GUNNISON COUNTY BOARD OF COMMISSIONERS
REGULAR MEETING AGENDA

DATE: **Tuesday, March 3, 2026**
PLACE: **Board of County Commissioners' Meeting Room at the Gunnison County Courthouse (REMOTE OPTION BELOW)**

GUNNISON COUNTY HOUSING AUTHORITY MEETING:

8:30 am

- Call to Order
- A Resolution Delegating to the Executive Secretary Authority to Negotiate and Execute Contracts on Behalf of Gunnison County Housing Authority
- A Resolution Confirming that the Policies and Procedures of Gunnison County Apply to the Gunnison County Housing Authority
- Ratification; Agreement to Provide Services; Richey, May & CO, LLP; Anthracite Place Apartments, LLC; Gunnison County Housing Authority; $12,200
- Adjourn

GUNNISON COUNTY BOARD OF COUNTY COMMISSIONERS REGULAR MEETING:

8:35 am

- Call to Order; Agenda Review
- Minutes Approval
    1. February 17, 2026 Regular Meeting
- Scheduling
- Consent Agenda: These items will not be discussed unless requested by a Commissioner or citizen. Items removed from consent agenda for discussion may be rescheduled later in this meeting, or at a future meeting.
    1. Acknowledgment of County Manager's Signature; Professional Services Agreement; Raymond Alspach; Facilities; 2/12/2026 to 12/31/2026; $60,000
    2. Small Dollar Grant Award; 25EM25-26-05; Emergency Management Performance Grants (EMPG); Emergency Management; 10/1/2025 to 6/30/2026; $54,943
    3. Colorado Division of Aeronatutics Discretionary Aviation Grant Resolution; CDAG# 26-GUC-I01; Gunnison-Crested Butte Regional Airport; 3/3/2026 to 12/31/2027; $33,898.80
    4. Grant Application; Choose When 2026 Application; Caring for Colorado Foundation; Health and Human Services; 7/1/2026 to 6/30/2027; $50,000
    5. Community Resource Network Participation Agreement and Addendum; Contexture HIE; Health and Human Services; $3,000
    6. Behavioral Health 260 Program License Agreement; CredibleMind, Inc.; Health and Human Services; 3/3/2026 to 3/3/2027; $18,500
    7. Grant Application; Colorado Health Foundation; Juvenile Services; $246,950
    8. Grant Award Letter; Intergovernmental Agreement; PO 471102493; CDAG# 26-GUC-01; Gunnison-Crested Butte Regional Airport; 3/3/2026 to 6/30/2029; $525,000; Local Share $58,334
    9. Amendment #1; Gunnison County, Colorado Employee Medical Benefit Plan, Cost Plus Plan; Human Resources; 1/1/2025
    10. Grant Application; MetRec; Gunnison/Hinsdale Early Childhood Council; Health and Human Services; $15,000
    11. Teacher Professional Development Services Order Form; Denver Museum of Nature & Science; Gunnison/Hinsdale Early Childhood Council; Health and Human Services; 4/25/2026; $875
    12. Acknowledgment of County Manager's Signature; Professional Services Agreement; Little Foot Building, LLC; 1/1/2026 to 12/31/2026; $60,000

13. Grant Application; 2026 Gunnison Rotary Community Grant Application; Juvenile Services; $1,800
14. A Resolution Authorizing ATV, OHV, and UTV Use on Certain County Roads in Somerset, Colorado

8:40 am

- Local Landmark Designation for Hartman Castle Nomination
    1. A Resolution Designating the Hartman Castle and Original Ranch House Located at 279 County Rd 50, Gunnison, Colorado, to be Each Individually Designated a Gunnison County Historic Landmark

8:50 am

- Local Landmark Designation for Crystal Townsite Buildings Nomination
    1. A Resolution Designating the Following Buildings Located in the Former Townsite of Crystal, Which is Located Between Marble and Schofield Along Forest Road 314, Gunnison County, Colorado, to be Individually a Gunnison County Historic Landmark

9:00 am

- Public Hearing; Wildfire Code and Land Use Resolution (LUR) Amendment
    1. A Resolution Adopting the "Colorado Wildfire Resiliency Code," with Amendments
    2. A Resolution Amending the Gunnison County Land Use Resolution

10:00 am

- Boards and Commissions Appointments:
    1. Gunnison Basin Sage-grouse Strategic Committee Public At-Large Alternate (Fill one vacancy for two-year term ending 2/1/2028)
        - Applicant: Steffanie Chain

10:05 am

- Correspondence; Draft Environmental Impact Statement (DEIS) Comments Regarding Post-2026 Operational Guidelines and Strategies for Lake Powell and Lake Mead

10:10 am

- A Resolution Supporting Colorado Communities for Climate Action and Joining as a Member

10:15 am

- Land Use Change Approvals:
    1. Lot Cluster; LUC-25-00025; Matt and Dana Wise
    2. Boundary Line Adjustment; LUC-24-00011; Hartman Castle

10:25 am

- Break

10:35 am

- Potential Upcoming Legislation Discussion

11:35 am

- Unscheduled Public Comment: Limit to 5 minutes per item. No formal action can be taken at this meeting.
- Commissioner Items: Commissioners will discuss among themselves activities that they have recently participated in that they believe other Commissioners and/or members of the public may be interested in hearing about.
- Adjourn

Please Note: Packet materials for the above discussions will be available on the Gunnison County website at http://www.gunnisoncounty.org/meetings prior to the meeting.

ZOOM MEETING DETAILS:
Join Zoom Meeting: https://gunnisoncounty-org.zoom.us/j/89798905619
One tap mobile
+12532158782,,82753657556#,,,,*471302# US (Tacoma)
+13462487799,,82753657556#,,,,*471302# US (Houston)

AGENDA ITEM or FINAL CONTRACT REVIEW SUBMITTAL FORM

Agenda Item: A Resolution Delegating to the Executive Secretary

Action Requested: Board of County Commissioners' Signature

Parties to the Agreement:

Term Begins: **Term Ends:** **Grant Contract #:**

Summary:

Resolution Delegating to the Executive Secretary Authority to Negotiate and Execute Contracts on Behalf of the Gunnison County Housing Authority

Fiscal Impact: n/a

Submitted by: Holly Perry **Submitter's Email Address:** hperry@gunnisoncounty.org

Finance Review: ○ Required ◉ Not Required

Comments:

Reviewed by: Discharge Date:

County Attorney Review: ◉ Required ○ Not Required

Comments:
Legally sufficient. SO 2/23/26

Reveiwed by: GUNCOUNTY1\sobaid Discharge Date: 2/23/2026 Certificate of Insurance Required

Yes ○ No ◉

County Manager Review:

Comments:

Reveiwed by: GUNCOUNTY1\mbirnie Discharge Date: 2/25/2026

○ Consent Agenda ◉ Regular Agenda ○ Worksession Time Allotted: 5

Agenda Date: 3/3/2026

Revised April 2015

GUNNISON COUNTY HOUSING AUTHORITY

RESOLUTION NO. 2026-_____

A RESOLUTION DELEGATING TO THE EXECUTIVE SECRETARY AUTHORITY TO NEGOTIATE AND EXECUTE CONTRACTS ON BEHALF OF THE GUNNISON COUNTY HOUSING AUTHORITY

WHEREAS, the Gunnison County Housing Authority ("GCHA") is a county housing authority created and operating under the Constitution and laws of the State of Colorado, particularly C.R.S. § 29-4-501 *et seq.*; and

WHEREAS, the Gunnison County Board of County Commissioners ("County") first authorized the creation of the GCHA by Resolution Nos. 1979-33 and 1979-34; and

WHEREAS, the current and operating GCHA was formed on August 17, 1982, pursuant to the Certificate of Formation of the Gunnison County Housing Authority, said Certificate being accepted by the Colorado Division of Housing on August 18, 1982; and

WHEREAS, the GCHA is authorized pursuant to C.R.S. § 29-4-505 to "make and execute contracts and other instruments necessary or convenient to the exercise of the powers of the authority", to "to exercise any of the public powers granted to city housing authorities" and to "do all acts and things necessary or convenient to carry out the powers" of the GCHA; and

WHEREAS, pursuant to its bylaws first adopted by Gunnison County Resolution No. 1979-34 and C.R.S. § 29-4-504(5), the GCHA Board has appointed the County Manager to act as the Executive Secretary of GCHA; and

WHEREAS, pursuant to its bylaws and C.R.S. § 29-4-504(5), the GCHA Board "may delegate to one or more of its agents or employees such powers or duties as it may deem proper;"

NOW, THEREFORE, BE IT RESOLVED by the Board of the Gunnison County Housing Authority ("Board") that:

1. The foregoing recitals are incorporated herein by reference and adopted as findings and determinations of the Board.

2. The Board hereby authorizes the Executive Secretary, without further action by the Board, to execute on behalf of the Board any and all contracts with an aggregate direct financial payment or receipt by the GCHA over the term of the contract of not more than one hundred and fifty-seven thousand dollars ($157,000). The Executive Secretary shall provide each proposed contract to the Gunnison County Attorney and the Gunnison County Finance Director for review and written approval prior to execution. The Executive Secretary will also schedule each contract executed

pursuant to this Resolution on a GCHA agenda for acknowledgement of his or her signature. In January of each calendar year, beginning in 2027, this authority will automatically adjust according to the Consumer Price Index (CPI) Calculator as compared to the current year's authority, rounded to the nearest one-thousand ($1000) dollars. The CPI is a measure of the average change in prices over time in a market basket of goods and services. The Bureau of Labor Statistics (BLS) releases CPI data monthly, and the CPI Calculator utilized by the BLS shall be used to calculate the annual financial increase to the Executive Secretary's contract execution authority. GCHA staff will inform the Board of the new limit each January.

3. The Board further authorizes the Executive Secretary, without further action by the Board, to negotiate and execute contracts and related documents for the purchase or sale of real property on behalf of the GCHA for GCHA purposes, subject to Board review within thirty (30) days of either 1) the execution of a property purchase or sale agreement pursuant to this Resolution; or 2) the scheduled closing date of any real property transaction negotiated pursuant to this Resolution, whichever first occurs.

4. The Board further authorizes the Executive Secretary, without further action by the Board, to negotiate and execute contracts, leases, agreements and other documents related to the lease, transfer or management of housing units on behalf of the GCHA.

5. All actions previously taken by the Executive Secretary that were in accordance with the authority granted in this Resolution are hereby ratified, approved and confirmed *nunc pro tunc*.

6. Nothing in this Resolution shall be construed to afford any person or entity any cause of action against the County, the GCHA, or their officials, officers, employees, agents or attorney, nor create any intended or incidental third-party beneficiaries.

7. If any section, subsection, paragraph, clause or other provision of this Resolution for any reason is held to be invalid or unenforceable, the invalidity or unenforceability of such section, subsection, paragraph, clause or other provision shall not affect any of the remaining provisions of this Resolution, the intent being that the same are severable.

8. This Resolution shall take effect immediately upon its passage and approval, and shall remain in effect unless and until repealed or amended by subsequent Resolution.

INTRODUCED by Commissioner _____, seconded by Commissioner _____, and adopted this _____ day of _____ 2026.

GUNNISON COUNTY HOUSING AUTHORITY

By _____
Laura Puckett Daniels, Chairperson

By _____
Elizabeth Smith, Vice-Chairperson

By _____
Jonathan Houck, Board Member

Attest:

_____
Deputy County Clerk

AGENDA ITEM or FINAL CONTRACT REVIEW SUBMITTAL FORM

Agenda Item: A Resolution Confirming that the Policies and Procedures

Action Requested: Board of County Commissioners' Signature

Parties to the Agreement:

Term Begins: **Term Ends:** **Grant Contract #:**

Summary:

Resolution Confirming that the Policies and Procedures of Gunnison County Apply to the Gunnison County Housing Authority

Fiscal Impact: n/a

Submitted by: Holly Perry **Submitter's Email Address:** hperry@gunnisoncounty.org

Finance Review: ○ Required ◉ Not Required

Comments:

Reviewed by: Discharge Date:

County Attorney Review: ◉ Required ○ Not Required

Comments:
Legally sufficient. SO 2/23/26

Reveiwed by: GUNCOUNTY1\sobaid Discharge Date: 2/23/2026 Certificate of Insurance Required

Yes ○ No ◉

County Manager Review:

Comments:

Reveiwed by: GUNCOUNTY1\mbirnie Discharge Date: 2/25/2026

○ Consent Agenda ◉ Regular Agenda ○ Worksession Time Allotted: 5

Agenda Date: 3/3/2026

Revised April 2015

GUNNISON COUNTY HOUSING AUTHORITY

RESOLUTION NO. 2026-_____

A RESOLUTION CONFIRMING THAT THE POLICIES AND PROCEDURES OF GUNNISON COUNTY APPLY TO THE GUNNISON COUNTY HOUSING AUTHORITY

WHEREAS, the Gunnison County Housing Authority ("GCHA") is a county housing authority created and operating under the Constitution and laws of the State of Colorado, particularly C.R.S. § 29-4-501 *et seq.*; and

WHEREAS, the Gunnison County Board of County Commissioners ("County") first authorized the creation of the GCHA by Resolution Nos. 1979-33 and 1979-34; and

WHEREAS, the current and operating GCHA was formed on August 17, 1982, pursuant to the Certificate of Formation of the Gunnison County Housing Authority, said Certificate being accepted by the Colorado Division of Housing on August 18, 1982; and

WHEREAS, the GCHA is authorized pursuant to C.R.S. § 29-4-505 to "make and execute contracts and other instruments necessary or convenient to the exercise of the powers of the authority", to "to exercise any of the public powers granted to city housing authorities" and to "do all acts and things necessary or convenient to carry out the powers" of the GCHA; and

WHEREAS, pursuant to its bylaws first adopted by Gunnison County Resolution No. 1979-34 and C.R.S. § 29-4-504(5), the GCHA Board has appointed the County Manager to act as the Executive Secretary of GCHA; and

WHEREAS, pursuant to its bylaws and C.R.S. § 29-4-504(5), the GCHA Board "may delegate to one or more of its agents or employees such powers or duties as it may deem proper;"

NOW, THEREFORE, BE IT RESOLVED by the Board of the Gunnison County Housing Authority ("Board") that:

1. The foregoing recitals are incorporated herein by reference and adopted as findings and determinations of the Board.

2. The Board hereby expresses its desire and intent that the policies and procedures adopted by the Gunnison County Board of County Commissioners, the County Manager, or their respective designees, apply to the Gunnison County Housing Authority.

