the Fund discovers that benefits have been improperly paid for a former spouse or that the Administrative Office was not properly notified, the Fund will take steps to recover such improper payments from the participant, which may include either litigation of a setoff against future benefits.

IMPORTANT NOTICE

In this booklet we have attempted to explain as clearly and briefly as possible the benefits that are available to you under the Plan. All the provisions of the Plan are contained in the Plan Document adopted by the Board of Trustees. Since the Plan Document is complete in detail, it will govern the final interpretation of any specific provision.

In the case of a conflict between the Plan and Trust Documents or the Collective Bargaining Agreement and this Summary Plan Description, the Plan and Trust Documents or Collective Bargaining Agreement shall control.

Participants and beneficiaries, including retirees, benefits, eligibility rules, and contributions required from participants, if any, are subject to modification, amendment and/or termination by the Board of Trustees.

This Summary Plan Description supersedes and replaces all previous Summary Plan Descriptions and Summaries of Material Modifications.

COLORADO FINISHING TRADES HEALTH AND WELFARE FUND
2821 SOUTH PARKER ROAD, SUITE 1005, AURORA, COLORADO 80014
TELEPHONE: (303) 745-1941 TOLL-FREE: (800) 659-0841

January 2013

Dear Participant:

The Board of Trustees is pleased to present this booklet describing the eligibility and benefit provisions of your Health and Welfare Fund.

This Fund was established and is maintained through a Collective Bargaining Agreement between your Union and Participating Employers. The benefits provided to you by this Fund are funded by employer contributions supplemented by such earnings as may be realized from the Fund's investments and, under certain circumstances, employee contributions. The Fund is a welfare benefit fund.

The Trustees are dedicated to providing you with the best health benefits possible utilizing the funds available. We urge you to read this Summary Plan Description thoroughly to familiarize yourself with the eligibility rules, benefits available, and those circumstances which might result in disqualification, ineligibility, denial, loss, forfeiture, or suspension of any benefit which you or your beneficiary might otherwise expect the Fund to provide.

Sincerely,
Your Board of Trustees

IF YOU HAVE QUESTIONS

If you have a question about the Health and Welfare Fund, please use the following guide to help you determine whom to call:

▶ Contact the Administrative Office at 303-745-1941 or 1-800-659-0841 if:

- You have a question about eligibility for you or a dependent.
- You have a question about a medical, dental, death or weekly disability claim.
- You have a question about payment of Retiree or COBRA contributions.
- There is a problem with the eligibility/dependent information shown on your ID cards.
- You need a new ID card.
- You are receiving Workers' Compensation Benefits.

▶ Contact CIGNA at 1-800-768-4695 or www.cignasharedadministration.com if:

- You need to locate a network provider.
- You need to pre-certify medical care.
- You wish to contact Case Management about your medical needs.

▶ Contact Envision Rx Options at 1-800-361-4542 or www.envisionrx.com if:

- You have a question about a prescription drug claim.
- You need information on how to order or refill a mail order prescription.

▶ Contact VSP at 1-877-7191 or www.vsp.com if:

- You have a question about your vision benefits.
- You need to locate a VSP network provider.

IMPORTANT INFORMATION TO HELP YOU IDENTIFY THIS PLAN

- **Name of Plan.** This Plan is known as the COLORADO FINISHING TRADES HEALTH AND WELFARE FUND.
- **Type of Plan.** This Fund is maintained for the purposes of providing medical benefits and compensation in the event of sickness, accident or death.
- **Plan Identification Number.** The number assigned to this Plan by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 501. The number assigned to the Fund by the Internal Revenue Service is 84-0837011.
- **Plan Sponsor and Plan Administrator:** Board of Trustees.
  a) Members. This Plan is sponsored, maintained, and administered by a Board of Trustees, which consists of an equal number of employer and Union representatives. The Board of Trustees is both the Plan Sponsor and the Plan Administrator for purposes of ERISA. This Board has the primary responsibility for decisions regarding eligibility rules, type of benefits, administrative policies, management of Plan assets, and interpretation of Plan provisions.

  As of January 1, 2013, the Trustees of this Plan are:

Union Trustees	**Employer Trustees**
Douglas Melphy (Chairman) District Council No. 15 2170 S. Lipan St. Denver, CO 80223	Bruce Plocher (Secretary) 6490 S. Oak Ct. Littleton, CO 80127
Rob West District Council No. 15 2170 S. Lipan St. Denver, CO 80223	Kevin Croshal Next Generation Surfaces LLC POB 1213 Englewood, CO 80150
Mike Williams District Council No. 15 2170 S. Lipan St. Denver, CO 80223	Mike Olsen A-1 Glass 3070 S. Wyandot Englewood, CO 80110

  b) Address and Telephone Number. If you wish to contact the Board of Trustees, you may use the address and telephone numbers below:

2821 South Parker Road, Suite 1005
Aurora, Colorado 80014
(303) 745-1941 or 1-800-659-0841

- **Administrative Operations.** The Board of Trustees is legally designated as the Plan Administrator. The Board has selected a professional employee benefit administration firm, Compusys of Colorado, Inc. to serve as the Administrative Manager of the Plan. The Administrative Manager serves as the "Administrative Office" and maintains eligibility records, accounts for contributions, informs participants of Plan changes, and other routine administrative functions as directed by the Board of Trustees. You may contact the Administrative Manager at the following address and phone number:

Compusys of Colorado, Inc.
2821 South Parker Road, Suite 1005
Aurora, Colorado 80014
(303) 745-1941 or 1-800-659-0841

Additionally, the following professionals have been retained by the Board of Trustees to assist in the operation of the Plan:

Attorney

Martin Buckley, Esq.
Berenbaum Weinshienk PC
370 17th St., Suite 4800
Denver, CO 80202-5698
(303) 592-8333

Auditor

Needles & Associates, LLC
350 Interlocken Blvd., Suite 220
Broomfield, CO 80021
(303) 430-4225

Consultant

BHA Consulting LLC
5400 Laurel Springs Pkwy, Suite 1306
Suwanee, Georgia 30024
(678) 456-6200

- **Collective Bargaining Agreements.** This Plan is maintained pursuant to one or more Collective Bargaining Agreements. Copies of any or all of these Agreements shall be made available to you for your inspection at the Plan Office or at your Local Union Office during normal business hours. Further, should you so request, a copy of the Agreements shall be made available at your place of employment within 10 days of your request if you will advise your employer of your desire to examine the Agreements. You may obtain a copy of the Agreements for a reasonable charge by contacting the Board of Trustees at the address or phone number listed.
- **Participating Employers.** You are entitled to receive from the Plan Administrator, upon request, information as to whether a particular employer or employee organization is participating employer with the Fund and, if so, the employer's address.
- **Source of Contributions.** The primary source for the benefits provided under this Plan is employer contributions. The Collective Bargaining Agreement determines the amount of contribution. In certain instances, as described in this booklet, participants may make self-contributions to the Plan in order to continue their eligibility for benefits. A portion of the Plan's assets is invested, which also produces additional Fund income.
- **Trust Fund.** All contributions and investment earnings are accumulated in a Trust Fund. All benefits are paid directly from the Trust Fund.
- **Identification of Insurance Company.** Life and Accidental Death and Dismemberment benefits are insured through ReliaStar Life Insurance Company. Vision benefits are insured through Vision Service Plan (VSP). Medical benefits are self-funded, with reinsurance provided through ING. All remaining benefits are self-insured and paid directly by the Fund.

- **Accounting, Plan and Reporting Year.** Each 12-month period ending on June 30th constitutes a fiscal year for accounting purposes of all reports to the Department of Labor, to the Internal Revenue Service, and, where required, to any agency of those states in which contributing employers are located. The same 12-month period comprises a Plan Year within the meaning of ERISA.
- **Procedure for Obtaining Additional Plan Documents.** If you wish to inspect or receive copies of additional documents relating to this Plan, contact the Administrative Office. You will be charged a reasonable fee to cover the cost of any materials you wish to receive.
- **Eligibility for Benefits.** Please see the Eligibility Rules section of this booklet.
- **Effective Date.** The effective date of this Summary Plan Description is January 1, 2013.
- **Agent for Service of Legal Process**. When legal disputes involving the Plan arises, any legal documents should be served upon:

  Martin Buckley, Esq.
  Berenbaum Weinshienk PC
  370 17th St., Suite 4800
  Denver, CO 80202-5698
  (303) 592-8333

  Service of Legal process may also be made upon any Trustee or the Plan Administrator (Board of Trustees). The address of the Plan office and the addresses of the Trustees are provided under the fourth bullet, "Board of Trustees."
- **Continuation of Plan.** The Board of Trustees currently intends to continue the Plan described herein, but reserves the right, in its discretion, to amend, reduce or terminate the Plan at any time for the active participants, retirees, former participants and all dependents.
- **Accumulation of Assets and Funding of Benefits.** All contributions from Participating Employers are made in accordance with Collective Bargaining Agreements between the Union and the employer. The amounts of these contributions are set forth in the agreements. All benefits provided to Participants in the Plan, their spouses, and their beneficiaries are funded from employer and, in some instances, employee contributions and earnings on investments.
- **Facility of Payment**. If the Trustees determine that a person entitled to benefits under the Plan is unable to care for his affairs because of illness, accident or other incapacity, any payment due may be paid to his legal guardian or other representative. Any such payment shall be made for the account of such incapacitated person, and shall to the extent thereof be a complete discharge of the obligations under this Plan to such person.
- **Erroneous Payment**. If the Trustees determine that a claim has been erroneously paid as a result of a clerical error or on the basis of fraudulent or misleading statements made by the claimant, service provider, or any other entity, then the Trustees shall reserve the right to take necessary action to recover such payment.

PROVISIONS APPLICABLE TO THE HEALTH AND WELFARE FUND

NOTICE OF GRANDFATHERED HEALTH PLAN

The Colorado Finishing Trades Health and Welfare Fund believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Administrative Office at 1-800-659-0841 or in writing to Colorado Finishing Trades Health and Welfare Fund, 2821 South Parker Road, Suite 1005, Aurora, Colorado 80014. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

NOTICE OF YOUR RIGHT TO DOCUMENTATION OF HEALTH COVERAGE

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions present before you enroll in health coverage. Under the law, a pre-existing condition generally may not be imposed for more than 12 months (18 months for a late enrollee). The 12-month (or 18 month) exclusion period is reduced by your prior health coverage. Upon termination from this Plan you and all dependents covered under your health coverage will receive a "Certificate of Creditable Coverage" that will show evidence of your prior health coverage through this Plan. When enrolling for new health coverage, check with your new plan administrator to see if your new plan excludes coverage for pre-existing conditions and if you need to provide a certificate or other documentation of your previous coverage.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under Federal law, group health plans and health insurance issuers offering group health coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother of the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (for example, your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable than the earlier portion of the stay. In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay up to 48 hours (or 96 hours).

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Under Federal law, group health plans and insurance issuers offering group health coverage that includes medical and surgical benefits with respect to a mastectomy shall include medical and surgical benefits for breast reconstructive surgery as part of a mastectomy procedure. Breast reconstructive

surgery in connection with a mastectomy shall at a minimum provide for: (1) reconstruction of the breast on which the mastectomy was performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prostheses and physical complications for all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient. As part of the Plan's Schedule of Benefits, such benefits are subject to the Plan's appropriate cost control provisions, such as Deductibles and Coinsurance.

MILITARY SERVICE (USERRA)

If an Eligible Employee is on active duty for 31 days or less, he will continue to receive healthcare coverage for up to 31 days, in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If the Employee is on active duty for more than 31 days, USERRA permits him to continue medical, dental, and vision coverage for himself and his dependents at his own expense for up to 24 months. This continuation right operates in the same way as Continuation of Coverage (COBRA). In addition, he or his dependent(s) may be eligible for healthcare coverage under service sponsored insurance.

Coverage will not be offered for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in or aggravated during performance of service in the uniformed services. The uniformed services and the Department of Veterans Affairs will provide care for service-connected disabilities.

When the Employee is discharged (not less than honorably) from "service in the uniformed services," his full eligibility will be reinstated on the day he returns to work with an Employer, provided that he returns to employment within:

90 days from the date of discharge if the period of service was more than 180 days; or

a) 14 days from the date of discharge if the period of service was 31 days or more but less than 180 days; or
b) at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight 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.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

If an Employee works for a contributing Employer who employs at least 50 employees during the current or preceding calendar year, the Employee may be eligible to take a leave of absence under the Family and Medical Leave Act (FMLA). To qualify for such a leave, the Employee must have been employed by the same contributing Employer for a minimum of 1,250 hours within the 12-month period immediately preceding the commencement of the FMLA leave. If the Employee qualifies, he or she may take up to a total of 12 weeks of FMLA leave during any 12-month period, during which period the Employer is obligated to continue payments for coverage through the Plan and benefits will be continued subject to all other provisions of the Plan and Trust.

FMLA leave may be taken for any of the following reasons:

a) birth or care of a newborn child;
b) placement of a newly adopted child or foster child;
c) care of a spouse, son, daughter or parent with a “serious health condition”; or
d) a “serious health condition” that makes the Employee unable to perform his job.

A "serious health condition" generally means an illness, injury, impairment, or physical or mental condition involving:

i) in-patient care in a hospital, hospice, or residential medical care facility;
ii) any incapacity requiring absence from work, school, or other regular daily activities of more than three (3) calendar days that also involves continuing treatment by or under the supervision of a healthcare provider; and
iii) continuing treatment by or under the supervision of a healthcare provider for a chronic or long-term health condition that is incurable or so serious that, if not treated, would likely result in a period of incapacity of more than three days.

SUBROGATION AND REIMBURSEMENT RIGHTS

In the event that a Covered Individual receives any benefits (the "Benefits") under this Plan arising out of any loss, injury, or illness (the "Injury") for which the Covered Individual has asserted or may assert any claim or right to recovery against a third party or parties or his or her or their insurer(s), including against any insurer on any policy of insurance issued to and in the name of such Covered Individual, then any payment or payments by the Fund for such Benefits shall be made on the condition and with the agreement and understanding that the Fund shall receive reimbursement from the Covered Individual to the extent of, but not exceeding, the amount or amounts received by the Covered Individual (the "Recovery") from such third party or parties or his or her or their insurer(s) (the "Responsible Party"), whether by way of settlement or in satisfaction of any judgment(s) or otherwise.

The Covered Individual shall provide reimbursement to the Fund, starting with the first dollar that the Covered Individual receives from the Responsible Party, no matter whether the Recovery is designated as actual or punitive damages, costs or expenses, medical expenses, pain and suffering, lost wages, workers' compensation, disability payments, loss of consortium, loss of work payments, emotional distress, or otherwise, and the Covered Individual shall continue to make reimbursement to the Fund until the Fund has received full reimbursement for all Benefits related to the Injury; provided, however, that a Covered Individual shall not be required to make reimbursement in excess of his or her Recovery.

The Fund has the right to first recovery and the "make whole" doctrine is not applicable to the Fund's subrogation and reimbursement rights. The Fund has the right of first reimbursement for all Benefits paid related to the Injury, such first reimbursement to be paid out of any Recovery the Covered Individual is able to obtain, even if the Covered Individual has not been fully compensated for the Injury. Any Recovery held by the Covered Individual or third party on behalf of the Covered Individual shall be deemed to be held in trust on behalf of the Fund, and the Fund shall have an equitable lien upon any recovery.

If it becomes necessary for the Covered Individual to retain an attorney in order to obtain a Recovery or to recover Benefits paid by the Fund relating to the Injury, the amount to be restored to the Fund may, at the sole discretion of the Fund, be reduced by the Fund's *pro rata* share of those attorneys' fees and expenses. The pro rata shares shall be calculated by multiplying the total attorneys' fees and expenses

actually incurred by the Covered Individual by the Fund's gross reimbursement (before considering any party's attorneys' fees or expenses) divided by the total gross Recovery (before considering any party's attorneys' fees or expenses). The Fund, however, is not required to reduce the amount reimbursed to the Fund for any attorneys' fees and expenses. The Fund does not recognize the "Common-Fund Doctrine," the "Fund Doctrine," the "Attorneys' Fund Doctrine," or any other legal theory compelling the Fund to reduce the amount it is owed hereunder in order to pay any portion of a Covered Individual's attorney's fees and costs.

If the Trustees retain an attorney to enforce the subrogation and reimbursement rights under this Section, then the Covered Individual shall be liable for, in addition to all amounts outlined in the previous paragraphs, expenses involved, including the Fund's reasonable attorneys' fees and expenses. As a means of enforcing its subrogation and reimbursement rights under this Section, the Fund may, in addition to any other means allowed by law or equity, set off future Benefits to the Covered Individual or lessen the reduction allowed by the Fund for the Covered Individual's attorneys' fees and expenses incurred in obtaining the Recovery. However, this Section shall not limit the Fund's right to recover its attorneys' fees and expenses and shall be cumulative with all other rights the Fund may have to recover its attorneys' fees and expenses.

As security for all amounts due to the Fund under this Section, the Fund shall be subrogated to all of the claims, demands, actions, and rights of recovery of the Covered Individual against the Responsible Party or his or her or their insurer(s) to the extent of any and all Benefits paid under this Plan. The Covered Individual shall execute and deliver any instruments and documents requested by the Trustees and shall do whatever else the Trustees shall deem necessary to protect the Fund's rights. The Covered Individual shall take no action to prejudice the Fund's rights to such reimbursement and subrogation. The Trustees may withhold any Benefits to which the Covered
Individual is entitled under this Plan until the Covered Individual executes and delivers any such instruments and documents as may be requested by the Trustees.

Prior to the payment of Benefits under this Plan to a Covered Individual or assignee of a Covered Individual for injuries, expenses, or losses for which a third party is or may be liable in whole or part, the Covered Individual or assignee or both may be required to execute a written subrogation and reimbursement agreement in form and substance satisfactory to this Plan.

OTHER PROVISIONS

- **Not in Lieu of Worker's Compensation**
  This Plan is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

- **Authority of Trustees to Interpret and Construe Plan**
  The Trustees shall have the right to make any and all determinations pursuant to the Plan. This includes, but is not limited to, the discretionary authority to determine eligibility for benefits, to determine the amount of benefits payable, to determine the meaning and applicability of Plan provisions, to construe Plan terms, and to promulgate rules for processing and reviewing claims. Any and all determinations of the Trustees shall be conclusive and binding upon all parties having dealings with the Plan. It is the intent of the Trustees to maintain sole and complete authority to construe the Plan terms, including the definition of all Plan terms and the summary of all terms in this Summary Plan Description. In the event you are dissatisfied with a decision of the Board of Trustees, you may appeal the decision as outlined in the Claim Appeal Section of this Summary Plan

Description. You must use the appeal procedure before filing a lawsuit against the Fund. The decisions of the Board of Trustees are entitled to judicial deference.

- **No Vested Benefits**
  There are no vested benefits under this Plan.

- **Authority of Trustees to Modify Benefits or Terminate Plan**
  It is the intention of the Trustees to continue operation of the Plan. The Trustees reserve the right to modify or terminate the Plan at any time. This includes the right to modify the level of benefits, to change the amounts to be contributed toward the cost of providing benefits by the sponsors or by the participants, or to change the class or classes. The Plan may be modified or terminated by vote of the Board of Trustees. In the event of any modification of the Plan, the Board of Trustees will communicate such modification to the Plan participants. Amendment or termination of the Plan may terminate your right to receive benefits, may limit your benefits, and may increase the amount which you must contribute toward the cost of providing benefits, or may reduce the benefits to which you were previously entitled.

- **Use of Assets upon Termination of Plan**
  If the Plan is terminated, the assets will be used for sole and exclusive benefit of the participants.

STATEMENT OF YOUR RIGHTS

As a participant in the Colorado Finishing Trades Health and Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended from time to time.

ERISA provides that all Plan Participants shall be entitled to the following:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor.
2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.
3. 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.
4. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result qualifying event. You or your dependents 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.
5. Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of

creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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. 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 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 domestic relations order or 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.

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 Inquires, 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.

PRECERTIFICATION OF HOSPITAL ADMISSIONS

PRECERTIFICATION OF SCHEDULED AND EMERGENCY HOSPITALIZATIONS

The precertification coordinator must be notified of a proposed non-emergency hospitalization before the start of the scheduled confinement. Non-emergency Hospital confinements are those that can be scheduled in advance.

The precertification coordinator for this Fund is CIGNA. You or your provider must contact CIGNA 7 to 10 days prior to admission at 1-800-768-4695. Failure to obtain pre-certification will result in a reduction of benefits payable.

Admissions due to 1) injury, 2) normal delivery, or 3) life threatening situations are considered emergency hospitalization. In the event of an emergency hospitalization, the precertification

coordinator must be notified within 48 hours of admission or 72 hours if admission is on a weekend or holiday.

Following notice of the admission, the precertification coordinator will provide notice of the Medical Necessity of the admission and the number of days of Hospital confinement which are authorized, which will not be less than that required by any applicable law. **Please note: precertification is not a guarantee of coverage – all claims will still be subject to eligibility provisions at the time service is rendered.**

Continued Confinements
In the event of confinement beyond the number of days authorized, the precertification coordinator will evaluate the need for continued confinement, this is also called concurrent review. The precertification coordinator's decision shall be based upon peer review or other professional medical opinion and individual case considerations. The attending Physician or Covered Individual may, at any time, initiate a request for re-evaluation or extension.

Coverage for days beyond the authorized amount may not be covered by the Fund or may be covered at a reduced level.

CLAIMS PROCEDURES

PRE-APPROVAL OF A CLAIM
This Fund requires pre-certification of hospitalizations as described above. While non-inpatient care does not require pre-certification, because certain treatments and procedures are not covered under the Fund we encourage you to contact the Administrative Office prior to receiving any treatment or service in order to determine that the treatment will be covered.

The following rules apply to pre-approval of treatment:

1. **Approval of Medically Necessary Treatment –** As explained in this booklet, a Charge must be Medically Necessary or be a covered preventive care service to be covered by the Plan. If there is any doubt about whether your expected treatment will be considered Medically Necessary, you may contact the Administrative Office for an advance decision. As explained in the following pages, you may appeal any adverse decision made by the Fund regarding Medical Necessity.
2. **Compliance with Plan Provisions, Exclusions and Limitations** – Various plan provisions, Exclusions and Limitations have been adopted and/or included in this Plan in an effort to help control the cost of providing benefits under this Plan. If there is any question as to whether your anticipated treatment will be covered under the Plan, you may contact the Administrative Office in advance. Once appropriate information is received, the Administrative Office will let you know whether your expected treatment will be covered under the Plan. If you receive an adverse decision, you may appeal that decision as explained on the following pages.

If you make a request for pre-approval of treatment, the Fund has a responsibility to respond to your request in a timely manner as follows:

1. **Urgent Care Claims –** If proposed treatment is determined to be "urgent" in nature, as defined below, a decision on your request for pre-approval will be made and communicated to you within 72

hours of receipt of your request. If it is determined that additional information is necessary to make a decision on your claim, you will be notified within 24 hours after receipt of the request. You will then be given no less than 48 hours to provide the requested information.

An "Urgent Care Claim" is a claim which, if treated as a claim for non-urgent care:

a) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or
b) In the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

2. **Non-Urgent Care Claims** – If proposed treatment is determined to be of a "non-urgent" nature, a decision on your request for pre-approval will be made and communicated to you within 15 days of receipt of your request. If it is determined that additional information is necessary to make a decision on your claim, the Plan may require up to an additional 15 days to make a decision on your request. If such an extension is necessary, you will be notified within 15 days of receipt of your request regarding the extension and a decision will be made as soon as possible. If the extension is required because it was necessary for you to provide additional information, you will be given at least 45 days to provide the requested information.

These procedures for processing requests for pre-approval for urgent and non-urgent care claims have been adopted solely as guidelines. It will continue to be the practice of the Trustees, as the Plan Administrator, along with the Administrative Office staff, to timely process all requests for pre-approval and to respond to all such requests immediately, but always within the time limits prescribed above where possible.

DISABILITY, POST-SERVICE and CONCURRENT CARE CLAIMS

For disability, post-service and concurrent (on-going) care claims, the Plan Administrator's designee shall notify the claimant of a benefit determination within the following time periods:

1. **Disability Claims** – For claims relating to the determination of disability and weekly disability benefits, notification of benefit determination shall be made within 45 days after the Plan's receipt of the claim. If additional time is required, the 45-day period may be extended one time for up to 30 days provided that the Plan Administrator's designee determines that such an extension is necessary due to matters beyond the Plan's control and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension and the date by which the Plan expects to render a decision. If, prior to the end of the first 30-day extension period, the Plan Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Plan Administrator notifies the claimant, before the expiration of the first 30-day extension period of the circumstances requiring the extension and the date the Plan expects to render a decision. The notice of extension shall specifically explain the standards on which entitlement to a benefit is based, unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. The claimant shall be afforded at least 45 days within which to provide the specified information.
2. **Post Service Claims** – For claims relating to services which have already been rendered, notification of benefit determination shall be made within 30 days after the Plan's receipt of the claim. If additional time is required due to matters beyond the Plan's control, the claimant will be notified

before the expiration of the 30-day period of the circumstances requiring the extension of time and of the date by which the Plan expects to render the benefit determination. The extension shall not exceed 15 days beyond the initial 30-day period. If an extension is necessary due to the failure of the claimant to submit sufficient information, the notice shall describe the required information and afford the claimant at least 45 days from receipt of the notice to provide the information.

3. **Ongoing or Concurrent Treatment** – If the Plan has approved an ongoing course of treatment over a period of time or number of treatments, any reduction or early termination of coverage of the treatments constitutes an Adverse Benefit Determination. The Plan Administrator's designee shall notify the claimant sufficiently in advance of the reduction or early termination to allow the claimant to appeal and obtain a review before the benefit is reduced or terminated. If claimant requests at least 24 hours before the expiration to extend the course of treatment beyond the period of time or number of treatments for an Urgent Care Claim, the Plan Administrator's designee shall notify the claimant of the benefit determination within 24 hours after the receipt of the claim by the Plan.

If your claim or pre-approval is denied, you will receive an initial claim determination from the Fund which will outline the reason for the denial as well as how you can appeal the adverse benefit determination.

APPEAL PROCEDURES

To initiate an appeal, you must submit a written request within 180 days of receipt of a denial notice. The request for review should be made to the Board of Trustees, Colorado Finishing Trades Health and Welfare Fund. You should state the reason why you feel your request should be approved and include any information supporting your appeal.

If a claim for benefits has been wholly or partially denied, the Covered Individual shall have one hundred eighty (180) days from receipt of the denial notice in which to apply in writing to the Administrative Office for review by the Board of Trustees. The Covered Individual shall have the right (a) to representation; (b) to review pertinent documents; (c) to submit written comments, documents, records, and other information relating to the claim for benefits; and (d) upon request and free of charge, to reasonable access to, and copies of, all documents, records, and other information relevant to his claim for benefits. In making a decision on review, the Board of Trustees or a committee of the Board of Trustees will (a) review and consider all comments, documents, records, and all other information submitted by the Covered Individual or the Covered Individual's duly authorized representative, without regard to whether such information was submitted or considered in the initial claim determination; (b) grant no deference to either the original claim denial or the first level review decision, if applicable, but will assess the information provided as if it were looking at the claim for the first time and the person(s) reviewing the claim will not be the same person(s) who made the initial decision or the prior review (if any), nor will they be subordinates of those individuals; (c) if the appeal of an adverse benefit determination is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment, which such healthcare professional shall be an individual who 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 (d) identify the medical or vocational experts whose advice was obtained on behalf of this Plan in connection with a claimant's adverse benefit determination.

The Board of Trustees shall make a benefit determination on review no later than (i) the date of the first (1st) meeting of the Board of Trustees that immediately follows receipt by the Administrative Office of a written request for review or (ii) if such written request for review was not received by the Administrative Office more than seven (7) days before such meeting, the date of the second (2nd) meeting of the Board of Trustees following the date the Administrative Office received the written request for review. If special circumstances require a delay in the decision, the Board of Trustees shall, prior to commencement of the extension, send a written notice to you setting forth the special circumstances requiring an extension and the date by which the benefit determination is expected to be rendered, and the Board of Trustees shall issue its decision no later than the date of the third (3rd) meeting next following the date the Administrative Office received the written request for review. The Administrative Office shall notify you of the benefit determination as soon as possible, but not later than five (5) days after the benefit determination is made.

Expedited Appeal Process

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing inpatient Hospital stay. The Administrative Office, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, the Board of Trustees will respond orally with a decision within 72 hours, followed up in writing.

Notification of Decision on Appeal

The Board of Trustees, or their committee, shall review any facts and information submitted by you, make a final decision, and notify you in writing of their decision within the time period outlined above. If the adverse benefit determination is upheld, the notification will set forth the following in a manner calculated to be understood by the claimant:

1. The specific reason(s) for the adverse determination;
2. Reference to the specific Plan provisions on which the determination is based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits;
4. A statement of any additional voluntary appeal procedures offered by the Plan and the claimant's right to obtain information about such procedures, should the Board of Trustees adopt such procedures, and a statement of the claimant's right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974, as amended; and
5. The following information where applicable:
   a) If an internal rule, guideline, practice or procedure was relied upon in making the adverse determination, a statement that copy of such rule, guideline, practice or procedure will be provided free of charge to the claimant upon request;
   b) If the adverse benefit determination is based on a Medically Necessary or Experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment applied to the terms of the Plan with respect to the claimant's medical circumstances used in making the determination; and
   c) A statement that you and your Plan may have other voluntary dispute options, such as mediation. While this Plan does not currently offer voluntary alternative dispute resolution

options, you can contact your local U.S. Department of Labor Office and your State Insurance Regulatory Agency to see what options might be available to the Plan.

ACCESS TO PLAN DOCUMENTS

At any time during the course of these appeal proceedings a claimant will be granted access to, and copies of, documents, records and other information relied upon by the Trustees, or their committee, in making their decision, as requested by the claimant.

No legal action may be commenced or maintained against the Plan or Fund, or to recover any benefits under the Plan, unless the participant (or his legal representative, if any) has first fully complied with and timely exhausted all of the application of benefits, claims review procedures and appeal procedures under the Plan, and in no event may any such action be brought later than 120 days following the Trustees' final decision on review or, if 120 days is not reasonable under the circumstances, such extended time that is reasonable not to exceed, in any event, one (1) year following the Trustees' final decision on review.

CONTACT INFORMATION FOR APPEALS

Board of Trustees
Colorado Finishing Trades Health and Welfare Fund
2821 South Parker Road, Suite 1005
Aurora, Colorado 80014

HOW TO OBTAIN BENEFITS

Here are a few suggestions that will help you get the most out of your benefit program and, at the same time, help assure prompt payment of your claims:

- **Use CIGNA PPO Providers and show your ID card.** When you know that you or one of your Eligible Dependents is going to require medical treatment, this booklet will explain your benefits or you may contact the Administrative Office for assistance. Make sure you locate an In-Network Provider who will provide quality medical care at a discounted fee and will enable you to take advantage of the highest level of benefits available under the Plan. You can contact **CIGNA** at 1-800-768-4695, or search for providers online at **www.cignasharedadministration.com**. Be sure to have your health benefit identification card with you at all times. It is especially important that you present this card when you are admitted to a Hospital or when you visit a Physician or other service provider. Your ID card supplies the service providers with the name of your Plan, as well as the number to call to verify eligibility and benefits. It also identifies you as a member of the **CIGNA PPO** network, affording you access to the Preferred Provider discounts. By presenting this ID card to a **CIGNA PPO**, the provider will also automatically file your claim for you. This eliminates your need to file the claim.
- **Submit all expenses just in case.** The Trustees suggest that you submit medical expenses to the Administrative Office even if you are not certain if they are eligible for coverage under the Plan. The Administrative Office will review such expenses and pay the expense that is eligible. By following this procedure, you will avoid inadvertently not receiving benefits for which you are entitled.
- **Include all Necessary Information.** To avoid any confusion as to whom a bill is for, please be sure to list your name and Social Security Number on each item you send to CIGNA or the Administrative Office and be certain to include your dependent's Social Security Number as well on any items submitted for them.

- **Additional Materials.** If you receive additional bills or statements that relate to your claim, you should send them to the Administrative Office as soon as possible.

KEEP MEDICAL RECORDS!

Accurate medical records are extremely important in the event you want to claim benefits.

- Since the Calendar Year Deductible applies separately to each individual, keep separate medical records for each member of your family.
- Save all bills and/or statements for Covered Charges and in each case record the date the expense was incurred (not the date of the bill) and for whom.
- A bill or cash receipt for prescription drugs must indicate the date of purchase, the prescription number and the name of the prescribing physician.
- Keep copies of the Explanation of Benefits (EOB) that you receive from the Administrative Office as a record of what expenses have been paid.

HOW TO FILE A CLAIM

TIME LIMIT FOR FILING A CLAIM

You must furnish the Plan with proof of loss within ninety (90) days after the date of the loss, if reasonably possible. However, in no event will claims delayed in excess of one (1) year from the date of service be acceptable or payable.

MEDICAL claims must be filed with CIGNA at the following address:

CIGNA Healthcare
P.O. Box 188004
Chattanooga, TN 37422-8004

DENTAL claims must be filed with the Administrative Office at the following address:

Colorado Finishing Trades Health and Welfare Fund
2821 South Parker Road, Suite 1005
Aurora, Colorado 80014

Note: When you submit a dental claim for a dependent child, you must indicate the primary policy holder/employee name and date of birth.

PRESCRIPTION DRUG claims are processed at the point of service through EnvisionRx. In some instances you may have to file a paper claim with EnvisionRx or the Administrative Office. Prescription claims may be mailed to:

Envision Pharmaceutical Services, Inc.
2181 East Aurora Road, Suite 201
Twinsburg, OH 44087

NOTE FOR PAINTERS PARTICIPANTS: Retail Pharmacy claims being submitted for reimbursement must be submitted to the Administrative Office at the address shown above for Dental claims.

VISION claims must be filed with VSP. Contact VSP at 1-800-877-7191 for more information.

LIFE, AD&D and DISABILITY claims must be filed with the Administrative Office.

PROCEDURES FOR FILING CLAIMS WITH CIGNA
In most cases your providers will file your claims for you. However, if you need to present a claim:

1. If it is the first claim you have filed in any given year, you will need to submit a fully completed claims form. If all questions are not answered it may be necessary to return the claim which will delay settlement.
2. Submit all supporting bills. The bill or statement from the medical provider should include the following information:
   a) The Name and Social Security Number of the Covered Employee, and the Social Security Number of the Eligible Dependent if applicable.
   b) The full name of the patient.
   c) Date of each treatment.
   d) Procedure code and description of each service performed during treatment.
   e) Diagnosis and/or code.
   f) Charge amount for each procedure.
3. Mail the bills (with claim form if needed) to the appropriate claim address listed above.

If you fail to include **all** requested information, the form will be returned to you as soon as a determination has been made that requested information is missing, but in no event more than 30 days after the claim form was initially received from you.

It is your responsibility to provide the service providers with information about your coverage under the Plan and about their responsibility to file all claims with CIGNA. The information necessary for filing claims appears on the identification card that has been provided to you.