3. The Board hereby reserves the ability to exempt or exclude the Gunnison County Housing Authority from any Gunnison County policy or procedure

by majority vote of the Board.

4. The policies and procedures of Gunnison County that apply to the Gunnison County Housing Authority include, but are not necessarily limited to, the following, and as they are amended or updated from time to time:

a. 1.1. 2 - County Financial, Procurement, Travel, and Grant Policies;
b. 1.2.1.3 - Gunnison County Financial Policies;
c. 1.2.4.3.1 - Emergency and Disaster Management Procedures;
d. 1.2.4.3.2 - Emergency Operations Plan;
e. 1.2.4.3.6 - Disaster Recovery Plan;
f. 1.2.7.1 - Bring Your Own Device;
g. 1.2.7.2 - Fixed Asset Inventory;
h. 1.2.7.3 - Departmental Social Media;
i. 1.2.7.4 - Personal Social Media;
j. 1.2.9.3 - Standard Hours of Operation;
k. 1.2.11.1 - Handling Requests for Public (Open) Records;
l. 4.2.1 - CCOERA Retirement Plan;
m. 4.2.3 - Life, Accidental Loss and Disability Coverage;
n. 4.3.1 - Gunnison County Personnel Policies and Employee Handbook;
o. 4.3.2 - Gunnison County Supervisor Policies;
p. 4.3.3 - Motor Pool & Personal Vehicle Policy;
q. 4.4.1 - HIPAA Privacy and Procedures;
r. 4.4.2 - Individually Identifiable Health Information;
s. 5.1.1 - Hard Key and Access Badge Issuance/Replacement/Return Policy;
t. 5.1.2 - Overnight and Long-Term Parking Prohibition Policy in County Parking Lots Adjacent to County Buildings;
u. 5.2.3 - Allowances, Restrictions and Responsibilities Regarding Animals in County Facilities and on County Grounds; and
v. 5.2.5 - Regarding Consumption of Alcoholic Beverages on Gunnison County Property.

5. The Executive Secretary shall be responsible for ensuring that the employees and contractors of the Gunnison County Housing Authority comply with the Gunnison County policies and procedures applicable to the Gunnison County Housing Authority.

6. Nothing in this Resolution shall be construed to afford any person or entity any cause of action against the County, the GCHA, or their officials, officers, employees, agents or attorney, nor create any intended or incidental third-party beneficiaries.

INTRODUCED by Commissioner _____, seconded by Commissioner _____, and adopted this ___ day of _____ 2026.

GUNNISON COUNTY HOUSING AUTHORITY

By

_____

Laura Puckett Daniels, Chairperson

By

_____

Elizabeth Smith, Vice-Chairperson

By

_____

Jonathan Houck, Board Member

Attest:

_____

Deputy County Clerk

AGENDA ITEM or FINAL CONTRACT REVIEW SUBMITTAL FORM

Agenda Item: Ratification; Agreement to Provide Services; Riche

Action Requested: County Manager Signature

Parties to the Agreement:

Term Begins: **Term Ends:** **Grant Contract #:**

Summary:

2025 Anthracite Audit; Richey May

Fiscal Impact:

Submitted by: Holly Perry **Submitter's Email Address:** hperry@gunnisoncounty.org

Finance Review: (●) Required ( ) Not Required

Comments:

Reviewed by: GUNCOUNTY1\mlamonica Discharge Date: 2/13/2026

County Attorney Review: (●) Required ( ) Not Required

Comments:
Paragraph 9 of the general terms, "Indemnification," calls for the Housing Authority to indemnify the contractor, and vice versa. Otherwise, legally sufficient. SO 2/20/26

Reveiwed by: GUNCOUNTY1\sobaid Discharge Date: 2/20/2026 Certificate of Insurance Required

Yes ( ) No (●)

County Manager Review:

Comments:

Reveiwed by: GUNCOUNTY1\mbirnie Discharge Date: 2/25/2026

(●) Consent Agenda ( ) Regular Agenda ( ) Worksession Time Allotted: 0

Agenda Date: 3/3/2026

Revised April 2015

RICHEY MAY
RICHEY, MAY & CO., LLP

December 30, 2025

Anthracite Place Apartments, LLC
c/o Gunnison County Housing Authority
307 N Wisconsin St
Gunnison, CO 81230

Agreement to Provide Services

This agreement to provide services (the "Agreement") is intended to describe the nature and scope of our services.

Objective and Scope of the Audit

As agreed, RICHEY, MAY & CO., LLP("RICHEY MAY" or "we") will audit the financial statements of **Anthracite Place Apartments, LLC** (the "Company" or "you"), which comprise the balance sheet as of **December 31, 2025** and the related statements of income, partners' equity, and cash flows for the year then ended, and the related notes to the financial statements.

Also, the supplementary information accompanying the financial statements, as listed below, will be subjected to the auditing procedures applied in our audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic financial statements or to the basic financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America, and our auditor's report will provide an opinion on it in relation to the basic financial statements as a whole.

- Schedule of Revenue and Expenditures

Responsibilities of RICHEY MAY

We will conduct our audit in accordance with auditing standards generally accepted in the United States of America ("GAAS"). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement, whether caused by error or fraud. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. The procedures selected depend on our judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to error or fraud.

We have identified the following significant risks of material misstatement as part of our audit planning:

- Management override of controls
- Improper distributions

Our work will be based primarily upon selected tests of evidence supporting the amounts and disclosures in the financial statements and, therefore, will not include a detailed check of all of your Company's transactions for the period. Because of the inherent limitations of an audit, together with the inherent

limitations of internal control, an unavoidable risk that some material misstatements may not be detected exists, even though the audit is properly planned and performed in accordance with GAAS.

Also, an audit is not designed to detect errors or fraud that are immaterial to the financial statements. However, we will inform you of any material errors or fraud that come to our attention. We will also inform you of possible illegal acts that come to our attention, unless they are clearly inconsequential. In addition, during the course of our audit, financial statement misstatements relating to accounts or disclosures may be identified, either through our audit procedures or through communication by your employees to us, and we will bring these misstatements to your attention as proposed adjustments. At the conclusion of our audit, we will communicate to those charged with governance (as defined below) all uncorrected misstatements.

In making our risk assessments, we consider internal control relevant to the Company's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we will express no such opinion. An audit is not designed to provide assurance on internal control or to identify significant deficiencies or material weaknesses in internal control. However, we will communicate to you and those charged with governance in writing concerning any significant deficiencies or material weaknesses in internal control relevant to the audit of the financial statements that we identify during our audit.

We are also responsible for communicating with those charged with governance what our responsibilities are under GAAS, an overview of the planned scope and timing of the audit, and significant findings from the audit.

Our audit of the financial statements does not relieve you of your responsibilities.

Responsibilities of Management and Identification of the Applicable Financial Reporting Framework

Our audit will be conducted on the basis that you and those charged with governance acknowledge and understand that you and those charged with governance have responsibility (1) for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America; (2) for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to error or fraud; (3) for identifying and ensuring that the Company complies with the laws and regulations applicable to its activities; and (4) to provide us with access to all information of which you are aware that is relevant to the preparation and fair presentation of the financial statements, such as records, documentation, and other matters.

You acknowledge and understand your responsibility for the preparation of the supplementary information in accordance with the applicable criteria. You also agree to include our report on the supplementary information in any document that contains the supplementary information and that indicates that we have reported on such supplementary information. You also agree to present the supplementary information with the audited financial statements or, if the supplementary information will not be presented with the audited financial statements, to make the audited financial statements readily available to the intended users of the supplementary information no later than the date of issuance of the supplementary information and our report thereon.

Management is responsible for adjusting the financial statements to correct material misstatements relating to accounts or disclosures, after evaluating their propriety based on a review of both the applicable authoritative literature and the underlying supporting evidence from the Company's files; or otherwise concluding and confirming in a representation letter (as further described below) provided to us at the conclusion of our audit that the effects of any uncorrected misstatements are, both individually and in the aggregate, immaterial to the financial statements taken as a whole.

As required by GAAS, we will request certain written representations from management at the close of our audit to confirm oral representations given to us and to indicate and document the continuing appropriateness of such representations and reduce the possibility of misunderstanding concerning matters that are the subject of the representations. Because of the importance of management's representations to an effective audit and provided the audited financial statements and our report thereon are not included in a registration statement under the Securities Act of 1933 or in a Private Placement Memorandum, the Company agrees, subject to prevailing laws and regulations, to release and indemnify RICHEY MAY, its Permitted Assignees (as defined herein under "Assignment"), and each of their respective employees from any liability and costs relating to our services rendered under this Agreement attributable to any knowing misrepresentations by management.

Expected Form and Content of the Auditor's Report

At the conclusion of our audit, we will submit to you a report containing our opinion as to whether the financial statements, taken as a whole, are fairly presented based on accounting principles generally accepted in the United States of America. If, during the course of our work, it appears for any reason that we will not be in a position to render an unmodified opinion on the financial statements, or that our report will require an Emphasis of Matter or Other Matter paragraph, we will discuss this with you. It is possible that, because of unexpected circumstances, we may determine that we cannot render a report or otherwise complete the engagement. If, for any reason, we are unable to complete the audit or are unable to form or have not formed an opinion, we may decline to express an opinion or decline to issue a report as a result of the engagement. If, in our professional judgment, the circumstances require, we may resign from the engagement prior to completion.

Client Acceptance Matters

RICHEY MAY is accepting the Company as a client in reliance on information obtained during the course of our client acceptance procedures. James Hawkins is responsible for directing the engagement and issuing the appropriate report or authorizing another individual to issue the report on the Company's financial statements.

Ownership of Working Papers

The working papers prepared in conjunction with our audit are the property of RICHEY MAY, constitute confidential information, and will be retained by us in accordance with RICHEY MAY's policies and procedures.

Reproduction of Audit Report

If the Company plans any reproduction or publication of our report, or any portion of it, a copy of the entire document in its final form should be submitted to us in sufficient time for our review and written approval before printing. You also agree to provide us with a copy of the final reproduced material for our written approval before it is distributed. If, in our professional judgment, the circumstances require, we may withhold our written approval.

Posting of Audit Report and Financial Statements on Your Website

You agree that, if you plan to post an electronic version of the financial statements and audit report on your website, you will ensure that there are no differences in content between the electronic version of the financial statements and audit report on your website and the signed version of the financial statements and audit report provided to management by RICHEY MAY. You also agree to indemnify RICHEY MAY from any and all claims that may arise from any differences between the electronic and signed versions.

Availability of Records and Personnel

You agree that all records, documentation, and information we request in connection with our audit will be made available to us (including those pertaining to related parties), that all material information will be disclosed to us, and that we will have the full cooperation of, and unrestricted access to, your personnel during the course of the engagement.

You also agree to ensure that any third-party valuation reports that you provide to us to support amounts or disclosures in the financial statements (a) indicate the purpose for which they were intended, which is consistent with your actual use of such reports; and (b) do not contain any restrictive language that would preclude us from using such reports as audit evidence.

Assistance by Your Personnel

We also ask that your personnel prepare various schedules and analyses for our staff. However, except as otherwise noted by us, no personal information other than names related to Company employees and/or customers should be provided to us. This assistance will serve to facilitate the progress of our work and minimize costs to you.

Other Services

We are always available to meet with you and other executives at various times throughout the year to discuss current business, operational, accounting, and auditing matters affecting your Company. Whenever you feel such meetings are desirable, please let us know. We are also prepared to provide services to assist you in any of these areas. We will also be pleased, at your request, to attend your directors' and stockholders' meetings.

As part of our engagement to opine on the financial statements, you have also engaged us to perform the following non-attest services.

1. You have asked us to assist in the preparation of the financial statements, related notes and other supplemental information.
2. You have engaged us to assist in preparing depreciation schedules related to the Project's assets. You will provide the estimation of useful lives of assets.

Independence

Professional and certain regulatory standards require us to be independent, in both fact and appearance, with respect to your Company in the performance of our services. Any discussions that you have with personnel of RICHEY MAY regarding employment could pose a threat to our independence. Therefore, we request that you inform us prior to any such discussions so that we can implement appropriate safeguards to maintain our independence.