PAYMENT OF CLAIMS
All claims will be processed for payment as soon as possible. However, no claim can be paid until all information necessary to process that claim has been received. If it is determined that additional information is required from you or on your behalf, you will be given 45 days in which to provide any missing information necessary to process the claim.

Once the information required to make a determination as to whether a claim is payable has been received, a decision will be made promptly and you will be notified regarding any benefit payments. In no event will the decision regarding payment be made more than 30 days after the claim has been fully and properly filed.

DEFINITIONS

The following definitions apply to terms used in this booklet.

ACCIDENT or ACCIDENTAL BODILY INJURY. When used in connection with Medical Expense Benefits is defined as a traumatic injury caused solely by mischance, without intent or volition, resulting indirectly and independently of all other causes and incurred while covered under this Plan.

ALLOWABLE EXPENSE. Any necessary, Reasonable and Customary item of expense which is covered, wholly or partially, under at least one of the Plans covering the person for whom the claim is made. Allowable expenses include expenses which would have been paid by another plan if all conditions of that plan had been satisfied.

AMBULANCE or AMBULANCE SERVICE. A licensed company with a recognized vehicle for the transportation of the sick or injured to a Hospital. Eligible Charges include only professional ambulance service for local transport to and from the place the disability was contracted to a Hospital equipped to furnish special treatment necessary for the disability. "Local" is defined as the immediate geographic area in which the disability occurred.

CALENDAR YEAR DEDUCTIBLE or CYD. The amount of Covered Charges that must be paid by a Covered Individual each calendar year before Plan benefits will be applied to any remaining Covered Charges for the rest of that year. The calendar year deductible amount is described in the Schedule of Benefits in this booklet.

CHARGE. A "Charge" shall be deemed to be incurred on the date on which the particular service, treatment or supply giving rise to such charge is rendered or obtained. In the absence of due proof to the contrary, when a single charge is made for a series of services, treatments or supplies, each item shall be deemed to bear a pro rata share of the charge.

CHILDREN. The Eligible Employee's natural children, stepchildren, legally adopted children, children placed for adoption with the Employee (irrespective of whether the adoption has or does become final), and children for whom the Eligible Employee has been awarded legal guardianship by a court of competent jurisdiction.

a) With respect to adoptions, placement for adoption, and legal guardianship the Child must not have attained age eighteen (18) as of the date of such adoption, placement for adoption or order of legal custody in order to qualify as the Eligible Employee's Child for Plan purposes.
b) The term "placed for adoption", for purposes of this definition, means the assumption and retention by the Eligible Employee of a legal obligation for total or partial support of such child in anticipation of adoption of such child. A placement for adoption of a child with the Employee terminates upon the termination of such legal obligation.

COINSURANCE. The percentage of remaining Covered Charges payable by the Plan, after application of all Deductibles and Co-Pay amounts.

COLLECTIVE BARGAINING AGREEMENT. Any negotiated labor contract between an employer and the Union which requires the Participating Employer to contribute to this Fund, and any amendment, modification or renewal thereof.

CO-PAYMENT or CO-PAY. A set dollar amount payable by the Covered Individual to a PPO Provider at the time a treatment or service is rendered. The Co-Pay does not apply toward any Deductible or out-of-pocket maximum. For prescription drugs, the Co-Pay is the amount of the cost of the prescription which is payable by the Covered Individual to the pharmacy at the time the prescription is purchased.

COSMETIC SURGERY. Surgery or services rendered for the alteration of tissue for the improvement of a person's appearance rather than improvement or restoration of bodily function.

COVERED CHARGE. The lesser of the actual billed Charge or the Reasonable and Customary Charge or the applicable amount negotiated by the Provider Network for Medically Necessary expenses, as defined in the booklet, which are furnished upon the recommendation and approval of the attending Physician.

COVERED EMPLOYMENT. Any hours worked for a Participating Employer for which the Participating Employer is obligated to make contributions to the Fund pursuant to a Collective Bargaining Agreement.

COVERED INDIVIDUAL. An Eligible Employee or Eligible Retiree and his or her Eligible Dependents.

CUSTODIAL CARE. Care which is designed primarily for the maintenance or assistance of daily living and which does not require the continuous attention of trained medical or paramedical personnel. Such care may involve preparation of special diets, supervision over medication that can be self-administered and assistance getting in and out of bed, walking, dressing, and eating.

DEDUCTIBLE. The amount of Covered Charges that must be paid by a Covered Individual before Plan benefits will be applied to any remaining Covered Charges. In addition to the Calendar Year Deductible, there may be deductibles that apply to certain services, admissions and/or visits.

DISABLED. Means the individual is unable to perform his or her occupational duties due to pregnancy, Non-Occupational Illness or Injury for a limited period of time.

DURABLE MEDICAL EQUIPMENT. Equipment for the treatment of a medical condition which is (i) necessary for the medical treatment of a disease or injury, as certified in writing by the attending Physician; (ii) serves a therapeutic purpose with respect to the condition being treated in accordance with accepted medical practice; (iii) is truly durable in nature and made to withstand repeated use, such as a wheelchair; and (iv) does not have a value to the patient or members of the patient's family in the absence of the condition for which the equipment is prescribed.

ELIGIBLE DEPENDENT. The following are considered as "Eligible Dependents" for purposes of this Plan:

a) Your legal spouse.
b) Children of an Eligible Employee who are:
    i) under 19 years of age;
    ii) 19 years of age or over, but have not attained their 26th birthday, who are not eligible for group health coverage through their own employer;
    iii) 19 years of age or over, but have not attained their 26th birthday, who are participating in the Union's apprenticeship program and are not eligible for group health coverage through their own employer, except as provided under this Fund.
    iv) Required to be covered by the Eligible Employee pursuant to the terms of a Qualified Medical Child Support Order within in the meaning of ERISA, 29 U.S.C. §1169; or
    v) 26 years of age or over and are mentally or physically disabled and incapable of self-sustaining employment, provided that such disability occurred prior to the age at which they otherwise would have ceased to be an Eligible Dependent under this Plan, and the Child is dependent upon the Employee for support and maintenance provided the Trustees receive adequate proof of such incapacity and dependency initially and on a continuing basis as required by the Plan.

See Active Plan Eligibility Requirements for more information on Qualified Medical Child Support Orders.

ELIGIBLE EMPLOYEE. An Employee or Inside Employee who is eligible for benefits under the Plan by having satisfied the eligibility requirements outlined in this booklet.

ELIGIBLE RETIREE. A former Employee or former Inside Employee who is eligible for benefits under the Plan by having met the eligibility requirements outlined in the booklet.

EMPLOYEE. An employee who is working in a job classification for which Participating Employers are required, under the terms of the current Collective Bargaining Agreements, to make certain contributions to the Fund.

EXCLUSIONS AND LIMITATIONS. Certain Charges, services or supplies which are limited or excluded from payment under this Plan.

EXPERIMENTAL or INVESTIGATIONAL. Any treatment, procedure, facility, equipment, drugs, drug usage, or supplies that is not recognized as having scientifically established medical value, or that does not meet generally accepted standards of medical practice.

FUND. Colorado Finishing Trades Health and Welfare Fund.

HOSPITAL. A legally constituted and operated institution which:

a) Is primarily engaged in providing, for compensation from its patient and on an In-Patient basis, diagnostic and therapeutic facilities for surgical and medical diagnosis, treatment and care of injured or sick persons by or under the supervision of a staff of Physicians;
b) Continuously provides 24-hour-a-day nursing services by registered graduate nurses; and
c) Has a laboratory, x-ray equipment and operating rooms where major surgical operations may be performed or can provide emergency and surgical services through a contract with another licensed Hospital.

The term "Hospital" also includes:

a) A legally constituted and operated long term acute care facility which provides diagnostic and medical treatment or rehabilitation to patients with chronic disease or complex medical conditions for an extended period of admission (typically 20 days or more); or
b) To the extent that such benefits are provided under this Plan, a facility providing inpatient treatment of Mental Health Conditions or substance abuse.

In no event, however, shall the term "Hospital" include any institution or part thereof which is used, other than incidentally, as a place for rest, a place for the aged, a nursing home, a hotel or the like.

HOUR BANK. Any covered hours of employment in excess of the required hours for satisfaction of eligibility will be credited to the hour bank. The hours in an individual hour bank account may be used to continue eligibility for benefits during periods in which the Employee may not have worked sufficient hours with a Participating Employer to maintain eligibility.

IN-NETWORK. A healthcare provider or facility that is participating in the Provider Network.

INSIDE EMPLOYEE. An individual who is employed by a Participating Employer and upon whose behalf contributions to the Fund are made under a Participation Agreement. Also referred to as Non-Bargaining Employee.

LIFE THREATENING EMERGENCY. For purposes of this Plan, "Life Threatening Emergency" means the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to result in serious and immediate impairment of the individual's body functions or the ability to regain maximum function, or in death.

MEDICALLY NECESSARY/MEDICAL NECESSITY. A service or supply that meets all of the following conditions:

a) Is consistent with the symptom or diagnosis and treatment of the patient's illness or injury;
b) Is appropriate with regard to standards of good medical practice and recognized by an established medical society in the United States;
c) Is not considered Experimental by an established medical society in the United States;
d) Is not solely for the patient's convenience or that of his Physician of the facility at which the patient receives treatment; and

e) Is specifically allowed by the licensing statutes that apply to the provider who renders the service.

MEDICARE. The program established by Title XVIII of the Social Security Act (Federal Health Insurance for the Aged) as it is constituted on the effective date of the Policy and may subsequently be amended.

MENTAL HEALTH CONDITION. A neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

NON-OCCUPATIONAL ILLNESS OR INJURY. An illness or injury that does not arise out of (or in the course of) any work for pay or profit, nor in any way results from such work for pay or profit. However, if proof is furnished to the Trustees that an individual covered under a Workers' Compensation law (or other law of similar purpose), is not covered for a particular illness under that law, that illness will be considered a Non-Occupational Illness regardless of its cause.

In the event an Employee claims that an illness or injury is work related and the employer disputes this contention, the Trustees agree to be bound by the final decision of any court or commission which determines the issue. In the event a legal determination is not sought in such case, the Trustees may decide whether the illness or injury is occupational or a Non-Occupational Illness or Injury. In the event payments are made under this Plan for a condition later determined to be occupational and compensable under any Workers' Compensation or similar law, the Employee receiving the payments is obligated to pay back to the Trustees the amount of benefits received from any settlement or judgment obtained.

NON-PARTICIPATING PROVIDER or NON-NETWORK or NON-PPO. A Hospital, Physician, pharmacy or other service provider who has not entered into a contractual agreement with the Plan for the purpose of furnishing health care services.

NURSE. A Registered Nurse (RN), Licensed Practical Nurse (LPN), or a Nurse's Aide if the Aide is supported at least three times per week by a Registered Nurse.

PARTICIPATING EMPLOYER. Any corporation, partnership, proprietorship or other business entity that is obligated to make contributions to the Fund in accordance with the provisions of a written Collective Bargaining Agreement in force with the Union and the Union on behalf of its salaried employees or retired salaried employees, if any.

PARTICIPATING PROVIDER or IN-NETWORK or PPO. A Hospital, Physician, pharmacy or other service provider participating in the Provider Network that has entered into a contractual agreement with the Plan for the purpose of furnishing health care services.

PHYSICIAN. A Doctor of Medicine (M.D.), a Doctor of Osteopathy (D.O.), a Doctor of Podiatric Medicine (D.P.M.), a Doctor of Chiropractic (D.C.), a Doctor of Dental Surgery (D.D.S.), Doctor of Medical Dentistry (D.M.D.), or licensed psychologist (Ph.D.) practicing within the scope of his license and who is licensed to practice as such in the State in which treatment is rendered.

PLAN. Colorado Finishing Trades Health and Welfare Fund.

PROVIDER NETWORK. A network of providers including Hospitals, Physicians and other health service providers who have agreed to pre-negotiated Charges through a contractual agreement between the Board of Trustees and the Provider Network. This Fund currently uses the CIGNA PPO Network for medical claims.

PREGNANCY. Pregnancy, miscarriage, abortion, childbirth, or complication from pregnancy, miscarriage, abortion or childbirth. For purposes of this Plan, pregnancy will be considered as a Non-Occupational Illness and will be covered for Eligible Employees and their Eligible Dependent spouses only.

REASONABLE AND CUSTOMARY. The amount usually charged by eligible facilities and providers for a given service or supply, which is within the range of usual fees or prices charged for a similar service or supply within the same geographical area, and which is reasonable in light of the circumstances and medical condition(s) involved. When determined by this Fund, the "Reasonable and Customary" Charge for each particular service or supply shall be determined by the Claims Administrator on the basis of statistical data furnished by FAIR Health and will allow for differences in Charges due to differences in experience, education and skill level required for the performance of the particular service due to the medical circumstances.

RETIREE. A former Employee or former Inside Employee who has retired from employment with his or her employer, who is eligible for retirement benefits under Social Security or a qualified retirement plan associated with the Union, and who was an Eligible Employee at the time of such retirement.

ROOM AND BOARD. All Charges for room and board, general duty nursing, and other Charges which are made by the Hospital or other facility as a condition of occupancy of the class of accommodations occupied. "Room and Board" does not include Charges for professional services of Physicians, or charges for intensive nursing care.

SEMI-PRIVATE. The standard Charge by the Hospital for semi-private Room and Board accommodations, or the average of such Charges where the Hospital has more than one established level of Charges;

TOTALLY DISABLED. The complete inability of an Employee to perform each and every duty pertaining to his occupation, provided that an Employee shall not be deemed to be Totally Disabled during any period in which he is engaged in any other occupation for compensation or profit. The term "totally disabled", as it is applied to a dependent, means the complete inability of a dependent to perform each and every activity of a person of like age and sex in good health.

TRUSTEES, BOARD OF TRUSTEES OR BOARD. The persons designated to serve as Trustees of the Fund in accordance with the provisions of the Agreement and Declaration of Trust of the Colorado Finishing Trades Health and Welfare Fund.

UNION. Includes:

a) Carpet, Linoleum and Resilient Tile Layers Local 419;

b) Glassworkers and Glaziers Local Union No. 930;

c) Painters and Drywall Finishers Local Union No. 79; and

d) Any other union, authorized by the Board of Trustees to participate in the Fund, as provided by the Trust Agreement.

PLAN A SCHEDULE OF BENEFITS
(Glassworkers & Glaziers and Floor Coverers)

The benefits shown are those which were in effect as of January 1, 2013.
The Schedule of Benefits is subject to change by vote of the Board of Trustees.

COMPREHENSIVE MAJOR MEDICAL BENEFITS		
BENEFIT	**CIGNA PPO PROVIDERS**	**NON-PPO PROVIDERS**
CALENDAR YEAR DEDUCTIBLE (CYD) ▪ Per Individual/Family (3x for family)	$500/$1,500	$1,000/$3,000
The CYD is the amount of Covered Charges which must first be incurred during each year before benefits are payable by the Plan. All Covered Charges are subject to the CYD except In-Network Office Visits and In-Network Preventive Care Services. Non-PPO Charges do not apply toward satisfaction of the PPO Deductible and vice versa.		
EMERGENCY ROOM DEDUCTIBLE ▪ Per Occurrence (waived if admitted)	$100	$100
Emergency Room Covered Charges will be paid at the Coinsurance Percentage following application of the Emergency Room and Calendar Year Deductibles. The Emergency Room Deductible is applied per occurrence and will be waived if the patient is admitted to the Hospital within 24 hours of the emergency room visit.		
COINSURANCE PERCENTAGE ▪ After Deductibles ▪ After Reaching Max. Out-of-Pocket	 Plan pays 80% Plan pays 100%	 Plan pays 60% Plan pays 100%
The Coinsurance Percentages shown above will apply to all Covered Charges unless a benefit specific Coinsurance level is listed below (i.e., charges paid at 100% after Co-Pays and Non-PPO Chiropractic paid at 60%). All Charges for emergency services in the event of a life or limb threatening emergency will be paid at the PPO Provider level.		
MAXIMUM OUT-OF-POCKET ▪ Per Individual per Calendar Year	$10,000 in Covered Charges	$10,000 in Covered Charges
Charges applied toward the Calendar Year Deductible and Co-Pays do not apply toward satisfaction of the Maximum Out-of-Pocket amount. This amount is a combined total of PPO and Non-PPO Charges. Once met, the Plan will pay 100% of Covered Charges for the remainder of the calendar year, subject to Plan maximums.		
MAXIMUM ANNUAL BENEFITS PAYABLE ▪ Per Individual	$1,250,000	$1,250,000
MAXIMUM LIFETIME TRANSPLANT RELATED TRAVEL BENEFITS PAYABLE		
▪ Transplant Related Travel	$10,000	$10,000
PPO PHYSICIAN OFFICE VISITS Includes all services billed directly by Physician that are provided at the time of office visit.	Plan pays 100% after $25.00 Co-Pay, no CYD	Does Not Apply
PREVENTIVE CARE SERVICES Subject to standard age/frequency guidelines	Plan pays 100% after $25.00 Co-Pay, no CYD	Plan pays 60% after CYD
OUTPATIENT DIAGNOSTIC X-RAY/LAB ▪ Quest or LabCorp ▪ Other Providers	 Plan pays 80%, no CYD Plan pays 80% after CYD	 Does not Apply Plan pays 60% after CYD
CHIROPRACTIC BENEFITS ▪ Coinsurance ▪ Maximum	 100% after $25.00 Co-Pay 30 visits/year	 Plan pays 60% after CYD 30 visits/year
OTHER BENEFIT LIMITATIONS ▪ Kidney Dialysis ▪ Hospice Care ▪ Non-Surgical Treatment of Feet • Orthotics for Dependent Children ▪ Vision Therapy	 400 treatments per lifetime Maximum 30 days payable $500 per Calendar Year 1st $200 Paid at 100% $500 per Calendar Year	 400 treatments per lifetime Maximum 30 days payable $500 per Calendar Year 1st $200 Paid at 100% $500 per Calendar Year

PRESCRIPTION DRUG BENEFITS[1]		
BENEFIT	**RETAIL**	**MAIL ORDER**
CO-PAYMENTS[2]		
▪ Generic Drugs	$ 7.00	$ 14.00
▪ Brand Name Drugs	$ 30.00	$ 60.00
▪ Specialty Drugs (i.e., injectables)[3]	20% up to a maximum of $100	20% up to a maximum of $100
Dispensing Limitation	34-day supply	90-day supply
[1]Prescription Drug Benefits are not available for Retirees/Retiree Spouses who are over 65 or otherwise Medicare eligible.		
[2]If you choose to go to a Non-Participating pharmacy, you must pay 100% of the cost of the prescription to the pharmacy and then file a claim or reimbursement by the Plan.		
[3]For Specialty Drugs the one fill will be allowed at retail, and then additional fills must be obtained through the Specialty pharmacy.		