In order for us to remain independent, professional standards require us to maintain certain respective roles and relationships with you with respect to the non-attest services described above. Prior to performing such services in conjunction with our audit, management must acknowledge its acceptance of certain responsibilities.

We will not perform management functions or make management decisions on behalf of your Company. However, we will provide advice and recommendations to assist management of the Company in performing its functions and fulfilling its responsibilities.

The Company agrees to perform the following functions in connection with our performance of the (non-attest services):

a. Make all management decisions and perform all management functions with respect to the non-attest services provided by us.
b. Assign person with suitable skill and knowledge to oversee the non-attest services and evaluate the adequacy and results of the services.
c. Accept responsibility for the results of the non-attest services.

The services are limited to those outlined above. We, in our professional judgment, reserve the right to refuse to perform any procedure or take any action that could be construed as making management decisions or performing management functions. The Company must make all decisions with regard to our recommendations. By signing this Agreement, you acknowledge your acceptance of these responsibilities.

Fees

Our fees for these services will be based on the actual time spent at our standard hourly rates, plus travel and other out-of-pocket costs such as report production, word processing, postage, etc. Our standard hourly rates vary according to the degree of responsibility involved and the experience level of the personnel assigned to your audit. Our invoices for these fees will be rendered each month as work progresses and are payable upon presentation. In accordance with our firm policies, work may be suspended if your account becomes 30 days or more overdue and may not be resumed until your account is paid in full. If we elect to terminate our services for nonpayment, our engagement will be deemed to have been completed upon written notification of termination, even if we have not completed our report. You will be obligated to compensate us for all time expended and to reimburse us for all out-of-pocket expenditures through the date of termination. Based on our preliminary estimates, the fee will range from $9,350 to $10,500 for the audit and preparation of financial statements and $1,700 for the preparation of the tax return(s). The above estimates are based on anticipated cooperation from your personnel and the assumption that unexpected circumstances will not be encountered during the engagement. If significant additional time is necessary, we will discuss it with you and arrive at a new fee estimate before we incur the additional costs.

Our fees and costs will be billed periodically, and invoices are payable upon receipt. If we do not receive any written notice of dispute within 10 days of your receipt of the invoice, we will conclude that you have seen the invoice and find it acceptable. Invoices that are unpaid 30 days past the invoice date are deemed delinquent and we reserve the right to charge interest on the past due amount at the lesser of (a) 1.5% per month or (b) the maximum amount permissible by applicable law. Interest shall accrue from the date the invoice is delinquent. We reserve the right to suspend our services, withhold delivery of any deliverables, or withdraw from this engagement entirely if any of our invoices are delinquent. In the event that any collection action is required to collect unpaid balances due to us, you agree to reimburse us for all our costs of collection, including without limitation, attorneys' fees.

Confidentiality

Client has separately engaged RM Advisory to provide services for which licensure as a CPA firm is not required. In order to avoid duplication of efforts arising out of this arrangement, we request that you consent to our sharing with RM Advisory the information that we may obtain from you in the course of our engagement.

These services include the following:

1. Preparation of the 2025 federal and state tax returns.

Miscellaneous

We may from time to time and depending on the circumstances, use third-party service providers in serving your account. We may share confidential information about you with these service providers but remain committed to maintaining the confidentiality and security of your information. Accordingly, we maintain internal policies, procedures, and safeguards to protect the confidentiality of your personal information and we will take reasonable precautions to determine that they have appropriate procedures in place to prevent the unauthorized release of your confidential information to others. In the event that we are unable to secure an appropriate confidentiality agreement, you will be asked to provide your consent prior to the sharing of your confidential information with the third-party service provider. Furthermore, we will remain responsible for the work provided by any such third-party service providers.

This Agreement is intended to cover only the services specified herein, although we look forward to many more years of pleasant association with the Company. This engagement is a separate and discrete event, and any future services will be covered by a separate agreement to provide services.

Many banks have engaged a third party to electronically process cash or debt audit confirmation requests, and a few of those banks have mandated the use of this service. To the extent applicable, the Company hereby authorizes RICHEY MAY to participate in this electronic confirmation process through the third party's website (e.g., by entering the Company's bank account information to initiate the process and then accessing the bank's confirmation response) and agrees that RICHEY MAY shall have no liability in connection therewith.

Whenever possible, each provision of this Agreement shall be interpreted in such a manner as to be effective and valid under applicable laws, regulations, or published interpretations, but if any provision of this Agreement shall be deemed prohibited, invalid, or otherwise unenforceable for any reason under such applicable laws, regulations, or published interpretations, such provisions shall be ineffective only to the extent of such prohibition, invalidity, or unenforceability and such revised provision shall be made a part of this Agreement as if it was specifically set forth herein. Furthermore, the provisions of the foregoing sentence shall not invalidate the remainder of such provision or the other provisions of this Agreement.

This Agreement may be transmitted in electronic format and shall not be denied legal effect solely because it was formed or transmitted, in whole or in part, by electronic record; however, this Agreement must then remain capable of being retained and accurately reproduced, from time to time, by electronic record by the parties to this Agreement and all other persons or entities required by law. An electronically transmitted signature to this Agreement will be deemed an acceptable original for purposes of consummating this Agreement and binding the party providing such electronic signature.

We believe the foregoing correctly sets forth our understanding; however, if you have any questions, please let us know. If you find the foregoing arrangements acceptable, please acknowledge this by signing and returning to us a copy of this Agreement and retaining a copy for your files.

Very truly yours,

Richey, May & Co., LLP

Richey, May & Co., LLP

This engagement letter is subject to the General Business Terms attached as Exhibit A.

RICHEY MAY
RICHEY, MAY & CO., LLP

Acknowledged:

ANTHRACITE PLACE APARTMENTS, LLC

By: _____ Date: 2/13/26

Managing Member

Gunnison County Housing Authority

RICHEY MAY

RICHEY, MAY & CO., LLP

Exhibit A
General Business Terms

1. Services. Richey, May & Co., LLP ("**Consultant**") shall provide services to Client set forth in the engagement letter ("**Services**") to which these terms are attached (the "**Engagement Letter**"). For purposes of these terms and the Engagement Letter, "**Client**" shall mean the entity to which the Engagement Letter is addressed.

2. Consultant's Business

a) **Alternative Practice Structure.** Richey, May & Co., LLP and RM Advisory LLC practice in an alternative practice structure in accordance with the AICPA Code of Professional Conduct and applicable laws, regulations, and professional standards. In performing the engagement, Richey, May & Co., LLP will lease professional and administrative staff, both of which are employed by RM Advisory LLC or its related entities. These individuals will be under the direct control and supervision of Richey, May & Co., LLP, which is solely responsible for the performance of the Services. Additionally, the professional staff is subject to the standards governing the accounting profession, including the requirement to maintain the confidentiality of client information, and Richey, May & Co., LLP and RM Advisory LLC and its related entities have contractual agreements requiring confidential treatment of all client information. RM Advisory LLC also maintains custody of the files relating to the Services and Client consents to Richey, May & Co., LLP sharing Client confidential information in connection with the Services with RM Advisory LLC.

b) **Independence.** To ensure that Richey, May & Co., LLP's independence is not impaired under the AICPA's Code of Professional Conduct, Client shall: (i) provide information with respect to current and potential affiliates, including ownership percentage, to Consultant prior to the commencement of the engagement and upon any changes thereto that may occur during the engagement, (ii) notify Consultant of any planned transactions involving changes in ownership of Client or acquisitions of other entities by Client, (iii) inform the engagement partner before entering into any substantive employment discussions with Consultant personnel, and (iv) obtain preapproval of any nonattest services to be performed by RM Advisory LLC or any of Richey, May & Co., LLP's associated entities.

c) **No Hosting and Storage.** Professional standards prohibit Consultant from being the sole host or storage for Client financial and non-financial data. Client shall maintain its original data and records, and Consultant shall have no obligation to retain or maintain such original information. Client represents and warrants that it has all the data and records required to make its books and records complete.

3. Payment of Invoices. Client will compensate Consultant under the terms of the Engagement Letter for the Services performed and expenses incurred, through the term or effective date of termination of this engagement. Consultant's invoices are due upon receipt. If payment is not received within thirty (30) days of receipt of an invoice (i) such invoice shall accrue a late charge equal to the lesser of (A) 1 ½% per month or (B) the highest rate allowable by law, in each case compounded monthly to the extent allowable by law, and (ii) Consultant may also suspend or terminate the Services or withhold any Deliverables. Client shall be responsible for any taxes imposed on the Services or on this engagement, other than taxes imposed by employment withholding for Consultant's personnel or on Consultant's income or property.

4. Term. Unless terminated sooner as set forth below, this engagement shall terminate upon the completion of the Services. Either party may terminate this engagement, in whole or in part, if the other party materially breaches the Engagement Letter or these terms, and such breach is incapable of cure or, if capable of cure, remains uncured for thirty (30) days after receipt of written notice thereof from the non-breaching party. Consultant may immediately terminate this engagement or performance of any part of the Services upon written notice to Client if Consultant determines that the performance of any part of the Services would be in conflict with law, or independence, conflicts of interest, or other professional rules.

5. Ownership.

a) For purposes of these terms (i) "**IP**" means works of authorship, materials, information and other intellectual property; (ii) "**Consultant IP**" means all IP created prior to or independently of the performance of the Services, or created by Consultant or its subcontractors as a tool for their use in performing the Services, plus any modifications or

enhancements thereto and derivative works based thereon; and (iii) "**Deliverables**" means all IP that Consultant or its subcontractors create specifically for delivery to Client as a result of the Services.

b) Upon full payment to Consultant hereunder, and subject to the terms and conditions contained herein, Consultant hereby (i) assigns to Client all rights in and to the Deliverables, except to the extent they include any Consultant IP; and (ii) grants to Client the right to use, for Client's internal business purposes, any Consultant IP included in the Deliverables in connection with its use of the Deliverables. Except for the foregoing license grant, Consultant or its licensors retain all rights in and to all Consultant IP.

6. Confidentiality and Use.

a) To the extent that, in connection with this engagement, either Consultant or Client (each, the "**Receiving Party**") comes into possession of any confidential information of the other (the "**Disclosing Party**"), it will not disclose such information to any third party without the Disclosing Party's consent, using at least the same degree of care as it employs in maintaining in confidence its own confidential information of a similar nature, but in no event less than a reasonable degree of care. The Disclosing Party hereby consents to the Receiving Party disclosing such confidential information (i) as expressly set forth in the Engagement Letter, (ii) to contractors providing administrative, infrastructure and other services to the Receiving Party and subcontractors performing services in respect thereof, in each case, whether located within or outside of the United States, provided that such contractors and subcontractors have agreed to be bound by confidentiality obligations similar to those in this Section 6(a), (iii) as may be required by law, regulation, judicial or administrative process, or in accordance with applicable professional standards or rules, or in connection with litigation pertaining hereto, and (iv) with respect to Consultant as the Receiving Party, to Consultant's affiliates and to RM Advisory LLC and its affiliates. Confidential information shall not be deemed to include information that (A) is or becomes publicly available other than as the result of a disclosure in breach hereof, (B) becomes available to the Receiving Party on a non-confidential basis from a source that the Receiving Party believes is not prohibited from disclosing such information to the Receiving Party, (C) is already known by the Receiving Party without any obligation of confidentiality with respect thereto, or (D) is developed by the Receiving Party independently of any disclosures made to the Receiving Party hereunder

b) All Services and Deliverables shall be solely for Client's benefit and are not intended to be relied upon by any person or entity other than Client. Client shall not disclose the Services or Deliverables, or refer to the Services or Deliverables in any communication, to any person or entity other than Client except (i) as expressly set forth in the Engagement Letter, (ii) to Client's contractors solely for the purpose of their providing services to Client relating to the subject matter of such Engagement Letter, provided that they comply with the restrictions on disclosure set forth in this sentence, or (iii) to the extent included within Client-created materials that do not in any way, expressly or by implication, attribute such materials to Consultant or its subcontractors. Client agrees to indemnify and hold harmless Consultant, its affiliates and subcontractors, and their respective personnel from all Claims attributable to claims of third parties relating to the use or disclosure of the Services or Deliverables.

7. Limitation on Warranties. This is a services agreement. Consultant warrants that it shall perform the Services in good faith and in a professional manner. **EXCEPT TO THE EXTENT DISCLAIMING SUCH WARRANTIES IS INCONSISTENT WITH APPLICABLE PROFESSIONAL STANDARDS, CONSULTANT DISCLAIMS ALL OTHER WARRANTIES, EITHER EXPRESS OR IMPLIED, INCLUDING WARRANTIES OF MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE. CLIENT ACKNOWLEDGES THAT THE SERVICES DO NOT INCLUDE, AND CONSULTANT SHALL NOT BE RESPONSIBLE FOR PROVIDING, ANY PROCEDURES DESIGNED TO DISCOVER SIGNIFICANT ERRORS, FRAUD, DEFALCATIONS OR OTHER IRREGULARITIES, SHOULD ANY EXIST.**

8. Limitation on Damages. Each party, its subsidiaries, affiliates, subcontractors, and their respective personnel shall not be liable for any claims, liabilities, or expenses relating to or in connection with this engagement ("**Claims**") for an aggregate amount in excess of the fees paid by Client to Consultant pursuant to this engagement, except (i) to the extent resulting from the recklessness, bad faith, or intentional misconduct of the other party, its subsidiaries, affiliates, subcontractors or their respective personnel, or (ii) for payment for Services performed. In no event shall either party, its subsidiaries, affiliates, subcontractors, or their respective personnel be liable for any loss of use, data, goodwill, revenues or profits (whether or not deemed to constitute a direct Claim), or any consequential, special, indirect, incidental, punitive

or exemplary loss, damage, or expense relating to or in connection with this engagement. The provisions of this Section shall not apply to any Claim for which one party has an express obligation to indemnify the other. In circumstances where any limitation on damages or indemnification provision hereunder is unavailable, the aggregate liability of each party, its subsidiaries, affiliates, subcontractors, and their respective personnel for any Claim shall not exceed an amount that is proportional to the relative fault that their conduct bears to all other conduct giving rise to such Claim.