DENTAL REIMBURSEMENT BENEFIT (not available for Medicare Eligible Retirees)

The Fund will reimburse covered expenses at 100% up to the stated maximum.

Dental Reimbursement Maximum* – Per Family $2,000 per Calendar Year

* Does not apply to preventive care services for Eligible Dependent Children under the age of 19. Refer to page 41 for details on covered services.

VISION BENEFITS

Vision benefits are provided through an insured contract with VSP. Please refer to your VSP benefit summary for information on the benefits specifics and how to locate a participating VSP provider. You can also contact VSP at 1-800-877-7191 for additional information.

INCOME PROTECTION BENEFITS			
BENEFIT	**Eligible Employees**	**Eligible Dependent Spouses**	**Eligible Dependent Children**
LIFE INSURANCE[1]	$ 20,000	$ 5,000	$ 2,500
ACCIDENTAL DEATH & DISMEMBERMENT[1]	$ 20,000	N/A	N/A
WEEKLY DISABILITY (Active Bargaining only)	$150 per Week for up to 13 weeks	N/A	N/A
[1]Beginning at age 65, the amount of Life Insurance and AD&D benefits will be reduced. Please refer to the Life Benefits section of this SPD for more information on the age reduction schedule. Benefits for Eligible Dependent Children terminate at age 23.			

PLAN B SCHEDULE OF BENEFITS
(Painters)

The benefits shown are those which were in effect as of January 1, 2013.
The Schedule of Benefits is subject to change by vote of the Board of Trustees.

COMPREHENSIVE MAJOR MEDICAL BENEFITS		
BENEFIT	**CIGNA PPO PROVIDERS**	**NON-PPO PROVIDERS**
CALENDAR YEAR DEDUCTIBLE (CYD) ▪ Per Individual/Family (3x for family)	$1,000/$3,000	
The CYD is the amount of Covered Charges which must first be incurred during each year before benefits are payable by the Plan. All Covered Charges are subject to the CYD except PPO Office Visits, PPO Preventive Care Services, and outpatient x-ray/lab (unless provided at a Hospital). CYD does apply to advanced imaging, such as MRI, CAT scans and PET scans).		
EMERGENCY ROOM DEDUCTIBLE ▪ Per Occurrence (waived if admitted)	$250	$250
Emergency Room Covered Charges will be paid at the Coinsurance Percentage following application of the Emergency Room and Calendar Year Deductibles. The Emergency Room Deductible is applied per occurrence and will be waived if the patient is admitted to the Hospital within 24 hours of the emergency room visit.		
COINSURANCE PERCENTAGE ▪ After Deductibles ▪ After Reaching Max. Out-of-Pocket	 Plan pays 70% Plan pays 100%	 Plan pays 50% Plan pays 100%
The Coinsurance Percentages shown above will apply to all Covered Charges unless a benefit specific Coinsurance level is listed below (i.e., Charges paid at 100% after Co-Pays and Non-PPO Chiropractic paid at 70%). All Charges for emergency services in the event of a life or limb threatening emergency will be paid at the PPO Provider level.		
MAXIMUM OUT-OF-POCKET ▪ Per Individual per Calendar Year	$10,000 in Covered Charges	$15,000 in Covered Charges
Charges applied toward the Calendar Year Deductible and Co-Pays do not apply toward satisfaction of the Maximum Out-of-Pocket amount. This amount is a combined total of PPO and Non-PPO Charges. Once met, the Plan will pay 100% of Covered Charges for the remainder of the calendar year, subject to Plan maximums.		
MAXIMUM ANNUAL BENEFITS PAYABLE ▪ All Medical - Per Individual	$1,250,000	$1,250,000
PPO PHYSICIAN OFFICE VISITS Includes all services billed directly by Physician that are provided at the time of office visit.	Plan pays 70% after $25.00 Co-Pay, no CYD	Does Not Apply
PREVENTIVE CARE SERVICES Subject to standard age/frequency guidelines	Plan pays 100%, no CYD after $25.00 Co-Pay	Plan pays 50% after CYD
ROUTINE (PREVENTIVE) COLONSCOPY	Plan pays 70%, no CYD	Not Covered
OUTPATIENT DIAGNOSTIC X-RAY/LAB ▪ Quest or LabCorp ▪ Other Providers	 Plan pays 70%, no CYD Plan pays 70%, after CYD	 Does not Apply Plan pays 50% after CYD
CHIROPRACTIC BENEFITS ▪ Coinsurance ▪ Maximum	 Plan pays 70%, after CYD $500 per Calendar Year	 Plan pays 70%, after CYD $500 per Calendar Year
OTHER BENEFIT LIMITATIONS ▪ Kidney Dialysis ▪ Hospice Care ▪ Inpatient Hospital Facility Charges ▪ Skilled Nursing Facility Room and Board ▪ Licensed Birthing Facility ▪ Home Health Care	 400 treatments per lifetime 30 days per lifetime N/A $70/day, 70 days/Cal. Year $1,500 per occurrence $2,500 per disability	 400 treatments per lifetime 30 days per lifetime $500 per day $70/day, 70 days/Cal. Year $1,500 per occurrence $2,500 per disability

OTHER BENEFIT LIMITATIONS (cont.)		
▪ Non-Surgical Treatment of Feet	$500 per Calendar Year	$500 per Calendar Year
▪ Vision Therapy	$500 per Calendar Year	$500 per Calendar Year
▪ Transplant Related Travel	$10,000 per transplant	$10,000 per transplant

PRESCRIPTION DRUG BENEFITS[1]		
BENEFIT	**RETAIL Reimbursable through Medical Benefits**	**MAIL ORDER Through Drug Card Program**
CALENDAR YEAR DEDUCTIBLE (CYD)	$1,000 Medical CYD applies	None
CO-PAYMENTS		
▪ Generic Drugs	Plan pays 70%, after CYD	You pay $ 10.00
▪ Preferred Brand Name Drugs	Plan pays 70%, after CYD	You pay $ 20.00
▪ Non-Preferred Brand Name Drugs	Plan pays 70%, after CYD	You pay $ 40.00
▪ Specialty Drugs (i.e., injectables)[2]	Plan pays 70%, after CYD	You pay 20% up to a maximum of $100 per prescription
Dispensing Limitation per Co-Payment	34-day supply	90-day supply
[1]Prescription Drug Benefits are not available for Retirees/Retiree Spouses who are over 65 or otherwise Medicare eligible.		
[2]For Specialty Drugs the one fill will be allowed at retail, and then additional fills must be obtained through the Specialty pharmacy.		

INCOME PROTECTION BENEFITS (Not available for COBRA or Retiree Participants)	
BENEFIT	**Eligible Employees**
LIFE INSURANCE[1]	$ 20,000
ACCIDENTAL DEATH & DISMEMBERMENT[1]	$ 20,000
[1]Beginning at age 65, the amount of Life Insurance and AD&D benefits will be reduced. Please refer to the Life Benefits section of this SPD for more information on the age reduction schedule.	

COMPREHENSIVE MAJOR MEDICAL EXPENSE BENEFIT

For All Eligible Employees, Retirees and Their Eligible Dependents

Major Medical Expense Benefits become payable if a Covered Individual incurs Covered Charges that are in excess of the Deductible amount. All Covered Charges are subject to the Calendar Year Deductible unless otherwise specified. The Deductibles, Co-Pays, and maximum amounts are applied separately for each Covered Individual unless otherwise specified.

The following will describe in more detail the benefits shown in the Schedule of Benefits.

CIGNA PPO In-Network Providers

In-Network providers means a network of health care providers, including Hospitals, Physicians and other facilities, which provide services at discounted or fixed rates to participating members. This Fund has contracted with the **CIGNA PPO Network.** In-Network providers help ensure that you have access to the most cost-effective care without sacrificing quality. To be eligible for the In-Network discounts, present your medical ID card, identifying you as a member of the CIGNA PPO network, each time you visit a provider.

Below are some suggestions for obtaining the maximum benefit from your In-Network providers:

- Always use a participating provider. A directory of CIGNA PPO providers is available on-line at www.cignasharedadministration.com. Remember, the In-Network providers continue to be updated, so please check to make sure your doctor is In-Network every time you need care. For more information on finding a CIGNA PPO provider, contact CIGNA at **1-800-768-4695**.
- If hospitalization is necessary, ask your doctor to admit you to an In-Network Hospital. To obtain the full level of benefits, your Hospital admission must be precertified. You or your provider should call 1-800-768-4695 to start the precertification process.
- If you need to see a specialist, ask your doctor to refer you to another CIGNA PPO provider.
- Before a Hospital stay, confirm that the anesthesiologist, pathologist and radiologist providing services to you are also In-Network providers.

What if there is not a CIGNA PPO In-Network Provider available?

Covered Charges for services by a Non-Network provider in an area where access to an In-Network provider is not reasonably available will be payable at In-Network benefit levels. If possible, prior approval of use of the Non-Network provider should be obtained before receiving services. The Plan may require you to provide evidence sufficient to establish that an In-Network provider was not reasonably available.

PRECERTIFICATION OF HOSPITAL ADMISSIONS

Precertification is required for all Hospital admissions. Please refer to the General Provisions section for information on how to obtain precertification. If precertification is not obtained, payment of benefits will be reduced by $300.

CALENDAR YEAR DEDUCTIBLE

The Calendar Year Deductible is the amount to be paid in cash for services or supplies for treatment of an illness or injury or other covered condition before Plan benefits become payable. Only Covered Charges may be used to meet the Calendar Year Deductible. Physician Office Visit Co-Pays and non-

covered Charges are not applied toward the deductible. Certain expenses, as identified in the schedule of benefits, may be payable without application of the Calendar Year Deductible.

The Calendar Year Deductible is computed annually for each Covered Individual for whom major medical benefits are claimed. Any Covered Charges incurred during the final three months of a calendar year and subsequently applied to a Covered Individual's deductible, will be carried over toward satisfaction of the next calendar year's Deductible.

If two (2) or more Covered Individuals in the same family incur expenses for Covered Charges as the result of a common Accident, expenses for all Covered Individuals will be pooled and once the individual level of the Calendar Year Deductible has been met, the Calendar Year Deductible will have been deemed to have been met for the year in which the Accident occurred, for each Covered Individual involved, for all Covered Charges relating to the same Accident.

EMERGENCY ROOM DEDUCTIBLE

The Emergency Room Deductible is an amount in addition to the Calendar Year Deductible that must be satisfied for each visit to an emergency room before benefits will be payable. This Deductible will be waived if the patient is admitted to the Hospital from the emergency room.

COINSURANCE PERCENTAGE

Once a Covered Individual has satisfied all applicable Deductibles, the Plan will pay the appropriate Coinsurance Percentage, as specified in the Schedule of Benefits, of remaining Covered Charges incurred by that person during the remainder of the calendar year. The Covered Individual is responsible for payment of any remaining Covered Charges after application of the Coinsurance Percentage.

The level of Coinsurance Percentage may vary depending on whether a provider is In-Network (PPO) or Non-Network (Non-PPO). However, in instances where a Covered Individual receives services provided by a Non-PPO assistant surgeon, anesthesiologist or physician assistant when the services are rendered at a PPO Hospital and the primary surgeon is a PPO Provider, such Charges will be payable at the In-Network benefit levels. Services provided by a Non-PPO Physician in the emergency room of a PPO Hospital will also be payable at the In-Network benefit levels.

MAXIMUM BENEFIT PER LIFETIME

This is the maximum amount of major medical benefits payable for an individual by the Fund.

MAXIMUM OUT-OF-POCKET

If your eligible out-of-pocket expenses paid during one calendar year reach this level, your remaining major medical eligible expenses will be paid at 100%, not to exceed your Maximum Benefit per Calendar Year. The following expenses do not apply towards your out-of-pocket maximum: In-Network Physician office Co-pays, Charges applied toward calendar year, emergency room or Hospital admission Deductibles, and non-covered Charges.

PPO OFFICE VISIT CO-PAYMENTS

When you go to a primary care or specialist Physician's office and that provider is In-Network (PPO), all services provided at the time of that office visit and billed directly by the Physician on the same bill as the office visit itself will be subject to the PPO Physician Office Visit benefits outlined in the Schedules of Benefits. These Charges will be subject to a flat dollar Co-Payment and then paid at the Coinsurance percentage shown. The Calendar Year Deductible does not apply to these Charges.

COVERED CHARGES

Covered Charges are the amount of expenses to which the benefits available under the Plan will be applied. Covered expenses include only those Medically Necessary Covered Charges, as defined in the booklet, which are furnished upon the recommendation and approval of the attending Physician. Expenses in excess of Reasonable and Customary or the applicable amount negotiated by the In-Network providers will not be considered a Covered Charge.

Covered Charges are described as follows and are subject to the limitations described herein and as outlined in the Schedules of Benefits. Unless noted otherwise, these descriptions apply to both Plan A and Plan B (Painters) benefits.

1. **Appliances and Nursing Care and Physician Assistant**. Charges payable under Hospital benefits shall not be payable under this benefit. Covered Charges include:
   a. Insulin pumps, supplies and maintenance of such equipment where the patient has Type I or II diabetes and has:
      1) Completed a comprehensive diabetes education program;
      2) Been on multiple daily injections of insulin (at least 3 per day) with frequent self-adjustments of insulin for at least 6 months;
      3) Documented in a written log the frequency of glucose self-testing (an average of 4 times a day during the 2 months prior to the pump);
      4) Meets one (1) or more of the following while on a daily injection regimen:
         a) HBA1c greater than 7%;
         b) History of recurring hypoglycemia;
         c) Wide fluctuations in blood glucose before mealtimes;
         d) Dawn phenomenon with fasting blood sugars frequently exceeding 200mb; and/or
         e) History of severe glycemic excursions.

         and;
      5) Provided written documentation from the Physician addressing whether the above guidelines have been met.
   b. The rental (not to exceed purchase price) of a wheel chair, hospital bed and other similar Durable Medical Equipment. When determined by the Board of Trustees that purchase of Durable Medical Equipment would be less expensive than the rental thereof, or such equipment is not available for the rental, such purchase may be authorized by the Board of Trustees.
   c. Prosthetic devices (excluding replacements, repairs and maintenance).
   d. Casts, splints and surgical dressings.
   e. Oxygen and rental of oxygen equipment.
   f. Services of a registered nurse (RN), Licensed Practical Nurse (LPN) or licensed physiotherapist, except Charges made by one who normally resides in the Covered Individual's home or who is the wife, husband, child, brother, sister or parent of the eligible individual.
   g. Services of a Physician Assistant who is under the direct supervision of a Physician for the performance of medical services, including the prescribing of non-controlled substances, when the Physician does not see the patient or become directly involved in the medical service being provided.

2. **Blood and Blood Plasma**. Charges for blood and blood plasma, if not replaced.
3. **Chiropractic Benefits**. Chiropractic benefits are payable for office visits, examinations, manipulations, modalities, diagnostic x-ray and laboratory services for treatment of spinal maladjustments or subluxation only.
4. **Chronic Conditions of the Foot (non-surgical)**. The Plan will provide benefits for non-surgical Charges for chronic foot conditions, including orthotics. Chronic conditions of the foot include, but may not be limited to: callus or corn paring; toenail trimming or excision for toenail trimming; weak or fallen arches; flat or pronated foot metatarsalgia or foot strain; orthopedic shoes; supportive devices of the feet (arch support/heal lifts).
5. **Contact Lenses**. Charges incurred for contact lenses which are required because of surgery.
6. **Cosmetic Surgery**. Charges incurred in connection with Cosmetic Surgery which are necessary for:
   a. The prompt repair (within 90 days) of an Accidental Bodily Injury which is a Non-Occupational Injury occurring while the individual is a Covered Individual; or
   b. Repair of an abnormal congenital condition in a Dependent child where such condition has resulted in a functional defect.
7. **Dental**. Charges made by a dentist or oral surgeon for the treatment of accidental damage to sound natural teeth which have not been extensively restored or become extensively decayed or diseased, if the damage results from an Accident and the Charges are incurred within ninety (90) days of the Accident.
8. **Diagnostic X-ray and Laboratory**. Benefits are payable for X-ray and laboratory examinations for diagnosis of a sickness or due to an Accidental Bodily Injury.
9. **Home Health Care**. Covered Charges include only the Charges for any of the following medical services furnished on a visiting basis in a private residence (not necessarily the residence of the patient) for treatment of a Covered Individual's Accidental Bodily Injury or disease, when a Physician determines home care is necessary in lieu of inpatient hospitalization and such home care is provided by a home health agency recognized by Medicare:
   a. Home health aide services (part-time or intermittently) under the supervision of a registered nurse (R.N.) or a medical social worker and that are solely for the care of the patient;
   b. Respiratory and inhalation therapy;
   c. Professional nursing services provided by a registered nurse (R.N), a licensed practical nurse (LPN), or a licensed vocational nurse (LVN);
   d. Physical therapy, occupational therapy, or speech therapy and audiology; and
   e. Nutritional counseling by a registered dietitian.

   Home Health Care benefits will not be provided for the following services:
   a. A masseur, physical culturist or physical education instructor;
   b. Routine housekeeping chores, which are not necessary to prevent or postpone the Covered Individual's hospitalization, or similar services which would materially increase the amount of time required for the visit unnecessarily; and
   c. Any services rendered to the Covered Individual which could have been provided by any other properly trained person of the household without endangering the Covered Individual's life or seriously impairing his condition.
10. **Hospice Care**. If a Physician certifies that a Covered Individual is a Terminally Ill Patient, the Plan will pay for Covered Charges during any Hospice Benefit Period up to the maximum specified in the Schedule of Benefits. Hospice Care Covered Charges include:

d. The Charge, not to exceed Hospital benefits, of Hospice Care for the inpatient confinement of a Covered Individual.

e. The Charge for home Hospice Care furnished to the Covered Individual in a private residence (not necessarily the residence of the Covered Individual). The Covered Charges for home Hospice Care include:

1) services of a home health aide;

2) professional services of a registered nurse (RN), licensed practical nurse (LPN);

3) physical and respiratory therapy;

4) nutrition counseling and special meals;

5) services of a licensed or certified social worker for medical social services rendered during a Hospice Benefit Period not to exceed a maximum of **six (6) visits**.

The Plan will not pay for more than a total of **eight (8) days** of inpatient care for Respite Care per lifetime. No benefits will be paid for Hospice Care that is rendered by volunteers or individuals who do not normally charge for their services.

11. **Hospital Benefits**. Hospital benefits include the following:

a. The Hospital's Charge for its daily average Semi-Private room rate.

b. Hospital Charges for routine nursery care of a newborn child.

c. Confinement in an Intensive Care Unit, Critical Care Unit or Coronary Care Unit.

d. All other Hospital services and supplies for medical care and treatment, provided during confinement of a Covered Individual as a registered inpatient, excluding Charges for private duty nursing.

e. Charges for professional Ambulance service to transport a Covered Individual to or from a local Hospital or Skilled Nursing Facility where treatment is given. Air Ambulance is recognized if the Covered Individual's condition cannot be managed in the locale where the injury or illness occurs or due to the patient's critical condition.

f. When Hospital confined as a registered inpatient, for the treatment of a Mental Health Condition.

Coverage of Hospital Charges for long term acute care facility services require the Covered Individual to be receiving medical case management services by a vendor contracted by the Fund.

12. **Hospital Outpatient Benefits**. Hospital Charges for medical services or supplies provided during outpatient care of a Covered Individual resulting from Accidental Bodily Injury, sickness or surgery. Charges for medical services and supplies provided during outpatient surgery will be considered Hospital Charges if the Charges are made by a Licensed Ambulatory Surgical Center. Treatment received from a Licensed Ambulatory Surgical Center shall be limited to the twenty-four (24) hour period immediately following the surgical procedure performed.

13. **Injections**. Benefits are payable for Charges incurred on an outpatient basis for medical injections which are medically diagnosed as directly related to the disability or illness. This benefit does not include routine immunizations or routine injection treatments for allergies. PLAN A ONLY: Covered Charges are not subject to the Plan's Deductible or Coinsurance requirements and are payable at 100%.

14. **Medical Services**. Benefits are payable for medical services rendered by a Physician as follows:

a. Daily Physician visits when confined in a Hospital as a registered inpatient at a time when Hospital, Skilled Nursing Facility or Rehabilitation Facility Room and Board benefits are payable.

b. Office visits and consultations.

c. Physician's visits at a place other than a Hospital or Physician's office.

15. **Mental Health Conditions, Alcoholism and Drug Addiction**.

a. Outpatient. Benefits are payable for services rendered by a Physician to a Covered Individual, and Covered Charges for services by a Licensed Social Worker or Masters of Social Work if under the direct supervision of a Physician, for the outpatient treatment of a Mental Health Condition, alcoholism or drug addiction. Includes family or marital counseling.

b. Inpatient. Benefits are payable for services rendered when Hospital confined as a registered inpatient, for the treatment of Mental Health Condition or alcoholism or drug addiction.

16. **Organ Transplant Benefit**. The Plan will pay for Covered Transplant Procedures, as defined in this section, if all of the requirements of this section are met. Covered Transplant Procedures are payable if the recipient receives two (2) opinions from unrelated facilities or Physicians on the need for transplant surgery. The opinions must be given by a board certified specialist in the involved fields of surgery and in writing. The specialist must certify that alternative procedures, services or courses of treatment would not be effective in the treatment of the Covered Individual's condition. The Covered Individual must have no concurrent terminal disease.

Covered Transplant Procedures include:

a. Covered organ transplant procedures are heart, heart-lung, liver, lung (single and double), pancreas, kidney, pancreas and kidney combined, cornea and small intestine.

b. Allogeneic, autologous (including autologous bone marrow transplant in breast cancer and testicular cancer), syngeneic, and peripheral stem cell bone marrow transplant procedures are covered if the transplant procedure is used to treat leukemia, lymphoma, blood and genetic diseases and solid tumors. These procedures are not covered if the condition, illness or disease which necessitated the transplant was caused by any human T-cell leukemia virus.

c. Reimbursement for medical expenses related to the harvest of bone marrow or acquisition of peripheral stem cells for a covered bone marrow transplant procedure will be limited to expenses incurred for the following services:

1) Services for the harvest or acquisition of bone marrow or peripheral stem cells;

2) Hospitalization for up to two (2) days for bone marrow puncture;

3) Processing and storage of bone marrow or peripheral stem cells, but limited to the first thirty (30) days of expenses incurred for processing or storage services;

4) Purging or manipulation of bone marrow or blood;

5) Other services directly related to or part of the harvest or acquisition services covered under (a), (b), (c) or (d) above.

6) No harvest or acquisition expenses described under (a), (b), (c), (d) and (e) above are covered unless, and no reimbursement of such expenses will be made until after, the bone marrow transplant infusion is performed.

d. Circulatory assist device implants, hepatic assist device implants, kidney only and cornea transplants.

e. Subject to a limit of $200 per day and a maximum of $10,000 per Transplant procedure, the Plan will pay necessary expenses transportation, lodging and meals for the transplant patient and one companion, or two companions if the transplant patient is a minor, and the procedure is being performed at a PPO facility or a facility requested through a Plan sponsored program (such as case management or stop-loss insurance) and such facility is located more than 50 miles from the Covered Individual's home address.

17. **Prescription Drugs**. Includes:
    a. Drugs and medicines dispensed by an institution covered by the Plan while the Covered Individual is confined as inpatient or is being treated as outpatient.
    b. Medicines received and administered in a Physician's office, including injectable contraceptives.
    c. For PLAN B (Painters) ONLY – Legend drugs, insulin and diabetic supplies, lancets, and compounded medications where at least one ingredient is a legend drug prescribed by a Physician and obtained on an outpatient basis at a retail pharmacy. (For PLAN A retail pharmacy benefits, see page 36.)
18. **Pregnancy Benefits**. Plan benefits are payable for Charges incurred, by a female Eligible Employee or Dependent spouse of an Eligible Employee, as a result of Pregnancy, childbirth or a related condition.
    a. Plan benefits shall be payable for a complication of pregnancy for any covered female.
    b. Benefits are payable for care received in a licensed birthing center up to the maximum stated in the schedule of benefits, including Charges of a certified nurse/midwife.
    c. This Plan 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 forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section, or require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods. This Plan does not prohibit the discharge of the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) as applicable) provided the mother and the Physician (nurse midwife, or Physician Assistant) are in agreement.
19. **Preventive Care Benefits**. Subject to the limits shown in the Schedule of Benefits (including any limits on coverage to PPO Providers), this benefit includes routine preventive care procedures and immunizations, subject to generally accepted age and frequency guidelines.
20. **Radiotherapy/Chemotherapy**. Benefits are payable for radiotherapy, including the use of X-ray, radium, cobalt and other radioactive substances. Benefits are also payable for chemotherapy services.
21. **Reconstruction Following a Mastectomy**. Benefits are payable in accordance with Plan provisions for reconstructive surgery following a mastectomy, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of all stages of mastectomy, including lymphedemas.
22. **Rehabilitation Facility.** Covered Charges incurred as a result of confinement in a Rehabilitation Facility.
23. **Routine Colorectal Cancer Screening**. Plan benefits are payable for Charges incurred for routine preventive screening for colorectal cancer for Covered Individuals age fifty (50) or older in accordance with one of the following testing regimens:
    a. Yearly fecal occult blood test (FOBT) or fecal immunochemical test (FIT); or
    b. Flexible sigmoidoscopy once every 5 years; or
    c. Yearly FOBT or FIT, plus one flexible sigmoidoscopy every five (5) years; or
    d. Double contract barium enema once every five (5) years; or
    e. Colonoscopy once every 10 years.

    Benefits paid for Routine Colorectal Cancer Screening will not accumulate toward any yearly maximum benefit on physicals or preventive care benefits.
24. **Skilled Nursing Facility**. Covered Charges for confinement in a Skilled Nursing Facility are payable as follows:
    a. Room and Board Charges.

b. Services and supplies charged and furnished by the Skilled Nursing Facility, excluding services of a private duty nurse or Physician.

Such benefits are payable by the Plan provided a Physician certifies in writing that such confinement and services are in lieu of hospitalization and that such services are necessary for the treatment by the Physician of the injury or sickness.

25. **Surgery/Anesthesia**. Covered Charges for the following surgical services are payable:

a. Professional surgical services rendered by the operating Physician in the performance of a surgical procedure.

b. Professional surgical services rendered by an assistant surgeon, in the performance of a surgical procedure, not to exceed 20% of the amount allowed for the operating surgeon. The Plan will pay a benefit equal to the fee charged, not to exceed 10% of the amount allowed for the operating surgeon for the services of a legally licensed and qualified Physician Assistant or surgical assistant who is acting in the stead of an assistant surgeon as part of the surgical team.

c. Anesthesia services (including cost of anesthetics) rendered by a Physician or professional anesthetist in connection with a surgical procedure.

d. When multiple or bilateral procedures, which add significant time or complexity to patient care, are provided at the same operative session, the total amount allowed shall be 100% of the individual allowed amount for the major procedure plus 50% of the amount allowed for each lesser procedure.

e. When an incidental surgical procedure (such as incidental appendectomy, lysis or adhesions, excision of previous scar or a puncture of an ovarian cyst) is performed through the same surgical incision, the amount payable by the Plan shall be that of the major procedure only.

26. **Transportation**. Covered Charges include:

a. Charges actually made by an Ambulance Service which customarily renders Ambulance transportation in the course of its business for transportation of a Covered Individual from the place where he or she is injured by an Accident or stricken by an illness to the nearest Hospital where treatment is given for such injury or illness.

b. Charges for emergency transportation within the continental United States and Canada, and within Puerto Rico and Hawaii.

27. **Therapies**. Occupational Therapy, Physical Therapy (including aquatic Physical Therapy) or therapeutic massage therapy services prescribed by a Physician are payable up to two (2) consecutive months when in the judgment of the Physician significant improvement can be obtained.

Need for additional therapy must be certified by the attending Physician to be Medically Necessary and Reasonable. Benefits are not payable for therapeutic massage therapy, Occupational Therapy or Physical Therapy (including aquatic Physical Therapy) services to maintain function at the level to which it has been restored, or when no further significant practical improvement can be expected. Physical Therapy (including aquatic Physical Therapy), therapeutic massage therapy, and Occupational Therapy which are prescribed by a Physician in lieu of non-medical treatment (e.g., exercise) are not considered Medically Necessary and Reasonable treatment and are not payable by the Plan.

When prescribed or provided by a Physician, the following types of therapy are covered:

a. Occupational Therapy performed by a properly accredited occupational therapist (OT) or certified occupational therapy assistant (COTA).

b. Physical Therapy performed by a Physician or a registered physical therapist.

c. Therapeutic massage therapy performed by a properly certified therapist.

d. 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.

28. **Treatment for Morbid Obesity**. Benefits will be allowed for treatment, including prescription drugs, education by a dietician or nutritionist, surgical treatments such as gastric stapling or bypass, and behavioral when:

    a. The obesity is determined to be endogenous; and

    b. The person is considered to be morbidly obese according the Body Mass Index (BMI) scale.

    Treatments must be prescribed by a physician and benefits will not be allowed unless written authorization is received in advance from the Administrative Office. Approval for surgical treatments may require satisfaction of other generally accepted medical guidelines as established by the precertification coordinator.

29. **Vision Therapy**. The Plan will provide benefits for vision therapy.

PRESCRIPTION DRUG CARD BENEFIT

For All Eligible Employees, Non-Medicare Eligible Retirees and Their Eligible Dependents

This benefit for retail and mail order prescriptions is available through **EnvisionRx**. This benefit is not available to Retirees/Retiree Spouses who are over age 65 or are otherwise eligible for Medicare.

Benefits are only available for prescriptions purchased at a pharmacy participating in the EnvisionRx network or through Envision's mail order service. Call 1-800-361-4542 for confirmation of any pharmacy's participation.

Please refer to the Schedule of Benefits for **Coinsurance** and **Days Supply** details.

IMPORTANT INFORMATION REGARDING GENERIC DRUGS

If you or your doctor request a prescription be filled with a brand name drug when there is an equivalent generic alternative available, you will be required to pay the generic Coinsurance plus the difference in cost between the brand name and the generic.

FILLING PRESCRIPTIONS THROUGH MAIL ORDER

Mail Order can be used to conveniently obtain up to a 90-day supply of maintenance medications (those medications which you use on a long term basis). Typically a mail order prescription will be slightly less expensive than purchasing three 30-day supplies at a retail pharmacy. For information on EnvisionRx's mail order program through Orchard Pharmaceutical Services, contact Orchard at 1-866-909-5170 or visit online at www.orchardrx.com.

Mail Order prescriptions can be submitted to:

Orchard Pharmaceutical Services
PO Box 3094
North Canton, OH 44720

Your physician can call in your prescriptions to the Orchard Mail Order Pharmacy at 1-866-909-5170. Refills can be ordered by contacting Orchard at the above phone numbers, through their website at **www.orchardrx.com**, or by mailing in a refill form to the above address.

If your doctor is prescribing a maintenance medication that you would like to receive through mail order, be sure to inform him or her to fill out the prescription accordingly. If it is a new prescription, you may wish to have a second prescription for a 30-day supply that you can have filled at a retail pharmacy while submitting your new prescription to the Orchard Mail Order Pharmacy.

PRIOR AUTHORIZATION

Certain drugs may require prior authorization before a prescription can be processed under the drug card benefit. Please contact as necessary at 1-800-361-4542.

FILING A PAPER CLAIM

If you do not have your card at the time you purchase a prescription, you can send a paper claim to:

Envision Pharmaceutical Services, Inc.
2181 East Aurora Road, Suite 201
Twinsburg, OH 44087

SERVICES NOT COVERED

1. Prescriptions obtained at a pharmacy not participating in the EnvisionRx network;
2. Drugs for cosmetic purposes only;
3. Drugs available without a prescription, except insulin;
4. Allergens or allergy injections;
5. Emergency Contraceptives (such as Preven or Plan B);
6. Drugs for treatment of erectile dysfunction/impotency;
7. Prescription drugs when there is an equivalent available without prescription;
8. Prescription smoking cessation products, including nicotine gum and patches;
9. Medications prescribed for treatment of a substance abuse disorder (drugs and alcohol);
10. Infertility medications;
11. Appetite suppressants or diet pills;
12. Medical supplies and equipment (except syringes and needles for the administration of insulin and other self-administered injectables);
13. Drugs not prescribed by a provider acting within the scope of his or her license;
14. Experimental, Investigational or unapproved drugs;
15. Replacement prescriptions and relating supplies resulting from loss or theft;
16. Injectable drugs that require Physician supervision and are not typically considered self-administered drugs. Examples of physician supervised drugs are injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents.
17. Dietary supplements or fluoride products.
18. Biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis;
19. Drugs used to enhance athletic performance;
20. Growth hormones;
21. Prescriptions more than one year from the original date of issue.

COORDINATION OF BENEFITS FOR PRESCRIPTION DRUGS

The Coordination of Benefits provisions outlined in this SPD do not apply to the prescription drug benefit. This Plan does not cover prescription drugs on a secondary basis, with the exception of prescription drugs which are covered by Medicare Part B and for which Medicare Part B is the “primary”

plan. Those Medicare Part B prescription Charges can be filed under the Major Medical benefits for secondary payment.