9. Indemnification.

a) Consultant shall indemnify, defend and hold harmless Client and its personnel from and against any and all Claims attributable to claims of third parties solely for bodily injury, death or damage to real or tangible personal property, to the extent directly and proximately caused by the negligence or intentional misconduct of Consultant while engaged in the performance of the Services. Client agrees to indemnify and hold harmless Consultant, its affiliates and subcontractors and their respective personnel from all Claims attributable to claims of third parties relating to or in connection with the engagement, except to the except resulting from the recklessness, bad faith, or intentional misconduct of Consultant or its subcontractors.

b) The indemnified party shall provide the indemnifying party with prompt notice of any Claim for which indemnification is sought hereunder and shall cooperate in all reasonable respects with the indemnifying party in connection with any such Claim, provided however that the indemnified party's failure to comply with such notice and cooperation obligations shall not relieve the indemnifying party of its indemnification obligations, except to the extent the indemnifying party has been actually prejudiced by such failure. The indemnifying party shall be entitled to control the handling of any such Claim and to defend or settle any such Claim, in its sole discretion, with counsel of its own choosing that is reasonably satisfactory to the indemnified party. The indemnifying party shall not settle any Claim without the prior written consent of the indemnified party.

10. Sole Recourse. Client acknowledges and agrees that its sole and exclusive remedy with respect to any and all claims for any breach of the Engagement Letter, shall be against Consultant and no other entity or person, including without limitation, any entity using the brand Richey May or any affiliates. In furtherance of the foregoing, Client hereby waives, to the fullest extent permitted under law, any and all claims and causes of action for any breach of contract, tort, or other claim against such other parties and each of their respective representatives arising under or based upon any legal theory, except in the event of common law fraud or intentional misconduct.

11. Relationship and Responsibilities.

a) In addition to the responsibilities set forth in the Engagement Letter, Client shall cooperate with Consultant in the performance of the Services, including, (i) providing Consultant with adequate working space, equipment and facilities and timely access to data, information, and personnel of Client; (ii) providing experienced and qualified personnel having appropriate skills to perform their assigned tasks and duties in a competent and timely fashion; (iii) providing a stable, fully functional system infrastructure environment which will support the Services and allow Consultant and Client to work productively; and (iv) promptly notifying Consultant of any issues, concerns or disputes with respect to the Services. With respect to the data and information provided by Client to Consultant or its subcontractors for the performance of the Services, Client shall have all rights required to provide such data and information, and shall do so only in accordance with applicable law and with any procedures agreed upon in writing.

b) Client shall be solely responsible for, among other things (i) the performance of its personnel and agents; (ii) the accuracy and completeness of all data and information provided to Consultant for purposes of the performance of the Services; (iii) making all management decisions, performing all management functions, and assuming all management responsibilities; (iv) designating a competent management member to oversee the Services; (v) evaluating the adequacy and results of the Services; (vi) accepting responsibility for the results of the Services; and (vii) establishing and maintaining internal controls, including monitoring ongoing activities.

c) The Services may include advice and recommendations, but Consultant will not make any decisions on behalf of Client in connection with the implementation of such advice and recommendations. Consultant's performance is dependent upon Client's (i) timely and effective satisfaction of its responsibilities under these terms and the Engagement Letter, and (ii) timely decisions and approvals in connection with the Services, upon which Consultant shall be entitled to rely.

d) Consultant shall use diligent efforts to meet performance dates set forth in the Engagement Letter and shall notify Client promptly if Consultant encounters significant delays in completing the Services. Notwithstanding the foregoing, all performance dates contained in such Engagement Letter shall be regarded only as estimates.

12. AI Technology. Consultant may utilize machine learning, deep learning, and other artificial intelligence technologies, including generative artificial intelligence, statistical learning algorithms, models (including large language models), neutral networks, and other artificial intelligence tools or methodologies (collectively, "**AI Technology**") to assist Consultant in the performance of the Services. Notwithstanding the foregoing, any work product or insights generated by AI Technology for use in the Services will be subject to review and professional oversight by qualified personnel.

13. Survival and Interpretation. All provisions which are intended by their nature to survive performance of the Services shall survive such performance, or the expiration or termination of this engagement. In the event of any conflict or ambiguity between these terms and the Engagement Letter, these terms shall control. Each of the provisions of these terms shall apply to the fullest extent of the law, whether in contract, statute, tort (such as negligence), or otherwise, notwithstanding the failure of the essential purpose of any remedy. Any references herein to the term "including" shall be deemed to be followed by "without limitation."

14. Assignment and Subcontracting. Neither party may assign or subcontract any of its rights or obligations hereunder (including interests or Claims) without the prior written consent of the other party, provided that Consultant may assign any of its rights and obligations under the Engagement Letter to an affiliate or as part of the sale or transfer of all or substantially all of its assets and business, including by merger or consolidation. Notwithstanding the foregoing, Consultant may use subcontractors or other third-party service providers, which may be located within or outside the United States of America, to assist in performance of the Services. Consultant shall be responsible for performance of the Services by such subcontractors to the same extent that Consultant would be liable under these terms had Consultant performed the Services.

15. Non-exclusivity. Consultant may (i) provide any services to any person or entity, and (ii) develop for itself, or for others, any materials or processes including those that may be similar to those produced as a result of the Services, provided that, Consultant complies with its obligations of confidentiality set forth hereunder.

16. Non-solicitation. During the term of this engagement and for a period of one year thereafter, each party agrees that its personnel (in their capacity as such) who had substantive contact with personnel of the other party in the course of this engagement shall not, without the other party's consent, directly or indirectly employ, solicit, engage or retain the services of such personnel of the other party. In the event a party breaches this provision, the breaching party shall be liable to the aggrieved party for an amount equal to thirty percent (30%) of the annual base compensation of the relevant personnel in his/her new position. Although such payment shall be the aggrieved party's exclusive means of monetary recovery from the breaching party for breach of this provision, the aggrieved party shall be entitled to seek injunctive or other equitable relief. This provision shall not restrict the right of either party to solicit or recruit generally in the media.

17. Force Majeure. Neither party shall be liable for any delays or non-performance directly or indirectly resulting from circumstances or causes beyond its reasonable control, including. fire, epidemic or other casualty, act of God, strike or labor dispute, war or other violence, or any law, order or requirement of any governmental agency or authority.

18. Independent Contractor. Each party is an independent contractor and neither party is, nor shall be considered to be, nor shall purport to act as, the other's agent, partner, fiduciary, joint venturer, or representative.

19. Governing Law. These terms, the Engagement Letter and all matters relating to or in connection with this engagement, shall be governed by, and construed in accordance with, the laws of the State of Colorado, without regard to the principles of conflicts of law thereof.

20. Disputes.

a) Any action based on or arising out of this engagement, the Engagement Letter, or the Services shall be brought and maintained exclusively in any state or federal court, in each case located in Douglas County, Colorado. Each of the

parties hereby expressly and irrevocably submits to the jurisdiction of such courts for the purposes of any such action and expressly and irrevocably waives, to the fullest extent permitted by law, any objection which it may have or hereafter may have to the laying of venue of any such action brought in any such court and any claim that any such action has been brought in an inconvenient forum.

b) **THE PARTIES HEREBY IRREVOCABLY WAIVE, TO THE FULLEST EXTENT PERMITTED BY LAW, ALL RIGHTS TO TRIAL BY JURY IN ANY ACTION, PROCEEDING OR COUNTERCLAIM RELATING TO OR IN CONNECTION WITH THIS ENGAGEMENT.**

c) **Limitation on Action.** No action, regardless of form, relating to or in connection with this engagement, the Engagement Letter, or the Services may be brought more than one year after completion of the Services, except that an action for nonpayment may be brought not later than one year following the due date of the last payment owing to the entity being the action.

21. Response to Legal and Regulatory Inquiries. If Consultant receives a request, including a subpoena, summons, or discovery demand in litigation, from any governmental agency, investigative body or a third-party in a legal, administrative or similar proceeding in which Consultant is not a party to produce any documentation or information, or to provide testimony relating to this engagement, Consultant will invoice Client for Consultant's time and expense incurred in complying with the request, including attorneys' fees, as a separate engagement irrespective of whether Consultant is providing any other services to Client at that time. Client agrees that Consultant shall be entitled to compensation for time expended at its standard hourly rates and for reimbursement for all associated expenses, including any legal fees incurred in responding to such requests or subpoenas. Consultant will promptly inform Client of any such request unless legally prohibited from doing so. Charges may apply for additional requests for Consultant to provide copies of Client's records.

22. Approval of Deliverables. Client shall approve each Deliverable that conforms in all material respects to the requirements therefor set forth in the Engagement Letter. Approval of a Deliverable shall be deemed given if Client has not provided Consultant with written notice of a deficiency within five (5) days of delivery of such Deliverable.

23. Notices. All notices hereunder shall be (i) in writing, (ii) delivered to the representatives of the parties at the addresses set forth in the Engagement Letter, unless changed by either party by notice to the other party, and (iii) effective upon receipt.

24. Waivers and Amendments. No delay or omission by a party in enforcing its rights or remedies under these terms shall impair such right or remedy or be deemed to be a waiver thereof. No waiver of any right or remedy under these terms with respect to any occurrence or event on one occasion shall be deemed a waiver of such right or remedy with respect to such occurrence or event on any other occasion. No amendment or waiver of this Agreement or any SOW shall be valid unless in writing or signed by the parties.

25. Severability. If any provision of these terms or the Engagement Letter is unenforceable, such provision shall not affect the other provisions, but such unenforceable provision shall be deemed modified to the extent reasonably necessary to render it enforceable, preserving to the fullest extent permissible the intent of the parties set forth herein.

26. Entire Agreement. These terms, and the Engagement Letter, including attachments, constitute the entire agreement between the parties with respect to this engagement, supersede all other oral and written representations, understandings or agreements relating to this engagement.

AGENDA ITEM or FINAL CONTRACT REVIEW SUBMITTAL FORM

Agenda Item: Draft BOCC Minutes; 2/17/2026

Action Requested: Board of County Commissioners' Signature

Parties to the Agreement:

Term Begins: **Term Ends:** **Grant Contract #:**

Summary:

Draft BOCC Minutes; 2/17/2026

Fiscal Impact:

Submitted by: Holly Perry **Submitter's Email Address:** hperry@gunnisoncounty.org

Finance Review: ○ Required ◉ Not Required

Comments:

Reviewed by: Discharge Date:

County Attorney Review: ○ Required ◉ Not Required

Comments:

Reveiwed by: Discharge Date: Certificate of Insurance Required

Yes ○ No ○

County Manager Review:

Comments:

Reveiwed by: GUNCOUNTY1\mbirnie Discharge Date: 2/25/2026

○ Consent Agenda ◉ Regular Agenda ○ Worksession Time Allotted: 1

Agenda Date: 3/3/2026

Revised April 2015

GUNNISON COUNTY BOARD OF COUNTY COMMISSIONERS
REGULAR MEETING MINUTES
February 17, 2026

The February 17, 2026 meeting was held in the Board of County Commissioners' meeting room located at 200 E. Virginia Avenue, Gunnison, Colorado. Present, either in person or via Zoom, were:

Laura Puckett Daniels, Chairperson
Elizabeth Smith, Vice-Chairperson
Jonathan Houck, Commissioner
Sammy Obaid, Assistant County Attorney
Matthew Birnie, County Manager
Holly Perry, Deputy County Clerk
Others Present as Listed in Text

Due to Commissioner Puckett Daniels participating remotely via Zoom, Commissioner Smith will be running the meeting.

GUNNISON COUNTY LOCAL LIQUOR LICENSING AUTHORITY MEETING:

CALL TO ORDER: Commissioner Smith called the meeting to order at 8:30 am.

ALCOHOL BEVERAGE LICENSE #03-13185; SKYHIGHCOLORADO LLC DBA NUGGET CAFÉ; 4/6/2026 TO 4/6/2027:

Moved by Commissioner Houck, seconded by Commissioner Puckett Daniels to approve the liquor license as presented this morning. Motion carried unanimously.

ADJOURN: Commissioner Smith adjourned the meeting of the Gunnison County Local Liquor Licensing Authority at 8:31 am.

GUNNISON COUNTY HOUSING AUTHORITY MEETING:

CALL TO ORDER: Commissioner Smith called the meeting to order at 8:31 am.

CONSENT AGENDA: CM Birnie clarified that this is putting ongoing operations into place as Gunnison County moves from the transition period. **Moved** by Commissioner Houck, seconded by Commissioner Puckett Daniels to approve the consent agenda as presented this morning for the Gunnison County Housing Authority. Motion carried unanimously.

1. Acknowledgment of Executive Secretary's Signature; Amended and Restated Agreement Among Housing Authority Risk Retention Group, Inc and It's Members; Gunnison County Housing Authority; 1/1/2026
2. Acknowledgment of Executive Secretary's Signature; Proposal; HAI Group; Gunnison County Housing Authority; $5,700

ADJOURN: Commissioner Smith adjourned the meeting of the Gunnison County Housing Authority at 8:33 am.

GUNNISON COUNTY BOARD OF COUNTY COMMISSIONERS REGULAR MEETING:

CALL TO ORDER: Commissioner Smith called the meeting to order at 8:33 am.

AGENDA REVIEW: There were no changes made to the agenda.

MINUTES APPROVAL: **Moved** by Commissioner Houck, seconded by Commissioner Puckett Daniels to approve the February 3, 2026 Regular Meeting minutes as amended here this morning. Motion carried unanimously.

1. February 3, 2026 Regular Meeting

SCHEDULING: The Upcoming Meetings Schedule was discussed and updated.

CONSENT AGENDA: **Moved** by Commissioner Houck, seconded by Commissioner Puckett Daniels to approve the consent agenda as presented this morning. Motion carried unanimously.

1. Amendment No. Six to Contract Dated September 29, 2022; Jviation, A Woolpert Company, LLC; Project No. 110015580.07; Gunnison-Crested Butte Regional Airport; $871,352
2. Letter of Support; Town of Crested Butte's Application to the CEO Local IMPACT Accelerator Grant Program; Facilities
3. Acknowledgment of County Manager's Signature; Gunnison County Agreement for Professional Services with Magellan Strategies; Public Works; 1/1/2026 to 7/31/2026; $16,500
4. Impact Assistance Grant Application; Colorado Parks and Wildlife; Assessor's Office; Tax Year 2025; $21,241.13
5. Resolution; Pertaining to Open Fire Bans and the Imposition of Fire Restriction Stages and Exemptions

6. Acknowledgment of County Manager's Approval; 2026-27 Track 3 One-Year Optional Add-On; Health and Human Services; 4/1/2026 to 3/31/2027; $7,500
7. County Aid Agreement; Gunnison Conservation District; Finance; 1/1/2026 to 12/31/2026; $10,000
8. County Aid Agreement; Gunnison Country Food Pantry; Finance; 1/1/2026 to 12/31/2026; $14,000
9. County Aid Agreement; Gunnison Valley Animal Welfare League; Finance; 1/1/2026 to 12/31/2026; $12,000
10. County Aid Agreement; Gunnison Valley Health Foundation; Finance; 1/1/2026 to 12/31/2026; $11,500
11. Amendment #2 to the Gunnison County Flexible Spending Plan; Imagine360; Human Resources; 1/1/2026
12. Professional Services Agreement; Souder, Miller & Associates, Inc.; Public Works; 2/17/2026 to 12/31/2027; $59,820
13. Resolution to Lease, Purchase And/Or Finance Caterpillar Equipment
    a. Sales Agreement; Quote 290695; Wagner Cat; Contract No 001-70207654; Public Works; $637,445.82
    b. Governmental Equipment Lease-Purchase Agreement; Cat Financial; Contract No 001-70207654; Public Works
    c. Amendment to Governmental Equipment Lease-Purchase Agreement; Cat Financial; Contract No 001-70207654; Public Works
14. County Aid Agreement; Project Hope of Gunnison Valley; Finance; 1/1/2026 to 12/31/2026; $10,500
15. County Aid Agreement; Safe Ride of Gunnison, Inc.; Finance; 1/1/2026 to 12/31/2026; $4,000
16. Second Amendment to Agreement Regarding Assisted Living Gunnison Living Community; Board of Trustees of the Gunnison Valley Hospital; 10/31/2025 to 10/31/2030
17. County Aid Agreement; Six Points Evaluation and training, Inc.; Finance; 1/1/2026 to 12/31/2026; $12,000
18. Professional Services Agreement Extension; Vaisala Inc.; 12/1/2025 to 11/30/2026; Public Works; $10,670
19. Intergovernmental Agreement Inter-Agency Partnership for the Women, Infants, and Children Program; Board of County Commissioners of the County of San Miguel and Board of County Commissioners of the County of Ouray; Health and Human Services; 10/1/2025 to 9/30/2026
20. Letter of Support; Upper Gunnison River Water Conservation District (UGRWCD); Community Funding Partnership Re: Tomichi Basin Stream Restoration and Irrigation Diversion Improvement Project

COUNTY MANAGER'S REPORTS:

1. Gunnison County Housing Authority Transition – CM Birnie stated he will be asking for a resolution to clarify his authorities as County Manager also apply to his role in the Gunnison County Housing Authority.
2. Whetstone – CM Birnie explained that there was an additional test with Fire Department and since they exceeded flow requirements they are allowed to begin framing another building.
3. Assistant County Manager for Community and Economic Development Finalist Interviews – CM Birnie noted that the finalist interviews will be taking place this week.
4. Roads and Bridges Open House – CM Birnie reminded everyone of the two open houses on Wednesday.

COMMISSIONER ITEMS: This discussion began earlier than scheduled due to a gap in the meeting.

Commissioner Houck:

1. Colorado River Map Group – Commissioner Houck has been working with this group and Colorado Parks and Wildlife (CPW) regarding river access and management around recreation and other competing interests. They are also starting to set up local workshops within the community.
2. Uncompahgre Field Office – Commissioner Houck has been having conversations with CA Hoyt regarding comments for the Resource Management Plan Amendment (RMPA) litigation.
3. State Land Board – Commissioner Houck stated they are still meeting with counties regarding parcels that can be nominated for layered, additional uses, or expanding uses of leased state land.

Commissioner Puckett Daniels:

1. Sustainable Tourism and Outdoor Recreation Committee (STOR) – Commissioner Puckett Daniels relayed they had some conversations with reappointed member LB Mullins regarding Gunnison Wildlife Association and his comments. She has also been participating in subcommittees including trailhead infrastructure for Lower Loop Trailhead. Crested Butte Land Trust (CBLT) will be initiating a planning process this summer for management of the parcel of land. She is also participating in a fundraising subcommittee who is trying to determine who to grow the Gunnison Stewardship Fund. Lastly, Commissioner Puckett Daniels is involved with the Wildlife Vehicle Collisions subcommittee and they are starting to draft a scope of work for the $50,000 Regional Partnership Initiative (RPI) funding they received to build on the Colorado

Parks and Wildlife (CPW) and National Park Service (NPS) study of the Highways 50 and 135 corridors.

BREAK: The meeting recessed from 8:46 am until 9:34 am in order to hold the below Abatement Hearing.

HEARING; PETITION FOR ABATEMENT OR REFUND OF TAXES; PROPERTY TAX YEARS 2023 & 2024; R074074; PARCEL NO. 3701-250-09-004; LOT 2, GUNNISON SECURE STORAGE SUBDIVISION, #684299; GUNNISON SECURE STORAGE LLC: Petitioner's Agent Darla Jaramillo, Appraiser John Zimmerman and Appraiser III Bob Blackett were present for discussion.

1. Open Abatement Hearing. Commissioner Smith opened the Abatement Hearing at 8:47 am.

2. Public Notice Confirmation. Clerk Perry confirmed that the Abatement Hearing had been properly public noticed.

3. Identify Ex Parte Communications. There were no ex parte communications identified.

4. Staff Presentation. Appraiser Zimmerman introduced himself as a contract commercial appraiser for Gunnison County and relayed the abatement petition was properly filed. He explained that the applicant property is classified as mixed-use and therefore gave a recommendation to deny adjustment for the commercial aspect. He relayed in a previous submission, there were several buildings omitted from the petitioner's case that were included in the materials provided a few days before the hearing. However, this does not change his recommendation. Appraiser Zimmerman then explained that the petitioner is basing the valuation on the current vacancies it has since it's a new development, when Colorado law dictates to treat properties the same regardless of vacancies.

   Appraiser Blackett stated both he and Appraiser Zimmerman did a physical inspection of this property on November 25th. The applicant noted the duplex is a deed-restricted household, which the Assessor's Office didn't recognize, and Appraiser Blackett also changed the condition rating from excellent to good. Thus, he recommends a reduction in the residential aspect of the property.

5. Applicant Presentation. Petitioner's Agent Jaramillo referenced her Exhibit B and highlighted some excerpts from the Assessor Reference Library regarding the processes of valuation and abatements which are put out by the Division of Property Taxation of Colorado and relayed that evidence should be presented by the Assessor's Office for their recommendation.

   She described the property as 179-unit drive-up self-storage property with a deed restricted residential duplex. Originally the property had 82 units, and the additional 97 units were constructed during 2022. However, based on the dates looked at for valuation, the additional 97 units would have been vacant on June 30, 2022. Agent Jaramillo provided two previous Board of Assessment Appeals (BAA) cases where they have accepted a lease-up on self-storage properties.

   Following the description, Agent Jaramillo went over her own assessment and calculations using the model she explained was used in the previous BAA Appeals with three-year lease-up stabilization which brought the commercial value to $2,358,110 and residential to $50,000 with a final valuation of $2,408,110.

6. Board Questions. Commissioner Puckett Daniels clarified the duplex is being valued at $25,000 each, $50,000 total on her assessment to which Agent Jaramillo confirmed based on her comparables. Commissioner Puckett Daniels then relayed the comparables used did not match to what the petitioner's property is such as a unit that is one of 20 in a building or a mobile home park. Commissioner Puckett Daniels then asked Appraiser Zimmerman to clarify some aspects of the commercial side. Appraiser Zimmerman explained that one of three approaches of valuation is the income approach which includes occupancy rate and expense rate, and that they are only allowed to use the income methodology on commercial portion of this property.

   Commissioner Houck stated he does not see evidence that the Gunnison County Assessor's Office's assessment was not properly calculated and had no specific questions.

   Commissioner Smith confirmed the Assessor's Office used the mass appraisal process for the residential portion. Agent Jaramillo stated this is no longer at the level at the Assessor and the mass appraisal does not apply. Appraiser Zimmerman stated there are significant problems with Agent Jaramillo's assessment and lease-up formulas.

7. Public Comments. Commissioner Smith opened the Abatement Hearing to comments at 9:31 am.

8. Acknowledge Correspondence Received. No additional correspondence was identified.

9. Applicant Response. Agent Jaramillo added that the Assessor's Office has not provided sales for comparables. She feels they have presented enough evidence where they have not seen anything from the Assessor's Office.

10. Close Abatement Hearing. Commissioner Smith closed the Abatement Hearing at 9:34 am and immediately reconvened the Gunnison County Board of County Commissioners Meeting.

Commissioner Puckett Daniels relayed the agent's presentation was off in sales and would like to move forward with the Assessor's recommendation. Commissioner Houck suggested possibly pushing this hearing to another day, but he is comfortable moving forward. Commissioner Smith agreed. Commissioner Houck then highlighted per statute, the Assessor's recommendation is assumed correct, and the burden relies on the petitioner. **Moved** by Commissioner Smith, seconded by Commissioner Puckett Daniels to deny the applicant's petition for request for abatement or refund of taxes for property years 2023 and 2024, R074074 and accept the Assessor's recommendations for both the residential and commercial property adjustments.

BREAK: The meeting recessed from 9:43 am until 10:11 am in order to call to order as the Gunnison/Hinsdale Board of Human Services (see separate minutes) and from 10:11 am to 10:16 am for a short break.

GUNNISON/HINSDALE BOARD OF HUMAN SERVICES REGULAR MEETING: See separate minutes

RESOLUTION AUTHORIZING ATV, OHV, AND UTV USE ON CERTAIN COUNTY ROADS IN SOMERSET COLORADO: Assistant County Manager for Public Works Martin Schmidt was present for discussion.

Commissioner Puckett Daniels requested that ACM Schmidt show a map to better explain the areas the resolution refers to. ACM Schmidt then explained they did not include 9th and 10th street in the resolution, but included 1st through 8th Street, Pike Avenue, King Avenue and River Road which are all south of Highway 133. He emphasized that it does not give permission to cross the highway in any way that doesn't comply with state regulations.

Commissioner Puckett Daniels asked if they wanted to add additional verbiage regarding speed limits, helmet use, and other items previously discussed. CM Birnie relayed CA Hoyt recommended to bring it down to the County jurisdiction and authority. Commissioner Puckett Daniels then asked if Gunnison County could set a speed limit, but ACM Schmidt relayed they would need an engineering traffic study. CM Birnie reiterated ACM Schmidt stating the sheriff will still be enforcing the area and observe behavior. The Board all stated their concerns and comfort level with this resolution. Commissioner Smith suggested adding additional language regarding the physical landscape of Somerset and proposed giving directions to the Attorney's Office to make those changes and bring back an updated document while Commissioner Houck relayed it is unnecessary in his opinion. After further discussion, it was decided to give that direction to the Attorney's Office. Commissioner Puckett Daniels emphasized the resolution is not passing today, but it will still be considered at a future meeting once some language has been updated.