EXCLUSIONS AND LIMITATIONS

Applicable to all Medical and Prescription Drug Benefits

No benefits will be payable for or in connection with (a) any Charges which are not specifically included within the definition of "Covered Charges" or (b) any of the following, unless specifically allowed elsewhere in this SPD:

1. Charges which are not deemed to be Medically Necessary.
2. Charges in excess of Reasonable and Customary.
3. Charges incurred which are not necessary for the treatment of an illness or injury, except as specifically provided under "Covered Charges."
4. Charges for medical care not recommended and approved by a Physician.
5. Charges for any medical care received while not covered under this Plan.
6. Charges for drugs prescribed for cosmetic purposes only, drugs available without a prescription, smoking cessation products, appetite suppressants, or Experimental, Investigational or unproven drugs.
7. Charges incurred for Custodial Care.
8. Charges incurred in connection with confinement to any institution or part thereof used principally as a rest facility, a facility for the aged, chronically ill, drug addicts or alcoholics, or as a facility providing primarily Custodial, or educational care, except as specifically provided.
9. Charges which would not have been made in the absence of this coverage or for which the Covered Individual is not legally obligated to pay, or which are furnished without Charge or which are reimbursable by or through a national, state or political subdivision, agency or arm thereof.
10. Charges incurred due to Injury or Illness resulting from or sustained as the result of being engaged in (i) an illegal occupation, commission of or attempted commission of an assault or felonious act, unless such Injury or Illness is the result of domestic violence or the commission or attempted commission of a crime that is the direct result of an underlying health factor, (ii) participation in a riot, (iii) duty as a member of the Armed Forces of any State or Country, or (iv) war or act of war whether declared or undeclared. The Plan Administrator's discretionary determination that this exclusion applies will not be affected by any subsequent official action or determination with respect to prosecution of the Participant (including, without limitation, acquittal, or failure to prosecute) in connection with the acts involved.
11. Charges for the treatment of an occupational disease or injury.
12. Charges incurred due to Injury or Illness arising out of or in the course of any occupation or employment for wage or profit, for which the Covered Individual is entitled to any benefits under a Worker's Compensation Act or similar legislation.
13. Charges for any non-emergency treatment or supplies provided outside of the United States.
14. Charges of an organ donor if the donee is not a Covered Individual, unless such Charges are included in the global fee arrangement or case rate negotiated for the transplant and charged to the Covered Individual receiving the transplanted organ, and animal or artificial organ transplants.
15. Charges incurred for treatment on or to the teeth except as specifically described otherwise in this Summary Plan Description.

16. Charges for the treatment of cranio-mandibular disorders which include temporo-mandibular joint dysfunctions (TMJ), oral rehabilitation, orthognathic surgery, orthodontic movement, subteriosteal and endosseous implants.
17. Charges for dental or orthodontic treatment, except as specifically covered elsewhere in this Summary Plan Description and as covered under the Dental Benefits for Plan A.
18. Charges incurred for services or supplies which constitute personal hygiene, comfort or beautification items, regardless of intended use or even if prescribed by a Physician, including purchase or rental of supplies of common use such as exercise machines, air purifiers, air conditioners, water purifiers, hypoallergenic pillows or mattresses, water beds or tanning beds.
19. Charges for maintenance, repair or replacement of any Durable Medical Equipment.
20. Charges for continued rental of any Durable Medical Equipment once the total amount of rental Charges has reached the initial purchase price of said equipment.
21. Charges for recreational, educational or occupational therapy, including handbooks, videotapes, etc.
22. Charges for speech therapy, except as specifically provided under "Covered Charges."
23. Charges for eye examinations, contact lenses (except for contact lenses when required because of surgery) or fitting of glasses.
24. Charges for orthopedic shoes or supportive devices for the feet, such as arch supports, heel lifts, etc., except as specifically described otherwise in this Summary Plan Description.
25. Charges for hearing examinations, hearing aids or the fitting thereof.
26. Charges for acupuncture and massage therapy.
27. Charges for routine foot care.
28. Charges for genetic screening, except for those tests which are medically necessary for the diagnosis and treatment of certain types of cancer.
29. Charges for genetic counseling.
30. Charges for dental implants.
31. Charges for professional services, regardless of type, by a member of the immediate family of the Covered Individual or the Covered Individual's spouse.
32. Charges incurred as the result of diagnosis or treatment of Pregnancy with respect to a Dependent Child, except for treatment of complication resulting from pregnancy.
33. Charges for medical and Hospital care costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
34. Charges incurred for the removal of an organ or portion of an organ for donor purposes, unless such Charges are included in the global fee arrangement or case rate negotiated for the transplant and charged to the Covered Individual receiving the transplanted organ
35. Charges for medical care, services or supplies received or furnished in connections with, or as a result of, any Cosmetic Surgery, except as specifically provided under "Covered Charges."
36. Charges for nursing expenses, except as provided under "Covered Charges."
37. Charges for infertility services including infertility drugs, surgical or medical treatment programs for infertility.
38. Charges for the reversal of sterilization.
39. Charges for blood or blood plasma for which the Hospital or other supplier makes a refund of allowance to or on behalf of the Covered Individual, either as a result of a group blood bank, a private donor, or otherwise.
40. Charges for Experimental procedures.
41. Charges for enrollment in a health, athletic, weight loss, non-smoking, or other such program.
42. Charges for Radial Keratotomy or Keratoplasty.

43. Any Charges for Hospital Room and Board and general nursing care when the individual is admitted primarily for diagnostic study or medical observation when the necessary care can be provided on an outpatient basis.
44. Charges for Hospital Room and Board and general nursing duties for Hospital admittance on a weekend or holiday unless significant medical treatment is provided on those days.
45. Charges for expenses incurred for inpatient Hospital confinement after it has been determined by the Plan's precertification coordinator that inpatient Hospital confinement is no longer Medically Necessary, provided that the appeal process afforded by such coordinator has been exhausted by the Covered Individual.
46. Charges for medical care in connection with any procedure involving a voluntary embryo transfer.
47. Charges relating to a surgical sex transformation, sexual dysfunction or inadequacies.
48. Charges relating to services or expenses for biofeedback and any other form of self-care or self-help training.
49. Charges related to travel, whether or not recommended by a Physician.
50. Charges for the treatment of obesity, weight control or dietary control, except morbid obesity as specifically specified elsewhere in this Summary Plan Description.
51. Charges for special formulas, food supplements, food extracts, special diets, laetrile, vitamins, enzymes, nutrition counseling and any treatment or services rendered for or in connection with Pre-Menstrual Syndrome (PMS).
52. Charges for humidifiers, air conditioners, exercise equipment, whirlpools, health spas, swimming pools, air filtration units, vaporizers, heating lamps or pads, lift or contour chairs, vibrating chairs or beds, breast pumps, or blood pressure monitors or machines, whether or not prescribed by a Physician.
53. Charges for hair loss or restoration.
54. Charges for foreign travel immunizations.
55. Charge for wheelchair ramps, handrails or other specialized construction in or around the home; or commode, bath bench, or other convenience items for activities of daily living; batteries or routine maintenance of equipment or repair of wheelchair upholstery.
56. Charges for reports or appearances in connection with legal proceedings whether or not an Injury or Illness is involved; for Physician's telephone consultations and/or travel time; Charges in connection with shipping, handling, postage, internet or finance.
57. Charges for examinations or consultations provided by any public or private school or halfway house, or by employee thereof, or provided solely to satisfy institutional requirements.
58. Charges incurred through Medicare private contracting arrangements.
59. Charges for services or supplies resulting from injuries suffered by a Covered Individual in an automobile accident up to $10,000 or such higher amount as may be available for reimbursement to a Covered Individual under automobile medical payment insurance coverage, whether or not the Covered Individual has such coverage.
60. Charges provided by a Social Worker or the like, except as specifically provided under item 15 in Covered Charges.
61. Charges for completion of a claim form.
62. Charges for failure to keep a scheduled visit.
63. Charges which would not have been made if the person had no insurance.
64. Charges of any kind for which a claim is submitted for consideration that is more than twelve (12) months after the date which services were performed, or for which a claim is not properly submitted.

DENTAL REIMBURSEMENT BENEFIT

For All Eligible PLAN A Employees, Non-Medicare Eligible Retirees and Their Eligible Dependents (Glassworkers & Glaziers and Floor Coverers Only)

Under this benefit, the Plan will reimburse you at 100% for your out-of-pocket expenses for dental care received from any licensed dental/orthodontic provider, up to the Maximum Benefit amount as shown in the Schedule of Benefits.

Preventive and diagnostic services, as described below will not be subject to the Maximum Benefit for Eligible Dependent Children under the age of 19.

Preventive and diagnostic services include:

- Oral exams (Two per year);
- Routine cleanings (Two per year);
- Full mouth X-rays (one complete set every three years);
- Bitewing X-rays (Two per year)
- Panoramic X-ray (One every three years);
- Fluoride application (one per year);
- Sealants (limited to posterior teeth; one treatment per tooth every three years);
- Space Maintainers (limited to non-orthodontic treatment);

LIMITATIONS AND EXCLUSIONS APPLICABLE TO DENTAL BENEFITS

Benefits shall not be payable for any expense for dental procedures or supplies to the extent that payment is received from any group policy or prepayment plan (individual policies are not affected by this limitation);

VISION BENEFIT

For All Eligible PLAN A Employees, Retirees and Their Eligible Dependents (Glassworkers & Glaziers and Floor Coverers Only)

Vision benefits are available through an insured contract with VSP. For information on your VSP benefits, please contact them directly at 1-800-877-7191 or visit them online at www.vsp.com. For a copy of your VSP benefit brochure, you can also contact the Administrative Office at 303-745-1941 or 1-800-659-0841.

COORDINATION OF BENEFITS (COB)

This section applies if you or any one of your Dependents is covered under more than one plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each plan. Because of the growing number of group health plans (private and government) and the increasing number of two-income families, more and more people are becoming covered under two group health plans.

These coordination of benefits, or COB, provisions have been designed to control over-payments. The COB provisions in this Plan are integrated with all other group health plans, but not with an individual's personal health insurance policies.

Under the COB provision, if you or your Eligible Dependents also have coverage under another group health plan (or in the case of gainfully employed spouse, if that spouse is eligible to be covered under another group health plan offered by his or her employer, regardless of whether or not the spouse is enrolled in such coverage), the total benefits received by any one patient from all the plans combined may not amount to more than 100% of the allowable expenses. "Allowable expenses" are any necessary, Reasonable and Customary service or expense, including Deductibles, Coinsurance or Co-Payments, which are covered in full or in part by any Plan covering you. Payments will be reduced only the extent necessary to prevent an individual from making a profit on his group health coverage. You must report duplicate health coverage on your Claim Forms which you submit to secure reimbursement of the medical expenses.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- If you are confined to a private hospital room and no Plan provides coverage for more than a Semi-Private room, the difference in cost between a private and Semi-Private room is not an Allowable Expense.
- If you are covered by two or more Plans that provide services or supplies on the basis of Reasonable and Customary fees, any amount in excess of the highest Reasonable and Customary fee is not an Allowable Expense.
- If you are covered by one Plan that provides services or supplies on the basis of Reasonable and Customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the primary Plan's fee arrangement shall be the Allowable Expense.
- If your benefits are reduced under the primary Plan (through the imposition of a higher Co-Payment amount, higher Coinsurance percentage, a Deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

DEFINITIONS UNDER COORDINATION OF BENEFITS

The **Primary Plan** is the Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

The **Secondary Plan** is the Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

The Reasonable Cash Value is an amount which a duly licensed provider of healthcare services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

WHEN A PARTICIPANT IS COVERED BY TWO PLANS, WHICH PLAN PAYS FIRST

If the Plan does have a Coordination of Benefits rule, the first of the following rules that applies to the situation is the one to use:

- The Plan that covers you as an enrollee will be the Primary Plan and pays first, and the Plan that covers you as a Dependent will be the Secondary Plan.
- If an individual is covered under two plans through two jobs, the plan which has covered the employee for the longer period of time is the primary plan and pays first.
- If the claim is for a Dependent child whose parents are not divorced or legally separated, the Primary Plan will be the Plan that covers the parent whose birthday falls first in the calendar year as an enrollee or employee. For example, if your birthday is April 26, and your spouse's birthday is October 13, then claims for your Eligible Dependent Children should be submitted first to your plan. The application of this rule has nothing to do with age, only to the date in the calendar year on which your birthday falls.
- If the claim is for a Dependent of divorced or separated parents, benefits for the Dependent will be determined in the following order:
  1) First, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of the actual knowledge;
  2) Then, the Plan of the parent with custody of the child;
  3) Then, the Plan of the spouse of the parent with custody of the child;
  4) Then, the Plan of the parent not having custody of the child;
  5) Finally, the Plan of the spouse of the parent not having custody of the child.
- When another plan does not contain a COB provision, it will always be considered the primary plan. Payment under the secondary plan is made after the benefits from the primary plan have been paid. Such payment will be limited to the amount necessary to reimburse the individual for not more than 100% of Allowable Expenses. However, in some cases, the combined benefits may not pay 100% of your bills since you will only receive up to the stated maximums in each plan.
- If none of the above rules apply, then the plan which has covered the Participant for the longer period of time shall be considered the primary plan.

MEDICARE COORDINATION OF BENEFITS

Coordination of benefits with Medicare is subject to regulations and guidelines published by the Federal Government.

1. **Medicare Secondary for Active Eligible Employee or Spouse Age 65 or Older**. Any benefits for health care expenses which are payable for an Eligible Employee or Spouse who is eligible for Medicare will not have benefits coordinated with Medicare unless he or she has elected to have Medicare as primary coverage. This does not apply to an individual who is, or would be upon application, entitled to benefits as a result of end stage renal disease.
2. **Medicare Secondary for Disabled Covered Individual who is Under Age 65.** An Eligible Employee, Eligible Retiree, or Eligible Dependent, who is eligible for Medicare as a result of total and permanent disability will not have such benefits under the Plan coordinated with Medicare unless he has elected to have Medicare as his primary coverage. This does not apply to an individual who is, or would be upon application, entitled to benefits as a result of end stage renal disease.
3. **End Stage Renal Disease ("ESRD") Beneficiary.** Benefits will be payable under the Plan without regard to an Eligible Employee's or Eligible Dependent's entitlement to Medicare if such person is

entitled to Medicare as an ESRD beneficiary, and not more than 30 months have elapsed since the earliest of the following:

a) The month in which the Eligible Employee or Eligible Dependent began a regular course of renal dialysis;
b) The month in which the Eligible Employee or Eligible Dependent received a kidney transplant;
c) The month in which the Eligible Employee or Eligible Dependent was admitted to a Hospital in anticipation of a kidney transplant that was performed within the next two months; or
d) The second month before the month in which the kidney transplant was performed, if performed more than two months after Hospital admission.

4. **All Other Circumstances.** Under any circumstance other than discussed in 1, 2, and 3 above, the benefits will be reduced by the amount of benefits provided – or which would have been provided had the covered person been enrolled under all parts of Medicare – for those same expenses under Medicare.

ELIGIBILITY REQUIREMENTS

WHO IS ELIGIBLE?

All Employees working in a job classification for whom Participating Employers are required, under the terms of a current Collective Bargaining Agreement, to make contributions to the Colorado Finishing Trades Health and Welfare Fund. Such Employees will become eligible upon satisfaction of the initial eligibility and continuing eligibility provisions set forth below. This section is broken up into five sections as follows:

- **ACTIVE EMPLOYEES.** This section describes the eligibility requirements for active, bargaining unit Employees.
- **RETIRED EMPLOYEES.** This section describes the eligibility requirements applicable to retired bargaining unit Employees.
- **NON-BARGAINING ELIGIBILITY – ACTIVE INSIDE EMPLOYEES**. This section describes the eligibility requirements applicable to active Non-Bargaining Employees.
- **NON-BARGAINING ELIGIBILITY – RETIRED INSIDE EMPLOYEES**. This section describes the eligibility requirements applicable to retired Non-Bargaining Employees.
- **GENERAL ELIGIBILITY PROVISIONS.** This section describes the general eligibility provisions that apply regardless of Union affiliation, including when benefits become effective, termination of benefits, enrollment procedures, COBRA Continuation Coverage and coverage pursuant to Child Support Orders.

ACTIVE EMPLOYEES

INITIAL ELIGIBILITY

If you are not currently eligible, you will become eligible on the first day of the second calendar month following any period of not more than four (4) consecutive calendar months in which you work a total of at least three hundred ninety (390) hours of Covered Employment for one (1) or more Contributing Employers. For example, if you work at least 390 hours in the consecutive 4 month period of January through April, you would become eligible for benefits on June 1st. The month between the last month of the work period (April in the above example) and the month for which you are covered (June in the above example) is called the "lag month." This lag month allows time for Contributing Employer reports to be received and processed.

CONTINUING ELIGIBILITY – THE HOUR BANK

Once you become initially eligible, all hours worked in Covered Employment for a Contributing Employer will be credited to your Hour Bank, including any hours worked in excess of the 390 hours needed for your Initial Eligibility. One hundred thirty (130) hours of work credit will be deducted from your Hour Bank for each month of continued coverage. To continue the example above, if you have at least 130 hours credited to your Hour Bank for work in May, your coverage for benefits will continue for the month of July. As with Initial Eligibility, there is a lag month between the work month and the coverage month to allow for receipt and processing of contributions.

If you have more than 130 hours in your Hour Bank, those hours can accumulate to be used to help maintain eligibility during short periods of illness or seasonably low periods of employment. The

maximum number of hours you can have in your Hour Bank is five hundred twenty (520) hours after deduction for the current month's coverage.

SELF-PAYMENT FOR INSUFFICIENT HOUR BANK CREDITS

If your Hour Bank contains fewer than the 130 hours needed to continue coverage but contains at least 120 hours, you can self-pay the difference up to a maximum of ten (10) hours in order to continue your coverage. Self-pay will be made at the prevailing contribution rate. If your Hour Bank contains fewer than 120 hours, you can continue your coverage through COBRA Continuation Coverage, as described in the General Eligibility Provisions section.

CONTINUATION OF ELIGIBIITY WHILE DISABLED

If you are covered for benefits at the onset of a disability and you become continuously Disabled for more than thirty (30) days, no deduction will be made from your Hour Bank from the first day of the month in which your disability begins until the earlier of 1) the first day of the month following the month in which you are no longer Disabled or 2) the first day of the month following six (6) continuous months of continued eligibility under this provision. In other words, your Hour Bank will be "frozen" and the entire program of health and welfare benefits will remain in effect for you and your Eligible Dependents for up to six (6) months with no deduction from your Hour Bank. It is your responsibility to notify the Administrative Office of your disability.