LOT CLUSTER; LUC-26-00003; BONAPACE: Planning Technician Aidan McComas was present for discussion.

Planning Technician McComas stated this met the standards of the Crested Butte South Special Area Regulations needed for approval. **Moved** by Commissioner Puckett Daniels, seconded by Commissioner Houck to approve LUC-26-00003 Lot Cluster for Bonapace as presented. The motion was amended to include authorizing the signature of the full Board. Motion carried unanimously.

FOLLOW UP; STREET VACATION REQUEST FOR AGATE DRIVE AND A PEDESTRIAN EASEMENT ADJACENT TO LOTS 3, 4, 5, 6, 9, AND 10, BLOCK 2, MARBLE SKI AREA FILING #5 IN THE TOWN OF MARBLE, COLORADO; WILLIAM AND JUDY PERRY, CINDY SUPLIZIO AND PETER MUELLER: Assistant County Manager for Public Works Martin Schmidt, Permit Right of Way Manager Chris Hill and Planner Rachael Blondy were present for discussion.

1. A Resolution Vacating a Certain Portion of a Certain Street and Pedestrian Easement Lying within the Town of Marble, County of Gunnison, State of Colorado – ACM Schmidt reminded the Board that this application was already considered by the Board but may have needed an easement for a lumen line. He explained that it was determined the line was not in Agate Drive, and that no easement was required. **Moved** by Commissioner Houck, seconded by Commissioner Puckett Daniels to approve Resolution 2026-5 a Resolution Vacating a Certain Portion of a Certain Street and Pedestrian Easement Line within the Town of Marble, County of Gunnison, State of Colorado, as presented in the packet today and authorize the full Board's signature on the resolution. Motion carried unanimously.
2. Lot Cluster and Boundary Line Adjustment; LUC-25-00024; Suplizio-Mueller, Fox-Perry – Planner Blondy relayed the applicant has purchased another lot that they would like to be clustered. The Boundary Line Adjustment is to transition Agate Drive into three different parcels that were originally plotted to access. **Moved** by Commissioner Puckett Daniels, seconded by Commissioner Houck to approve LUC-25-00024, Lot Cluster and Boundary Line Adjustment for Suplizio-Mueller,

Fox-Perry as presented today and authorize the signature of the full Board on the Lot Cluster Agreement and the signature of the Chair on the plat. Motion carried unanimously.

GUNNISON COUNTY BOARDS AND COMMISSIONS APPOINTMENTS:

1. Planning Commission Alternate (Fill Two vacancies for one-year terms)
    - Applicants:
        1. Stuart Asay
        2. Betsy Dupree-Kyle
        3. Anna Fenerty
        4. Steve Jenkins
        5. Beverly Troxtell

Commissioner Puckett Daniels relayed that Anna Fenerty made an error in her calendar for the interview, but she is still interested in the position. She then stated that even though normally interviews are desired, the Board does have experience with working with Ms. Fenerty on previous projects or boards. Commissioner Puckett Daniels further noted her opinion would be valuable because she lives in town as a renter and is inclined to appoint her because she brings a set of skills that no one else does. Commissioner Smith is amendable to appointing Ms. Fenerty despite not having an interview. Commissioner Houck relayed he did listen to the recording of the interviews and is up to speed on the applicants and based on the interviews, applications and needs of the Board, he would like to appoint Anna Fenerty and Beverly Troxtell. Commissioner Puckett Daniels agreed with Commissioner Houck's viewpoint but is also open to appointing Betsy Dupree-Kyle due to her experience with oil and gas. However, she agrees with appointing Beverly Troxtell and Anna Fenerty. Commissioner Smith would like to encourage Steve Jenkins to keep being involved but also agrees with Commissioner Puckett Daniels and Commissioner Houck. **Moved** by Commissioner Smith, seconded by Commissioner Houck to appoint Anna Fenerty and Beverly Troxtell to the two vacancies for the Planning Commission alternates for one-year terms. Motion carried unanimously.

GRANT APPLICATION; CERTIFIED LOCAL GOVERNMENT (CLG) SUBGRANT APPLICATION; COLORADO OFFICE OF ARCHAEOLOGY AND HISTORIC PRESERVATION (OAHP); PHASE 1 RECONNAISSANCE LEVEL SURVEY OF HISTORIC BUILDINGS WITHIN THE CITY OF GUNNISON; HISTORIC PRESERVATION COMMISSION; $24,720: Geographic Information Services Manager Mike Pelletier and Historic Preservation Commission (HPC) members Jody Reeser and Heather Thiessen-Reily were present for discussion.

HPC Member Reeser relayed the surveys are needed for a knowledge base to help with potential support, protections and is a huge portion of the economy. They conducted a survey plan in 2016, and a high priority is within the City of Gunnison. Additionally, in 1998, the City did a survey of downtown buildings, however, there is no database for residential properties in the City. HPC was able to use Assessor database to discover about 150 homes were supposedly built from 1900 and before. HPC Member Reeser noted that History Colorado does a CLG Grant every year and with access to Historic Fund Granting, they would like to have four phases; the first being the northwest quadrant of the City. Overall, they have received good feedback locally regarding the potential survey. Commissioner Puckett Daniels asked what could happen once the information is available. HPC Member Reeser explained homeowners can pursue protections and the State offers tax breaks for historic buildings as well. **Moved** by Commissioner Houck, seconded by Commissioner Smith to support the grant application and authorize the Chair's signature stamp to be used on that today in order to meet the deadline for the application. Also included in the motion is an appreciation of the work done by the committee. Motion carried unanimously.

VOUCHERS AND TRANSFERS APPROVAL: Chief Finance Officer Melissa LaMonica was present for discussion.

1. January 2026 Voucher Report – **Moved** by Commissioner Houck, seconded by Commissioner Puckett Daniels to approve the vouchers in the amount of $8,450,227.85.
2. January 2026 Cash Transfer Report – **Moved** by Commissioner Houck, seconded by Commissioner Puckett Daniels to approve the cash transfer in the amount of $11,061,116.80.
3. January 2026 Purchase Card Report – The Board did not pose any questions about this report.
4. December 2025 Sales and Local Marketing Tax Report – The Board did not pose any questions about this report. Commissioner Houck commented that typically they are about a month or two out from seeing the impacts of what is going on weather-wise.

TREASURER'S MONTHLY REPORT: County Treasurer Teresa Brown was not present for the discussion, but she provided the January 2026 Treasurer's report and investment report for discussion and acceptance. **Moved** by Commissioner Houck, seconded by Commissioner Puckett Daniels to accept the Treasurer's Report as presented and authorize the use of the Chair's signature stamp on the document. Motion carried unanimously.

COMMISSIONER ITEMS (CONT'D):

Commissioner Puckett Daniels:

2. Legislative Updates – Commissioner Puckett Daniels relayed that the vacant home tax was postponed indefinitely and the wildlife passages bill has not been introduced but they are

reviewing a draft. She has been heavily involved with a Colorado Counties, Inc. Steering Committees (CCI) group on making amendments to the Colorado Outdoor Opportunities Act including to strengthen the language around local government needing to be part of Regional Partnering Initiatives (RPIs) and acknowledging impacts of recreation on counties. The Board agreed to be in support of the amend position at CCI.

3. Water Quality & Quantity (QQ) – Commissioner Puckett Daniels relayed they have taken an oppose stance for the two data center bills.
4. CCI and Counties & Commissioners Acting Together (CCAT) Steering Committees – Commissioner Puckett Daniels would like to have another discussion before March 4th regarding updates.
5. Gunnison Valley Regional Transportation Authority (RTA) – Commissioner Puckett Daniels will be participating at the meeting via Zoom.

Commissioner Smith:

1. Gunnison Valley Regional Transportation Authority (RTA) – Commissioner Smith relayed she will also be participating via Zoom.
2. Southwest Colorado Opioid Regional Council – Commissioner Smith relayed there is contention from Montrose County to get the voting membership to be more reflective of the population of the region whereas at the moment grants are scored based on merits of proposals and is how resources are allocated. Montrose County announced they do not want to be fiscal agent of the grants unless they get another voting seat, however, the City of Montrose may be interested.
3. Early Childhood Council – Commissioner Smith attended a meeting last week and left early to attend a meeting with Western Colorado University (WCU) and Gunnison Valley Health (GVH) regarding a space GVH renovated. WCU is proposing to take on the administrative director position of new program. She relayed there are two pro formas for consideration and there are conversations regarding going with one that will not be financially in the black. Commissioner Smith explained that the waitlist at Tenderfoot are in the 130s and they are considering using the renovated space purely for toddler and infant specific use as well as possibly contracting or getting a consultant on the analysis on what an infant/toddler subsidy to the center may look like. Commissioner Houck relayed the history of the funding of Tenderfoot and how it is an opportunity for businesses rather than all of the burden be on governments.
4. HB26-1001 – Commissioner Smith suggested if there is not Euclidean zoning to limit the areas of eligibility to ones that have special area regulations that could facilitate an administrative process. CM Birnie relayed that he and Planning Director Hillary Seminick have had discussions regarding this legislation.
5. Proposition 123- Commissioner Smith relayed the State is not amendable to more than one formula and that the new formula has increased the county obligations.
6. SB26-1070 – Commissioner Smith has reached out to several people regarding this bill. Commissioner Houck wants to make sure the Sheriff is deeply engrained in these conversations. Commissioner Puckett Daniels relayed she did speak with Sheriff Adam Murdie, who is in support of the stance the Board has taken and stated having a voice for law enforcement is very important.
7. County Revenue Working Group – Commissioner Smith attended last Friday regarding a long term approach to the constraints and challenge the Counties are having. She stated that counties cannot afford to treat revenues as abstract and spoke of the projects Gunnison County is currently doing and how they cannot do more.
8. Child Welfare Allocation Committee (CWAC) – Commissioner Smith attended a meeting and they had conversations regarding shifting costs and preparing for what counties will have to pay that they didn't in the past.

Commissioner Houck:

4. Hartman Castle Preservation Non-Profit – Commissioner Houck explained that they have applied for a grant to covert the property into a community event space and the Office of Just Transition would like to confirm that the county is generally in support of the contract. He then stated their desire to convert into community and event space would be a process that will need to go through a land use change application.

UNSCHEDULED PUBLIC COMMENT:

1. John Mlakar – Mr. Mlakar relayed the posted speed limit is 25 mph and he agrees that is too fast. He recommends having language regarding minimum regulations of the State to which Commissioner Puckett Daniels confirmed it is in the resolution.

ADJOURN: Commissioner Smith adjourned the meeting at 12:27 pm.

_____
Laura Puckett Daniels, Chairperson

_____
Elizabeth Smith, Vice-Chairperson

_____
Jonathan Houck, Commissioner

Minutes Prepared By:

_____
Holly Perry, Deputy County Clerk

Attest:

_____
Kathy Simillion, County Clerk

GUNNISON COUNTY BOARD OF COMMISSIONERS TEXT INCLUSION INTO MINUTES
Note: For all the details of each resolution including any exhibits, please refer to gunnisoncounty.org

BOARD OF COUNTY COMMISSIONERS OF THE COUNTY OF GUNNISON, COLORADO
RESOLUTION NO. 2026-3

A RESOLUTION OF THE BOARD OF COUNTY COMMISSIONERS OF GUNNISON COUNTY, COLORADO PERTAINING TO OPEN FIRE BANS AND THE IMPOSITION OF FIRE RESTRICTION STAGES AND EXEMPTIONS

WHEREAS, the Board of County Commissioners of Gunnison County ("Board"), pursuant to C.R.S. §§ 30-11-101(2) and 30-15-401, *et seq.* has the general enabling power to adopt ordinances, resolutions, rules and other regulations as may be necessary for the control or licensing of those matters of purely local concern, and to do all acts which may be necessary or expedient to promote the health and welfare of the residents and visitors of Gunnison County ("County"); and

WHEREAS, the Board may adopt ordinances to ban open fires and impose fire restriction stages within those portions of the unincorporated areas of the County where the danger of forest or grass fires is found to be high, pursuant to C.R.S. § 30-15-401(1)(n.5); and

WHEREAS, the Board is authorized to prohibit the sale, use, and possession of fireworks, including permissible fireworks, within those portions of the unincorporated areas of the County, pursuant to C.R.S. § 30-15-401(1)(n.7); and

WHEREAS, the Board passed Ordinance Nos. 8a, 14, 16, and 20 relating to fire bans and fire restrictions, including penalties for the violation of those Ordinances; and

WHEREAS, the Board acknowledges that from time-to-time fire conditions resulting from extended hot, dry and windy weather in the area make it prudent to impose restrictions on open fires, open burning and sale, use and possession of fireworks in order to reduce the danger of wildfire in the unincorporated areas of the County; and

WHEREAS, the Board specifically finds that in certain high fire-danger conditions such restrictions are in the best interests of the residents and visitors of the County in order to preserve the health, safety and welfare of the residents and visitors; and

WHEREAS, the Gunnison County Sheriff ("Sheriff') is authorized pursuant to C.R.S. §§ 30-10-512 and 30-10-513 to act as fire warden of the County and is responsible for coordination of fire suppression efforts in case of prairie, forest or wildland fires or wildfires occurring in unincorporated areas of the County outside the boundaries of a fire protection district or that exceed the capabilities of the fire protection district to control; and

WHEREAS, the Board believes that the Sheriff, as fire warden, is the appropriate person, using their expertise and discretion along with established fire restriction evaluation guidelines, and in consultation with local Fire Chiefs, State and Federal land management agencies, and State and Federal fire suppression authorities, to determine whether a restriction of open fires, open burning and use of fireworks should be implemented or elevated in times of extreme fire danger or suspended during times of decreased fire danger;

NOW THEREFORE, BE IT RESOLVED by the Board of County Commissioners of the County of Gunnison Colorado, that:

1. The Sheriff or their designee shall have the authority, in collaboration with local Fire Chiefs, State and Federal land management agencies, and State and Federal fire suppression authorities to declare Stage I or Stage II Restrictions regarding open fire, open burning or the sale, use or possession of fireworks, whenever the danger of forest or grass fires is found to be high and without the need for further proceedings or resolution ("Restrictions"). The Sheriff or their designee shall also have the authority to rescind those Restrictions when he or she determines it is appropriate considering the current fire danger.
    a. Stage I Restrictions shall allow the Sheriff to impose the following prohibitions:
        i. Building, maintaining, attending or using a fire, campfire or stove fire, including but not limited to agricultural and the burning of trash or debris, except:
            1. Building, maintaining, attending or using a fire in constructed, permanent fire pits or fire grates within developed recreation sites;
            2. Fires fueled by gas, jellied petroleum, or pressurized liquid fuel; or
            3. Fires burned in portable chimineas, fire pits and tiki torches wholly on or within private property.
        ii. Smoking, except:
            1. within an enclosed vehicle or building; or
            2. in a developed recreation site or while stopped in an area at least three feet (3') in diameter that is barren or clear of all flammable materials.
        iii. Restrictions or prohibitions on the sale, use and possession of fireworks pursuant to C.R.S. § 30-15-401(1)(n.7).
        iv. Using explosives, including but not limited to fuses or blasting caps, model rockets, exploding targets, tracer bullets or incendiary rounds.
        v. Welding or operating acetylene or other torch with open flame except in cleared areas of at least 10 feet (10') in diameter and in possession of a chemical pressurized fire extinguisher with a minimum rating of 2A.
        vi. Operating or using internal or external combustion engine without a spark arresting device properly installed, maintained and in effective working order.
    b. Stage II Restrictions shall allow the Sheriff to impose the following prohibitions:
        i. Building, maintaining, attending or using a fire, campfire or stove fire including but not limited to:
            1. Agricultural burning and the burning of trash or debris;
            2. Maintaining, attending or using a fire in constructed, permanent fire pits or fire grates within developed recreation sites;
            3. Fires fueled by gas, jellied petroleum, or pressurized liquid fuel, except that devices using pressurized liquid fuel or gas (e.g., stoves, grills or lanterns and shut-off valves are allowed when used at least three (3') or more from flammable material such as grasses or pine needles; and
            4. Fires burned in portable chimineas, fire pits and tiki torches.
        ii. Smoking, except within an enclosed vehicle or building.
        iii. Restrictions or prohibitions on the sale, use and possession of fireworks pursuant to C.R.S. § 30-15-401(1)(n.7).
        iv. Operating a chainsaw or other equipment powered by an internal combustion engine without a USDA or SAE approved spark arrester properly installed and in effective working order, a chemical pressurized fire extinguisher with a minimum rating of 2A kept with the operator, and round point shovel with an overall length of at least 35 inches (35") readily available for use.
        v. Welding, operating a torch with open flame, or any activities which generate flame or flammable material.
        vi. Using explosives, including but not limited to fuses or blasting caps, model rockets, exploding targets, tracer bullets or incendiary rounds.
        vii. Possessing or using a motor vehicle off established roads, motorized trails or established paring areas, except when parking in an area devoid of vegetation within ten feet (10') of the vehicle.
    c. Stage Ill Restrictions may only be imposed by the Board by duly adopted Resolution or Ordinance.
2. Any declaration by the Sheriff or their designee of Restrictions shall specify the Stage level, parameters, and the duration of the Restrictions as deemed necessary and appropriate. The Sheriff or their designee shall promptly coordinate notification to the public through press release(s) to local radio and print media, as well as posting on the County Internet Website and County Sheriff's Office Facebook page. Likewise, when conditions indicate a reduction or the suspension of Restrictions, the same notification to the public shall occur.
3. No less than three (3) business days after imposing or suspending any Restriction pursuant to this Resolution, the Sheriff shall present, for ratification by the Board, a written summary of the competent evidence and recommendations that are or were the basis of the decision to impose or suspend the Restriction. Notwithstanding the above, the Sheriff will engage in all reasonable efforts to immediately notify the members of the Board, the County Manager and the County Attorney regarding the imposition, modification or lifting of any Restrictions.

4. Nothing in this Resolution shall be construed to allow the burning or combustion of any material or any burning or fire activity otherwise prohibited by law.
5. The Sheriff or their designee shall consult with various state and federal land management agencies and obtain their recommendation prior to the Sheriff imposing or suspending any Restrictions. Recommendations shall be made pursuant to Fire Restriction Evaluation Guidelines as currently used by such agencies to evaluate the indicators that predict fire danger. Upon any implementation or suspension of Restrictions, the Sheriff or their designee shall coordinate and cooperate with these agencies to enforce the Restrictions.
6. This Resolution shall be enforced by the Sheriff or their designee, through their Deputies, the Fire Chief or their designee of any fire protection district or administering agencies of the state and federal lands located therein, and they shall have authority to order any person to immediately cease any violation of this Resolution. This shall include the right to issue a penalty assessment notice and the right to take such person or persons violating this Resolution into temporary custody.
7. Pursuant to Ordinance No. 20, any person who violates this Resolution commits a civil infraction and, upon conviction thereof, shall be punished by a fine of not more than one thousand dollars for each separate offense. The penalty assessment procedure provided in C.R.S. § 16-2-201, as amended, may be followed by any arresting law enforcement officer for any such violation. That penalty assessment procedure shall provide for a fine of five hundred dollars ($500.00) for each separate offense and a fine of one thousand dollars ($1,000.00) for any repeat offense by the same individual. Pursuant to C.R.S. § 30-15-402(2)(a), in addition to the foregoing penalties, persons convicted of a violation of this Resolution are subject to a surcharge of ten dollars ($10.00) to be paid to the clerk of the Gunnison County Court by the defendant, as well as any other penalties or surcharges set forth in C.R.S. § 30- 15-402, as amended, or as otherwise provided by law.
8. If any section, subsection, clause or sentence of this Resolution is judged by a court of competent jurisdiction to be invalid, such invalidity shall not affect, impair or invalidate any other provisions of this Resolution which can be given effect without the invalid provision.
9. The Board hereby finds, determines and declares that this Resolution is necessary for the immediate preservation and protection of the health, safety and welfare of the citizens of Gunnison County, Colorado because of the high danger of forest or wildland fires occurring in all unincorporated areas of the County. This Resolution shall take effect immediately upon adoption and remain in full force and effect until midnight Mountain Time, December 31, 2026 at which point this Resolution shall expire and no longer remain in effect, or until rescinded by subsequent Resolution or Ordinance adopted by the Board, whichever first occurs.

INTRODUCED by Commissioner Houck, seconded by Commissioner Puckett Daniels, and adopted this 17th day of February 2026.

BOARD OF COUNTY COMMISSIONERS
OF THE COUNTY OF GUNNISON, COLORADO

Houck – yes; Puckett Daniels – yes; Smith – yes.

BOARD OF COUNTY COMMISSIONERS
OF THE COUNTY OF GUNNISON, COLORADO
RESOLUTION NO. 2026-4

A RESOLUTION TO LEASE, PURCHASE AND/OR FINANCE CATERPILLAR EQUIPMENT

Caterpillar Model 816-11 Landfill Compactor, Serial Number: J6N00509

WHEREAS, the laws of the State of Colorado (the "State") authorize Gunnison County, a duly organized political subdivision of the State (the "County"), acting by and through the Board of County Commissioners of the County of Gunnison, Colorado (the "Board"), to purchase, acquire and lease personal property for the benefit of the County and its inhabitants and to enter into and necessary contracts; and

WHEREAS, the County wants to lease, purchase and/or finance equipment ("Equipment") from Caterpillar Financial Services Corporation and/or an authorized Caterpillar dealer ("Caterpillar") by entering into Sales Agreements with Caterpillar; and

WHEREAS, a copy of a Sales Agreement with Caterpillar has been presented to the Board at this February 17, 2026, meeting ("Agreement"); and

NOW, THEREFORE, BE IT RESOLVED by the Board of County Commissioners of the County of Gunnison, Colorado that (i) the Agreement, including all schedules and exhibits attached to the Agreement, is approved in substantially the form presented at the meeting, with any Approved Changes (as defined below), (ii) the County enters into the Agreement with Caterpillar and (iii) the Agreement is adopted as a binding obligation of the County; and

That Matthew Birnie, County Manager, Martin Schmidt, Assistant County Manager for Public Works, and/or Curtis Lupton, Fleet Manager for the Public Works Department, are authorized, directed and empowered

to (i) sign—or ratify-- and deliver to Caterpillar, and its successors and assigns, the Agreement and any related documents, and (ii) take or cause to be taken, all actions he deems necessary or advisable to acquire the Equipment, including the signing—or ratification-- and delivery of the Agreement and related documents; and

That the Clerk of the Board is authorized to attest to this Resolution and affix the seal of the Board to the Agreement, this Resolution, and any related documents; and
That nothing in this Resolution, the Agreement, or any other document imposes a pecuniary liability or charge upon the general credit of the County or against its taxing power, except to the extent that the payments payable under the Agreement are special limited obligations of the County as provided in the Agreement; and

That a breach of this Resolution, the Agreement or any related document will not impose any pecuniary liability upon the County or any charge upon its general credit or against its taxing power, except to the extent that the payments payable under the Agreement are special limited obligations of the County as provided in the Agreement; and that the authority granted by this Resolution will apply equally and with the same effect to the successors in office of the Authorized Persons.

INTRODUCED by Commissioner Houck, seconded by Commissioner Puckett Daniels, and adopted this 17th day of February 2026.

BOARD OF COUNTY COMMISSIONERS
OF THE COUNTY OF GUNNISON, COLORADO

Houck – yes; Puckett Daniels – yes; Smith – yes.

BOARD OF COUNTY COMMISSIONERS
OF THE COUNTY OF GUNNISON, COLORADO

RESOLUTION NO: 2026-5

A RESOLUTION VACATING A CERTAIN PORTION OF A CERTAIN STREET AND PEDESTRIAN EASEMENT LYING WITHIN THE TOWN OF MARBLE, COUNTY OF GUNNISON, STATE OF COLORADO

WHEREAS, the Board of County Commissioners of the County of Gunnison, Colorado ("Board"), by virtue of Colorado law, has authority and is the owner of certain roads and alleys lying within the County of Gunnison; and

WHEREAS, the Board has determined that not all platted roads and alleys are necessary for public access to privately owned property; and

WHEREAS, the Board has received a request from William and Judy Perry, Cindy Suplizio and Peter Mueller to vacate a certain portion of a certain street and a pedestrian easement lying within the Town of Marble, County of Gunnison, State of Colorado described as follows:

All that portion of Agate Drive and a pedestrian easement adjacent to Lots 3, 4, 5, 6, 9 and 10, Block 2, Marble Ski Area Filing #5 in the Town of Marble, according to the plat recorded October 4, 1971 at Reception Number 286205 in the office of the Gunnison County Clerk & Recorder.; and

WHEREAS, the vacation of the above described portion of the street lying within the Town of Marble, will not hinder any property owners of any lands from having access to their respective land nor disrupt existing travel modes or anticipated conditions in traffic or development patterns; and

WHEREAS, there will be no adverse impact to the natural environment, community needs or public health, safety and welfare from the vacation of the above described portion of the street and pedestrian easement lying within the Town of Marble; and

WHEREAS, the notices required by Colorado law for such vacation have been given and a public hearing on such vacation has been conducted; and

NOW, THEREFORE, BE IT RESOLVED by the Board of County Commissioners of the County of Gunnison, Colorado that the certain portion of a street and pedestrian easement lying within the Town of Marble, County of Gunnison, State of Colorado described as follows shall be and hereby is vacated:

All that portion of Agate Drive and a pedestrian easement adjacent to Lots 3, 4, 5, 6, 9 and 10, Block 2, Marble Ski Area Filing #5 in the Town of Marble, according to the plat recorded October 4, 1971 at Reception Number 286205 in the office of the Gunnison County Clerk & Recorder.; and

It is the specific intent of the Board that the vacation of the above described portion of a street and pedestrian easement lying within the Town of Marble shall accrue to and vest in the record owner(s) of adjacent real property pursuant to the provisions of C.R.S. § 43-2-302.

FURTHERMORE, this Resolution is contingent upon and shall not become effective until the recording in the records of the Office of the Clerk and Recorder of Gunnison County, Colorado of the following:

1. This Resolution.
2. Boundary Line Adjustment and Lot Cluster Agreement

INTRODUCED by Commissioner Houck, seconded by Commissioner Puckett Daniels, and adopted this 17th day of February 2026.