REINSTATEMENT OF ELIGIBILITY

In the event your eligibility terminates due to lack of the required number of Hour Bank credits, you will have a period of four consecutive months following your termination to work enough hours in Covered Employment to bring your Hour Bank balance up to a minimum of 130 hours. If the minimum 130 hour balance is restored during this 4-month period, your eligibility will be reinstated on the first day of the second month following the month in which you worked the needed hours. If coverage is not reinstated after the 4-month period, all remaining hours in your Hour Bank will be forfeited and you will have to meet the Initial Eligibility requirements described above to regain eligibility. If your eligibility was terminated as a result of performing Covered Employment for a Non-Contributing Employer, for intentional misrepresentation (including misrepresentation regarding a Dependent's eligibility status), for defrauding the Fund, or for helping to defraud the Fund, you are not eligible for reinstatement under this provision.

RETIRED EMPLOYEES

RETIRED EMPLOYEE ELIGIBILITY

Eligibility for participation in the Retiree Plan is subject to the following requirements:

1. You must be eligible under the Fund through the Hour Bank provisions described above at the time of your retirement. Eligibility must be as an active Eligible Employee or through Self-Pay and cannot be through COBRA coverage.

AND

2. You must be awarded a pension from one of the following pension funds:
   - the International Painters and Allied Trades Industry Pension Fund;
   - the Southern California, Arizona, Colorado and Southern Nevada Glaziers, Architectural Metal and Glassworkers Pension Plan; or
   - the Resilient Floor Covering Pension Fund

OR

3. If you have not been awarded a pension from one of the above pension funds, you must meet ALL of the following requirements:

   a) You have been an active participant under the Collective Bargaining Agreement of the Union for at least five (5) years immediately preceding your date of retirement and there is no lapse in coverage from active participation to retiree participation; and
   b) You have had contributions made on your behalf to the Fund in each of the five (5) years immediately preceding your date of retirement; and
   c) You have had adequate contributions made to the Fund on your behalf to provide eligibility for benefits in at least thirty-six (36) of the sixty (60) consecutive months immediately preceding your date of retirement; and
   d) At least eight (8) of the thirty-six (36) months of active eligibility must have been within the most recent twelve (12) months immediately preceding your date of retirement; and
   e) You must be a dues paying member of the Union or have a life membership in the Union; and
   f) You must not have elected COBRA Continuation Coverage under the Fund or you must have discontinued COBRA Continuation Coverage or exhausted the maximum continuation period.

Please Note: If you do not elect Retiree coverage under the Plan at the time your Active Coverage terminates, or if you terminate your Retiree coverage at any time, you will not be able to reinstate your Retiree coverage at a later date. The only way a Retiree may re-qualify for coverage is to meet the requirements for Initial Eligibility as an active Eligible Employee and then meet the eligibility provisions shown above.

RETIREE PREMIUMS

For coverage under the Plan, you must pay a monthly premium. These premiums are established by the Board of Trustees and are subject to change. Premiums are due by the first of the month and coverage will be terminated as of the first day of the month if the premium is not received by the last day of that month.

Please contact the Administrative Office for the current premium amounts.

Please Note: **While your coverage under the Plan will not terminate until the end of the month for which the premium is due, you will not be reflected as eligible until such time as the premium is received and recorded. This may result in the denial of claims and these claims will need to be refiled after your premium has been received. Providers calling to verify eligibility before your premium has been received may be informed that you are not eligible. To prevent these issues, please remit your premium at least two weeks prior to the beginning of the month.**

NON-BARGAINING ELIGIBILITY – ACTIVE INSIDE EMPLOYEES

WHO IS ELIGIBLE?

Active, Non-Bargaining Unit Employees of Participating Employers, who have signed a Participation Agreement, for whom contributions to the Fund have been received. Special Participating Employers must contribute on all Full-Time Non-Bargaining Employees. Full-Time hours qualification shall be as outlined in the Participation Agreement.

INITIAL ELIGIBILITY

You will become initially eligible under the Plan on the first day of the Benefit Month for which a contribution has been received by the Administrative Office. The first contribution will be made for the month immediately following the completion of sixty (60) days of employment.

CONTINUATION OF ELIGIBILITY

Once effective, your benefits will continue, subject to the terms and conditions of the Plan, for the next succeeding month, provided that the Administrative Office has received appropriate contributions on your behalf. Contributions received provide coverage for the following month (i.e., contributions due in January provide coverage for February). The contribution rate for Non-Bargaining Employees will be established by the Board of Trustees.

NON-BARGAINING ELIGIBILITY – RETIRED INSIDE EMPLOYEES

RETIRED EMPLOYEE ELIGIBILITY

Eligibility for participation in the Retiree Plan is subject to all of the following requirements:

1. You completely retiree from all work, services, employment, or consultation for wages, compensation, income or profit, whether as an employee, self-employed person, consultant or otherwise, within an industry represented by any Union under the Fund;
2. Upon retirement you must have been an Active Employee for a Participating Employer for five (5) continuous years immediately preceding your retirement; and
3. Your employer at the date of your retirement has been a Contributing Employer continuously during the five (5) continuous years immediately preceding your retirement; and
4. Your employer at the date of your retirement remains a Contributing Employer during the entire period of your coverage under the Retiree Plan or the employer goes completely out of business.

Please Note: If you do not elect Retiree coverage under the Plan at the time your Active Coverage terminates, or if you terminate your Retiree coverage at any time, you will not be able to reinstate your Retiree coverage at a later date. The only way a Retiree may re-qualify for coverage is to meet the requirements for Initial Eligibility as an active Eligible Employee and then meet the eligibility provisions shown above.

RETIREE PREMIUMS

For coverage under the Plan, you must pay a monthly premium. These premiums are established by the Board of Trustees and are subject to change. Premiums are due by the first of the month and coverage will be terminated as of the first day of the month if the premium is not received by the last day of that month.

Please contact the Administrative Office for the current premium amounts.

Please Note: **While your coverage under the Plan will not terminate until the end of the month for which the premium is due, you will not be reflected as eligible until such time as the premium is received and recorded. This may result in the denial of claims and these claims will need to be refiled after your premium has been received. Providers calling to verify eligibility before your premium has been received may be informed that you are not eligible.** To prevent these issues, please remit your premium at least two weeks prior to the beginning of the month.

GENERAL ELIGIBILITY PROVISIONS

WHEN YOUR BENEFITS BECOME EFFECTIVE

Your benefits will become effective for one month on the date you are eligible. Payment for medical expenses will be made only with respect to Charges which are incurred while the Employee or Retiree is eligible for benefits, except as may be specifically provided for under other provisions of this Plan.

WHEN ELIGIBLE DEPENDENT BENEFITS BECOME EFFECTIVE

Benefits with respect to Eligible Dependents become effective on the date they are eligible. Payment for medical expenses will be made only with respect to Charges which are incurred while the Eligible Dependent is eligible for benefits, except as may be specifically provided for under other provisions of this Plan.

DUAL COVERAGE

The Plan will coordinate when two Employees are married, but in no event will payment exceed 100% of Charges. Children of these Employees will also be coordinated with the same provision.

APPRENTICE DEPENDENT STATUS

An apprentices who qualifies as an Eligible Employee can also qualify as an Eligible Dependent for purposes of dual coverage, provided that the Apprentice meets the definition of an Eligible Dependent.

TERMINATION OF BENEFITS

Your benefits will terminate on the earliest of the following dates:

a) For bargaining Employees - The last day of month, if you fail to accumulate sufficient hours in your Hour Bank to continue coverage for the next month;

b) For Non-Bargaining Employees – The last day of the month, if you fail to have a benefit fund contribution made on your behalf for the next month;
c) The date that any required contribution is due and unpaid; or
d) The date the Plan is cancelled, terminated or discontinued in accordance with the respective terms.

Your benefits with respect to Eligible Dependents will terminate on the earliest of the following dates:

a) The date of termination of your benefits under the Plan, except that, in the event of your death, benefits with respect to your Eligible Dependents will be continued, subject to the other terms of the Plan, during the remainder of the month in which your death occurs and during any future months for which you would have been eligible based on accumulated hours prior to your death, including hours in your Hour Bank;
b) The date the Plan is amended so as to terminate the benefits of all Dependents; or
c) The date the dependent ceases to meet the definition of an Eligible Dependent under the Plan, except as specifically provided below.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

Federal law requires the Plan, in certain circumstances, to provide coverage for your children when you and your spouse divorce. The Plan must provide this coverage only if the Plan is served a Qualified Medical Child Support Order (QMCSO). If the Plan is served with a Medical Child Support Order, the Plan will review the Order in order to determine whether it is a "Qualified" Order. The Plan will provide to you, upon written request, a detailed statement of the Plan's process for determining whether the Order is qualified and the Plan's requirements for a "Qualified" Order.

A Qualified Medical Child Support Order means any judgment, decree, or order including approval of a settlement agreement which:

1. Issues from a Court of competent jurisdiction pursuant to a State's Domestic Relations Law;
2. Requires you to provide only the group health coverage available under the Plan for your children, even though you no longer have custody;
3. Clearly specifies your name and last known mailing address and the names and addresses of each child covered by the Order;
4. Provides a reasonable description of the coverage to be provided;
5. Specifies the length of time the Order applies and;
6. Identifies each plan affected by the Order.

These are the minimum requirements of a QMCSO. The Order must also meet other requirements of the Plan in order to be "Qualified". Please contact the Administrative Office for more information.

NATIONAL MEDICAL CHILD SUPPORT ORDER (NMCSO)

The Plan will also comply with National Medical Child Support orders promulgated pursuant to Section 401(b) of the Child Support Performance and Incentive Act of 1988; provided that the order specifies a Plan Participant by name and mailing address, contains the name and address of each alternate recipient (or the address of an official of a state or political subdivision that may be substituted for the alternate recipient), describes the coverage to be provided, and does not provide that the Plan provide any other type of form of benefit other than those types and forms provided under the Plan, and otherwise complies with the requirements of a NMCSO.

EXTENDED ELIGIBILITY FOR INCAPABLE DEPENDENTS

Eligibility providing benefits for medical care expenses may be continued beyond the limiting age for an Eligible Dependent child who is mentally or physically incapable of earning a living and who is dependent upon you for support and maintenance, provided that you furnish evidence of the dependent's incapacitation at least 31 days before the dependent reaches the limiting age.

Any benefits continued for such Eligible Dependent Children will terminate under any of the conditions described above, or, in any event, when the dependent ceases to be incapacitated, or at the end of the 31-day period after any requested proof of continued incapacity is not furnished.

COBRA CONTINUATION COVERAGE

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

WHAT IS COBRA CONTINUATION COVERAGE

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent Children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

QUALIFYING EVENTS

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent Children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;

- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

WHEN COBRA COVERAGE BECOMES AVAILABLE

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Colorado Finishing Trades Health and Welfare Fund, 2821 South Parker Road, Suite 1005, Aurora, Colorado 80014.

HOW COBRA COVERAGE IS PROVIDED

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their Children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and Children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the

60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Notice of the award of Social Security benefits must be provided to the Plan Administrator within 60 days of the date of the Social Security determination and before the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent Children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent Children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the **Administrative Office, 2821 South Parker Road, Suite 1005, Aurora, Colorado 80014 (1-800-659-0841).** For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

PLAN CONTACT INFORMATION

Colorado Finishing Trades Health and Welfare Fund
2821 South Parker Road, Suite 1005
Aurora, Colorado 80014
(303) 745-1941 or 1-800-659-0841

LIFE AND AD&D BENEFITS

As of January 1, 2013, Life Insurance and Accidental Death and Dismemberment (benefits are provided through an insured contract with ReliaStar Life Insurance Company (ReliaStar Life). This section is only a basic summary of the benefits and provisions of that insured contract. To request a copy of your life certificate or to view the group policy, please contact the Administrative Office at 303-745-1941 or 1-800-659-0841. Death benefits are paid to your beneficiary, all other benefits are paid to you. Life and AD&D benefits are not available for Retirees or if you are covered under COBRA Continuation Coverage.

BASIC LIFE INSURANCE, ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

Class	**Amount of Life Insurance***	**Full Amount of AD&D Insurance***
All Eligible Employees	$20,000	$20,000

* Beginning on and after your 65th birthday, ReliaStar Life decreases the amount of your insurance. ReliaStar Life pays a percentage of the amount otherwise payable as follows:

- From your 65th birthday to age 70, ReliaStar Life pays 65%,
- From your 70th birthday to age 75, ReliaStar Life pays 50%,
- From your 75th birthday and after, ReliaStar Life pays 30%.

Schedule of AD&D Benefits

Loss of life..... Full Amount
Loss of both hands, both feet or sight of both eyes ..... Full Amount
Loss of one hand and one foot..... Full Amount
Loss of speech and hearing in both ears..... Full Amount
Loss of one hand or one foot and sight of one eye ..... Full Amount
Loss of one hand or one foot or sight of one eye ..... 1/2 Full Amount
Loss of speech ..... 1/4 Full Amount
Loss of hearing in both ears ..... 1/4 Full Amount
Loss of thumb and index finger of same hand..... 1/4 Full Amount

Loss of hands or feet means loss by being permanently, physically severed at or above the wrist or ankle. Loss of sight means total and permanent loss of sight. Loss of speech and hearing means total and permanent loss of speech and hearing. Loss of thumb and index finger means loss by being permanently, physically, entirely severed. ReliaStar Life pays only one Full Amount while the Group Policy is in effect. If you have a loss for which you are paid ½ of the Full Amount, you will be paid no more than ½ of the Full Amount for the next loss.

ReliaStar Life does not pay a benefit for loss of use of the hand or foot or thumb and index finger.

DEPENDENT LIFE INSURANCE (GLASSWORKERS & GLAZIERS AND FLOOR COVERERS ONLY)

Class	**Amount of Life Insurance**
Spouse	$5,000
Child (each)	
- From birth but less than 6 months of age	$250
- 6 months but less than 19 years (or less than 23 years if student)	$2,500

WEEKLY DISABILITY BENEFITS

For Active Glassworker & Glazier and Floor Coverer Employees Only

DISABILITY

For purposes of eligibility for the Weekly Accident and Sickness Disability Benefit only, the term "Disability" is defined as being totally and continuously disabled as a result of an Accidental Bodily Injury or sickness such that the individual is prevented from performing each and every duty pertaining to that individual's occupation. Pregnancy and related events such as childbirth, abortion, and miscarriage are included in this definition.

WEEKLY BENEFIT

If an Eligible Employee becomes disabled as described above, the Plan will pay the weekly amount shown in the Schedule of Benefits for each full seven (7) day week that such Eligible Employee is disabled, subject to the limitations and provisions below. During partial weeks of total disability the benefit will be one-seventh (1/7) of the weekly disability amount for each day during such partial week that the Eligible Employee is disabled.

WHEN THE BENEFIT BEGINS

If you are Totally Disabled due to an Accident or sickness, and under the care of a legally qualified Physician, the Weekly Benefit will be paid to you beginning on the first day of an Accident and the eighth day of an illness.

MAXIMUM BENEFIT

Benefits are payable for up to 13 weeks during any disability as specified in the Schedule of Benefits.

SUCCESSIVE PERIODS OF DISABILITY

Two or more periods of disability are considered as one period for purposes of benefit payment unless, between periods of disability, you have returned to active full-time work for at least two (2) consecutive weeks, or unless the disabilities are due to causes entirely unrelated and begin after you have returned to full-time active work for at least one day.

EXCLUSIONS AND LIMITATIONS

No benefits shall be paid for:

1. Accidental injury or sickness resulting from war or any act of war, whether it is declared or undeclared.
2. Any period during which the Participant is not under the regular care and attendance of a Physician;
3. Accidental injury or sickness occurring while in the service of the armed forces of any country;
4. Any Accidental Bodily Injury or sickness which arises out of or occurs in the course of any occupation or employment for wage or profit, or for which the employee is entitled to benefits under any Workers Compensation of Occupational Disease law; or
5. Any intentionally self-inflicted injury or illness.

TAX INFORMATION

As a result of Federal legislation, Social Security Taxes are deducted from your weekly disability benefits at the time they are processed for payment to you. Benefits are taxable and should be reported on your tax return. The Administrative Office will mail you a tax form in January for the previous year's payments.

Weekly Disability claims should be filed with the Administrative Office. The Plan will not accept certification from a Chiropractor or Podiatrist for purposes of paying weekly disability benefits.

NOTE: Any participant shall not be eligible for Weekly Disability benefits during any period he or she is paying for COBRA or Retiree coverage. If you are applying for or receiving government sponsored unemployment benefits, be sure to inform the government agency of any weekly disability benefits you may be receiving so that these benefits can be properly coordinated.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date of Notice: ***January 1, 2013***

This Notice of Privacy Practices ("Notice") is made in compliance with the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). The *Colorado Finishing Trades Health and Welfare Fund* (the "Plan") is required by law to take reasonable steps to ensure the privacy of your Protected Health Information ("PHI"), as defined below, and to inform you about:

1. the Plan's uses and disclosures of PHI;
2. your privacy rights with respect to your PHI;
3. the Plan's duties with respect to your PHI;
4. your right to file a complaint with the Plan and with the Secretary of HHS; and
5. the person or office to contact for further information about the Plan's privacy practices.

The term "**Protected Health Information**" (PHI) includes all "Individually Identifiable Health Information" transmitted or maintained by the Plan, regardless of form (oral, written or electronic).

The term "**Individually Identifiable Health Information**" means information that:

- Is created or received by a health care provider, health plan, employer or health care clearinghouse;
- Relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and
- Identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Section 1. Notice of PHI Uses and Disclosures

1.1 Required PHI Disclosures

Upon your request, the Plan is required to give you access to certain PHI to inspect and copy it and to provide you with an accounting of disclosures of PHI made by the Plan. For further information pertaining to your rights in this regard, see Section 2 of this Notice.

The Plan must disclose your PHI when required by the Secretary of HHS to investigate or determine the Plan's compliance with the Privacy Standards.

1.2 Permitted uses and disclosures to carry out treatment, payment and health care operations

The Plan, its business associates, and their agents/subcontractors, if any, will use or disclose PHI without your consent, authorization or opportunity to agree or object, to carry out treatment, payment and health care operations. The Plan will disclose PHI to a business associate only if the Plan receives satisfactory assurance that the business associate will appropriately safeguard the information.

In addition, the Plan may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. The Plan will disclose PHI to The *Colorado Finishing Trades Health and Welfare Fund Board of Trustees* ("Plan Sponsor") for purposes

related to treatment, payment and health care operations. The Plan Sponsor has amended its plan documents to protect your PHI as required by the Privacy Standards. The Plan Sponsor will obtain an authorization from you if it intends to use or disclose your PHI for purposes unrelated to treatment, payment and health care operations.

Treatment is the provision, coordination or management of health care and related services by one or more health care providers. It also includes, but is not limited to, consultations and referrals between one or more of your providers.

For example, the Plan may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental X-rays from the treating dentist.

Payment means activities undertaken by the Plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the Plan, or to obtain or provide reimbursement for the provision of health care. Payment includes, but is not limited to, actions to make eligibility or coverage determinations, billing, claims management, collection activities, subrogation, reviews for medical necessity and appropriateness of care, utilization review and pre-authorizations.

For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill might be paid by the Plan.

Health care operations means conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, contacting health care providers and patients with information about treatment alternatives, reviewing the competence or qualifications of health care professionals, evaluating health plan performance, underwriting, premium rating and other insurance activities relating to creating, renewing or replacing health insurance contracts or health benefits. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse detection and compliance programs, business planning and development, business management and general administrative activities.

For example, the Plan may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

1.3 Uses and disclosures that require your written authorization

Your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you from your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes without authorization when needed by the Plan to defend against litigation filed by you.

1.4 Disclosures that require that you be given an opportunity to agree or disagree prior to the disclosure

The Plan may disclose to a family member, other relative, close personal friend of yours or any other person identified by you PHI directly relevant to such person's involvement with your care or payment for your health care when you are present for, or otherwise available prior to, a disclosure and you are able to make health care decisions, if:

- The Plan obtains your agreement;
- The Plan provides you with the opportunity to object to the disclosure and you fail to do so; or
- The Plan infers from the circumstances, based upon professional judgment, that you do not object to the disclosure.

The Plan may obtain your oral agreement or disagreement to a disclosure.

However, if you are not present, or the opportunity to agree or object to the disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, the Plan may, in the exercise of professional judgment, determine whether the disclosure is in your best interests, and, if so, disclose only PHI that is directly relevant to the person's involvement with your health care.

1.5 Uses and disclosures for which authorization or opportunity to agree or object is not required

Use and disclosure of your PHI is allowed without your authorization or opportunity to agree or object under the following circumstances:

a) When required by law, provided that the use or disclosure complies with and is limited to the relevant requirements of such law.
b) When permitted for purposes of public health activities, including disclosures to (i) a public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect and (ii) a person subject to the jurisdiction of the Food and Drug Administration (FDA) regarding an FDA-regulated product or activity for the purpose of activities related to the quality, safety or effectiveness of such FDA-regulated product or activity, including to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI also may be disclosed to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if authorized by law.
c) Except for reports of child abuse or neglect permitted by part (b) above, when required or authorized by law, or with your agreement, the Plan may disclose PHI about you to a government authority, including a social service or protective services agency, if the Plan reasonably believes you to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless (i) the Plan believes that informing you would place you at risk of serious harm or (ii) the Plan would be informing your personal representative, and the Plan believes that your personal representative is responsible for the abuse, neglect or other injury, and that informing such person would not be in your best interests. For the purposes of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure generally may be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.
d) The Plan may disclose your PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of: (i) the health care system, (ii) government benefit programs for which health information is relevant to beneficiary eligibility, (iii) entities subject to government regulatory programs for which health information is needed to determine compliance with program standards, or (iv) entities subject to civil rights laws for which health information is needed to determine compliance.
e) The Plan may disclose your PHI in the course of a judicial or administrative proceeding in response to an order of a court or administrative tribunal, provided that the Plan discloses only the PHI expressly authorized by such order, or in response to a subpoena, discovery request, or other lawful process, that is not accompanied by an order of a court of administrative tribunal if certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection, and the

time to object has expired and either no objections were raised or any objections were resolved in favor of disclosure by the court or tribunal.

f) The Plan may disclose your PHI to a law enforcement official when required for law enforcement purposes. The Plan may disclose PHI as required by law, including laws that require the reporting of certain types of wounds. Also, the Plan may disclose PHI in compliance with (i) a court order, court-ordered warrant, or a subpoena or summons issued by a judicial officer, (ii) a grand jury subpoena, or (iii) an administrative request, including an administrative subpoena or summons, a civil or authorized investigative demand, provided certain conditions are satisfied. PHI may be disclosed for law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose your PHI in response to a law enforcement official's request if you are, or are suspected to be, a victim of a crime. Further, the Plan may disclose your PHI if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Plan's premises.

g) The Plan may disclose PHI to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

h) The Plan may use or disclose PHI for research, subject to certain conditions.

i) When consistent with applicable law and standards of ethical conduct, the Plan may use or disclose PHI if the Plan, in good faith, believes the use or disclosure: (i) is necessary to prevent or lessen a serious and imminent threat to health or safety of a person or the public and is to person(s) able to prevent or lessen the threat, including the target of the threat, or (ii) is needed for law enforcement authorities to identify or apprehend an individual, provided certain requirements are met.

j) When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this Notice, uses and disclosures will be made only with your written authorization, subject to your right to revoke such authorization. You may revoke an authorization at any time, provided your revocation is done in writing, except to the extent that the Plan has taken action in reliance upon the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Section 2: Rights of Individuals

2.1 Right to Request Restrictions on PHI Uses and Disclosures

You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your requested restriction.

If the Plan agrees to a requested restriction, the Plan may not use or disclose PHI in violation of such restriction, except that, if you requested a restriction and later are in need of emergency treatment and the restricted PHI is needed to provide the emergency treatment, the Plan may use the restricted PHI, or it may disclose such information to a health care provider, to provide such treatment to you. If restricted PHI is disclosed to a health care provider for emergency treatment, the Plan must request that such health care provider not further use or disclose the information.

A restriction agreed to by the Plan is not effective to prevent uses or disclosures when required by the Secretary of HHS to investigate or determine the Plan's compliance with the Privacy Standards or uses or disclosures that are otherwise required by law.

The Plan may terminate its agreement to a restriction, if:

- You agree to or request the termination in writing;
- You orally agree to the termination and the oral agreement is documented; or
- The Plan informs you that it is terminating its agreement to a restriction, except that such termination is only effective with respect to PHI created or received after the Plan has informed you of the termination.

If the Plan agrees to a restriction, it will document the restriction by maintaining a written or electronic record of the restriction. The record of the restriction will be retained for six years from the date of its creation or the date when it last was in effect, whichever is later.

You or your personal representative will be required to request restrictions on uses and disclosures of your PHI in writing. Such requests should be addressed to the following individual: *Kevin Meza, c/o Compusys of Colorado, Inc., 2821 South Parker Rd, Suite 1005, Aurora, Colorado 80014.*

2.2 Right to Request Confidential Communications of PHI

You may request to receive communications of PHI from the Plan by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information to which the request pertains could endanger you. The Plan will accommodate all such reasonable requests. However, the Plan may condition the provision of a reasonable accommodation on:

- When appropriate, information as to how payment, if any, will be handled; and
- Specification by you of an alternative address or other method of contact.

You or your personal representative will be required to request confidential communications of your PHI in writing. Such requests should be addressed to the following individual: *Kevin Meza, c/o Compusys of Colorado, Inc., 2821 South Parker Rd, Suite 1005, Aurora, Colorado 80014.*

2.3 Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains PHI in the designated record set.

"**Designated Record Set**" means a group of records maintained by or for a health plan that is enrollment, payment, claims adjudication and case or medical management record systems maintained by or for a health plan; or used in whole or in part by or for the health plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The Plan will act on a request for access no later than 30 days after receipt of the request. However, if the request for access is for PHI that is not maintained or accessible to the Plan on-site, the Plan must take action no later than 60 days from the receipt of such request. The Plan must take action as follows: if the Plan grants the request, in whole or in part, the Plan must inform you of the acceptance and provide the access requested. However, if the Plan denies the request, in whole or in part, the Plan must provide you with a written denial. If the Plan cannot take action within the required time, the Plan may extend the time for such action by no more than 30 days if the Plan, within the applicable time limit, provides you with a written statement of the reasons for the delay and the date by which it will complete its action on the request.

If the Plan provides access to PHI, it will provide the access requested, including inspection or obtaining a copy, or both, of your PHI in a designated record set. The Plan will provide you with access to the PHI in the form or format requested if it is readily producible in such form or format; or, if it is not, in a readable hard copy form or such other form or format as agreed to between you and the Plan. The Plan may provide you with a summary of the PHI requested, in lieu of providing access to the PHI or may provide an explanation of the PHI to which access has been provided in certain circumstances. The Plan will arrange with you for a convenient time and place to inspect or obtain a copy of the PHI, or mail a copy of the PHI at your request. If you request a copy of PHI or agree to a summary or explanation of PHI, the Plan may impose a reasonable, cost-based fee.

If the Plan denies access to PHI in whole or in part, the Plan will, to the extent possible, give you access to any other PHI requested, after excluding PHI as to which the Plan has grounds to deny access. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, if applicable, a statement of your review rights, including a description of how you may exercise those review rights and a description of how you may complain to the Plan or to the Secretary of the HHS. If you request review of a decision to deny access, the Plan will refer the request to a designated licensed health care professional for review. The reviewing official will determine, within a reasonable period of time, whether to deny the access requested. The Plan will promptly provide you with written notice of that determination.

If the Plan does not maintain the PHI that is the subject of your request for access, and the Plan knows where the requested information is maintained, the Plan will inform you where to direct the request for access.

You or your personal representative will be required to request access to your PHI in writing. Such requests should be addressed to the following individual: *Kevin Meza, c/o Compusys of Colorado, Inc., 2821 South Parker Rd, Suite 1005, Aurora, Colorado 80014.*

2.4 Right to Amend PHI

You have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set.

The Plan may deny your request for amendment if it determines that the PHI or record that is the subject of the request:

- Was not created by the Plan, unless you provide a reasonable basis to believe that the originator of PHI is no longer available to act on the requested amendment;
- Is not part of the designated record set;
- Would not be available for your inspection under the Privacy Standards; or
- Is accurate and complete.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply within that deadline provided that the Plan, within the original 60-day time period, gives you a written statement of the reasons for the delay and the date by which it will complete its action on the request. If the Plan accepts the requested amendment, the Plan will make the appropriate amendment to the PHI or record that is the subject of the request by, at a minimum, identifying the records in the designated record set that are affected by the amendment and appending or otherwise providing a link to the location of the amendment. The Plan will timely inform you that the amendment is accepted and obtain your identification of and agreement to have the Plan notify the relevant persons with which the amendment needs to be shared as provided in the Privacy Standards.

If the request is denied in whole or part, the Plan must provide you with a written denial that (i) explains the basis for the denial, (ii) sets forth your right to submit a written statement disagreeing with the denial and how to file such a statement, (iii) states that, if you do not submit a statement of disagreement, you may request that the Plan provide your request for amendment and the denial with any future disclosures of the PHI that is the subject of the amendment, and (iv) includes a description of how you may complain to the Plan or to the Secretary of HHS. The Plan may reasonably limit the length of a statement of disagreement. Further, the Plan may prepare a written rebuttal to a statement of disagreement, which will be provided to you. The Plan must, as appropriate, identify the record or PHI in the designated record set that is the subject of the disputed amendment and append or otherwise link your request for an amendment, the Plan's denial of the request, your statement of disagreement, if any, and the Plan's rebuttal, if any, to the designated record set. If a statement of disagreement has been submitted, the Plan will include the above-referenced material, or, at the Plan's election, an accurate summary of such information, with any subsequent disclosure of the PHI to which the disagreement relates. If you do not submit a written statement of disagreement, the Plan must include your request for amendment and its denial, or an accurate summary of such information with any subsequent disclosure of the PHI only if requested by you.

You or your personal representative will be required to request amendment to your PHI in a designated record set in writing. Such requests should be addressed to the following individual: *Kevin Meza, c/o Compusys of Colorado, Inc., 2821 South Parker Rd, Suite 1005, Aurora, Colorado 80014.* All requests for amendment of PHI must include a reason to support the requested amendment.

2.5 Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date on which the accounting is requested. However, such accounting need not include PHI disclosures made: (a) to carry out treatment, payment or health care operations; (b) to individuals about their own PHI; (c) incident to a use or disclosure otherwise permitted or required by the Privacy Standards; (d) pursuant to an authorization; (e) to certain persons involved in your care or payment for your care; (f) to notify certain persons of your location, general condition or death; (g) as part of a "Limited Data Set" (as defined in the Privacy Standards), which largely relates to research purposes; or (h) prior to the compliance date of April 14, 2003. You may request an accounting of disclosures for a period of time less than six years from the date of the request.

The accounting will include disclosures of PHI that occurred during the six years (or such shorter time period, if applicable) prior to the date of the request for an accounting, including disclosures to or by business associates of the Plan. Except as otherwise provided below, for each disclosure, the accounting will include:

- The date of the disclosure;
- The name of the entity or person who received the PHI and, if known, the address of such entity or person;
- A brief description of the PHI disclosed; and
- A brief statement of the purpose of the disclosure that reasonably informs you of the basis for the disclosure, or, in lieu of such statement, a copy of a written request for disclosure.

If during the period covered by the accounting, the Plan has made multiple disclosures of PHI to the same person or entity for a single purpose, the accounting may, with respect to such multiple disclosures, provide the above-referenced information for the first disclosure; the frequency, periodicity or number of the disclosures made during the accounting period; and the date of the last disclosure.

If during the period covered by the accounting, the Plan has made disclosures of PHI for a particular research purpose for 50 or more individuals, the accounting may, with respect to such disclosures for which your PHI may have been included, provide certain information as permitted by the Privacy Standards. If the Plan provides an accounting for such research disclosures, and if it is reasonably likely that your PHI was disclosed for such research activity, the Plan shall, at your request, assist in contacting the entity that sponsored the research and the researcher.

If the accounting cannot be provided within 60 days after receipt of the request, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting unless you withdraw or modify the request for a subsequent accounting to avoid or reduce the fee.

You or your personal representative will be required to request an accounting of your PHI disclosures in writing. Such requests should be addressed to the following individual: *Kevin Meza, c/o Compusys of Colorado, Inc., 2821 South Parker Rd, Suite 1005, Aurora, Colorado 80014.*

2.6 The Right To Receive a Paper Copy of This Notice Upon Request

You have a right to obtain a paper copy of this Notice upon request. To request a paper copy of this Notice, contact the following individual: *Kevin Meza, c/o Compusys of Colorado, Inc., 2821 South Parker Rd, Suite 1005, Aurora, Colorado 80014.*

2.7 A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may include, but is not limited to, the following:

a) a power of attorney for health care purposes, notarized by a notary public;
b) a court order of appointment of the person as the conservator or guardian of the individual; or
c) an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Section 3: The Plan's Duties

3.1 Notice

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices with respect to PHI.

This Notice is effective beginning on the effective date set forth on Page 1 of this Notice, and the Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change the terms of this Notice and to make the new revised notice provisions effective for all PHI that it maintains, including any PHI created, received or maintained by the Plan prior to the date of the revised notice. If a privacy practice is changed, a revised version of this Notice will be provided to all individuals then covered by the Plan. If agreed upon between the Plan and you, the Plan will provide you with a revised Notice electronically. Otherwise, the Plan will mail a paper copy of the revised Notice to your home

address. In addition, the revised Notice will be maintained on any web site maintained by the Plan to provide information about its benefits.

Any revised version of this Notice will be distributed within 60 days of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this Notice. Except when required by law, a material change to any term of this Notice may not be implemented prior to the effective date of the revised notice in which such material change is reflected.

3.2 Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

a) disclosures to or requests by a health care provider for treatment;
b) uses or disclosures made to the individual;
c) disclosures made to the Secretary of HHS;
d) uses or disclosures that are required by law;
e) uses or disclosures that are required for the Plan's compliance with the Privacy Standards; and
f) uses or disclosures made pursuant to an authorization.

This Notice does not apply to information that has been de-identified. De-identified information is health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. It is not individually identifiable health information.

In addition, the Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan, and from which identifying information has been deleted in accordance with the Privacy Standards.

Section 4: Your Right to File a Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan. Any complaint must be in writing and addressed to the following individual: *Kevin Meza, c/o Compusys of Colorado, Inc., 2821 South Parker Rd, Suite 1005, Aurora, Colorado 80014.*

You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services, by writing to him at the following address: The Hubert H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201.

The Plan will not retaliate against you for filing a complaint.

Section 5: Whom to Contact at the Plan for More Information

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the following individual: *Kevin Meza, c/o Compusys of Colorado, Inc., 2821 South Parker Rd, Suite 1005, Aurora, Colorado 80014 (303) 745-1941.*

Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA. You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This Notice attempts to summarize the Privacy Standards. The Privacy Standards will supersede any discrepancy between the information in this Notice and the Privacy Standards.