BOARD OF COUNTY COMMISSIONERS
OF THE COUNTY OF GUNNISON, COLORADO

Houck – yes; Puckett Daniels – yes; Smith – yes.

Gunnison County Board of County Commissioners Calendar

(Two or more commissioners may be in attendance.)

Search Results from *2/27/2026 thru 4/30/2026*

Board of County Commissioners

1. **BOCC Regular Meeting**
   March 3, 2026, All Day @ BOCC Boardroom
2. **Mayors & Managers Meeting - Hosted by Crested Butte Mountain Resort**
   March 5, 2026, 12:00 PM - 1:30 PM
3. **BOCC Work Session**
   March 10, 2026, All Day @ BOCC Boardroom
4. **BOCC Regular Meeting**
   March 17, 2026, All Day @ BOCC Boardroom
5. **BOCC Work Session**
   March 24, 2026, All Day @ BOCC Boardroom
6. **Mayors & Managers Meeting - Hosted by Mt. Crested Butte**
   April 2, 2026, 12:00 PM - 1:30 PM
7. **BOCC Regular Meeting**
   April 7, 2026, All Day @ BOCC Boardroom
8. **BOCC Work Session**
   April 14, 2026, All Day @ BOCC Boardroom
9. **BOCC Regular Meeting**
   April 21, 2026, All Day @ BOCC Boardroom
10. **BOCC Work Session**
    April 28, 2026, All Day @ BOCC Boardroom

Gunnison-Hinsdale Board of Human Services

1. **Gunnison-Hinsdale Board of Human Services Meeting**
   April 21, 2026, All Day @ BOCC Boardroom

AGENDA ITEM or FINAL CONTRACT REVIEW SUBMITTAL FORM

Agenda Item: Acknowledgment of County Manager's Signature; Prof

Action Requested: County Manager Signature

Parties to the Agreement:

Term Begins: **Term Ends:** **Grant Contract #:**

Summary:

Professional Services Agreement with Raymond Alspach

Fiscal Impact:

Submitted by: Holly Perry for John Cattles **Submitter's Email Address:** hperry@gunnisoncounty.org

Finance Review: (●) Required ( ) Not Required

Comments:

Reviewed by: GUNCOUNTY1\mlamonica Discharge Date: 2/20/2026

County Attorney Review: (●) Required ( ) Not Required

Comments:
No notary confirmation of signautere. Otherwise, legally sufficient. SO 2/20/26

Reveiwed by: GUNCOUNTY1\sobaid Discharge Date: 2/20/2026 Certificate of Insurance Required

Yes (●) No ( )

County Manager Review:

Comments:

Reveiwed by: GUNCOUNTY1\mbirnie Discharge Date: 2/25/2026

(●) Consent Agenda ( ) Regular Agenda ( ) Worksession Time Allotted: 0

Agenda Date: 3/3/2026

Revised April 2015

PROFESSIONAL SERVICES AGREEMENT

THIS PROFESSIONAL SERVICES AGREEMENT ("Agreement") made effective the 12th day of February 2026, by and between the Board of County Commissioners of the County of Gunnison, Colorado, whose address is 200 East Virginia, Gunnison, Colorado 81230 (herein "Gunnison County") and Raymond Alspach, whose address is 116 South Taylor St, Gunnison CO 81230 (herein "Contractor").

RECITALS

The Contractor desires to provide professional services regarding Appliance Installations ("Services").

□ If this box is checked, the Services are identified in the Scope of Work attached hereto and incorporated herein by reference as Appendix "A ("Services").

Gunnison County desires to engage Contractor to provide Services according to this Agreement.

AGREEMENT

NOW THEREFORE, in consideration of the Recitals and the mutual covenants and obligations hereinafter set forth, the parties agree as follows:

1. SERVICES.

Contractor shall furnish all materials, labor, supervision, supplies and equipment to commence, diligently pursue, and complete the Services. All Services shall be performed in a timely manner and in accordance with generally accepted standards for Contractor's profession and all applicable federal, state and local laws and regulations affecting the Services or their subject matter. Contractor acknowledges that this is a non-exclusive Agreement, and Gunnison County may contract with additional or other providers able to furnish the same or similar services as it deems appropriate to do so.

2. TERM.

The term of this Agreement shall commence on the date first set forth above and shall terminate on December 31, 2026, unless sooner terminated or replaced as provided herein.

3. STRATEGIC RESULT.

□ If this box is checked, execution of this Agreement will assist the County with its _____ strategy, as outlined in the Gunnison County Strategic Plan.

4. COMPENSATION, BONUS AND EXPENSES.

In Consideration and exchange for Contractor's performance of the Services, during the Term, Gunnison County shall pay Contractor fees as more specifically not to exceed sixty thousand and No/100 U. S. Dollars ($60,000.00). Payment shall be made by Gunnison County to Contractor within 45 days of receipt of an invoice.

The Compensation shall compensate Contractor for all charges, expenses, overhead, payroll costs, employee benefits, insurance subsistence, and profits, except as specifically set forth in this Agreement.

□ If this box is checked, the term of this Agreement is for more than one (1) year. Accordingly, this Agreement is subject to Gunnison County making an annual budget appropriation in an amount sufficient to fund this Agreement. If Gunnison County fails or refuses to make such an appropriation, Gunnison County reserves the right to terminate this Agreement pursuant to the Termination paragraph of this Agreement.

5. INSURANCE.

Contractor agrees that at all times during the Term of this Agreement, and for three (3) years after the date the Term of this Agreement expires or the date this Agreement is terminated, or any applicable warranty period, Contractor shall maintain, in full force and effect and at its sole cost and expense, the following insurance policies. Within thirty (30) days of the execution of this Agreement, Contractor will provide insurance certificates to Gunnison County, listing Gunnison County as an additional insured, for the coverages required by this paragraph, which shall state that such policies shall not be materially changed or cancelled without thirty (30) days prior notice to Gunnison County. Written notice shall be sent to the parties identified in the Notices section of this Agreement and sent thirty (30) days prior to any cancellation or non-renewal unless due to non-payment of premiums, in which case, notice shall be sent ten (10) days prior. If written notice is unavailable from the insurer, Contractor shall provide written notice of cancellation, non-renewal and any reduction in coverage to the parties identified in the Notices section by certified mail, return receipt requested within three (3) business days of such notice by its insurer(s).

a. Worker's Compensation Insurance in accordance with Colorado and Federal law which adequately protects all labor employed by Contractor during the term of this Agreement.

b. Comprehensive General Liability Insurance or the equivalent in an amount no less than One Million and No/100 U.S. Dollars ($1,000,000.00) for injury to one person in any single occurrence; and no less than Two Million U.S. Dollars ($2,000,000.00) for injur(ies) to two or more persons in any single occurrence (i.e., in the aggregate).

c. Comprehensive automobile liability insurance on all vehicles used in the Services, in an amount no less than One Million and No/100 U.S. Dollars ($1,000,000.00) for injury to one person in any single occurrence; and no less than Two Million and No/100 U.S. Dollars ($2,000,000.00) for injur(ies) to two or more persons in any single occurrence (i.e., in the aggregate).

d. Professional Liability Insurance or the equivalent, such as Errors and Omissions coverage, in an amount no less than One Million and No/100 U.S. Dollars ($1,000,000.00) for injury to one person in any single occurrence; and no less than Two Million and No/100 U.S. Dollars ($2,000,000.00) for any injur(ies) to two or more persons in any single occurrence (i.e., in the aggregate). The provisions of this Paragraph 5 requiring the County to be named as an additional insured shall not apply to Professional Liability Insurance, unless otherwise expressly agreed to in writing by the parties.

The required insurance shall be underwritten by an insurer licensed or authorized to do business in Colorado. Combinations of primary and excess coverage may be used to achieve minimum coverage limits. Excess/umbrella policy(ies) must follow form of the primary policy(ies) with which they are related to provide the minimum limits and be verified as such on any submitted Certificate of Insurance. The County's acceptance of a certificate of insurance or other proof of insurance that does not comply with all insurance requirements set forth in this Agreement shall not act as a waiver of Contractor's breach of this Agreement or of any of the County's rights or remedies under this Agreement.

If excluded from any policy coverage, this Agreement shall be specifically named an insured contract. If any policy is in excess of a deductible or self-insured retention, the County must be notified by the Contractor. Contractor shall be responsible for the payment of any deductible or self-insured retention. Defense costs shall be in addition to the limits of liability. If this provision is unavailable that limitation must be evidenced on the Certificate of Insurance. A severability of interests or separation of insureds provision (no insured vs. insured exclusion) must be included. A provision that coverage is primary and non-contributory with other

coverage or self-insurance maintained by the County, excluding Professional Liability and Workers Compensation policies, if required.

For all coverages required under this Agreement, Contractor's insurer(s) shall waive subrogation rights against the County by policy endorsement. All subcontractors and subconsultants (including independent contractors, suppliers or other entities providing goods or services required by this Agreement) shall be subject to all of the requirements herein and shall procure and maintain the same coverages required of the Contractor. Contractor shall include all such subcontractors as additional insured under its policies (with the exception of Workers' Compensation) or shall ensure that all such subcontractors and subconsultants maintain the required coverages. Contractor agrees to provide proof of insurance for all such subcontractors and subconsultants upon request by the County.

The insurance coverages specified in this Agreement are the minimum requirements, and these requirements do not lessen or limit the liability of the Contractor to the County under this Agreement. The Contractor shall maintain, at its own expense, any additional kinds or amounts of insurance that it may deem necessary to cover its obligations and liabilities under this Agreement.

The insurance provisions of this Agreement shall survive expiration or termination of this Agreement. The failure of Gunnison County to specifically enforce this Paragraph 5 shall not be deemed a waiver of the requirements of this Paragraph.

6. INDEPENDENT CONTRACTOR.

In carrying out its obligations and activities under this Agreement, Contractor is acting as an independent contractor and not as an agent, partner, joint venture or employee of Gunnison County. Contractor does not have any authority to bind Gunnison County in any manner whatsoever.

Contractor acknowledges and agrees that Contractor is not entitled to: (i) unemployment insurance benefits; or (ii) Workers Compensation coverage, from Gunnison County. Further, Contractor is obligated to pay all applicable federal, state and local taxes owed in relation to the services.

7. INDEMNIFICATION.

Contractor irrevocably and unconditionally agrees to indemnify, defend and hold harmless Gunnison County, its Commissioners, agents and employees of and from any and all liability, claims, liens, demands, actions and causes of action whatsoever (including reasonable attorney's and expert's fees and costs) arising out of or related to any loss, cost, damage or injury, including

death, of any person or damage to property of any kind caused by the misconduct or negligent acts, errors or omissions of Contractor or its employees, subcontractors or agents in connection with this Agreement. Further, the County shall not be liable to Contractor or its affiliates for any loss of anticipated business opportunities, contracts, revenues, profits or savings; damage to goodwill or reputation; or indirect, special or consequential loss or damage, arising out of or in connection with this Agreement, whether for breach of contract, in tort (including negligence), under statute or any other law, and Contractor expressly disclaims any such claims or damages as against the County.

In case of any claim arising out of or related to this Agreement, Contractor will provide the County reasonably prompt notice of the relevant claim. Contractor will defend or settle, at its own expense, any demand, action, or suit on any claim subject to indemnification under this Agreement, through legal counsel selected by Contractor but approved by the County. Each party will cooperate in good faith with the other to facilitate the defense of any such claim and the County will tender the defense and settlement of any action or proceeding covered by this Section to Contractor or upon request. Claims may be settled without the consent of the County, unless the settlement includes an admission of wrongdoing, fault or liability by the County, whether express or implied.

This defense and indemnification obligation shall survive any termination or expiration of this Agreement. If Contractor is a government entity, the obligation of this Paragraph 7 shall not be deemed an indemnity, but the remaining obligations, including but not limited to the obligation to defend the County at Contractor's expense, shall continue to apply.

8. DISCRIMINATION.

The Contractor agrees to not discriminate against any person or class of persons by reason of age, race, color, sex, creed, religion, disability, national origin, sexual orientation or political affiliation in providing any services or in the use of any facilities provided for the public in any manner prohibited by Part 21 of the Regulations of the Office of the Secretary of Transportation. Contractor shall further comply with the letter and spirit of the Colorado Anti-Discrimination Act, as amended, and any other laws and regulations respecting discrimination in unfair employment practices. Additionally, Contractor shall comply with such enforcement procedures as any governmental authority might demand that Gunnison County take for the purpose of complying with any such laws and regulations.

9. AMERICANS WITH DISABILITIES ACT COMPLIANCE.

The Contractor represents and warrants to Gunnison County that at all times during the performance of this Agreement no qualified individual with a disability shall, by reason of such disability, be exclude from participation in, or denied benefits of the service, programs, or activities performed by the Contractor, or be subjected to any discrimination by the Contractor upon which assurance Gunnison County relies.

10. MISCELLANEOUS.

a. SEVERABILITY. If any clause or provision of this Agreement shall be held to be invalid in whole or in part, then the remaining clauses and provisions, or portions thereof, shall nevertheless be and remain in full force and effect.

b. AMENDMENT. No amendment, alteration, modification of or addition to this Agreement shall be valid or binding unless expressed in writing and signed by the parties to be bound thereby.

c. NO WAIVER OF GOVERNMENTAL IMMUNITY. The parties hereto understand and agree that the County is relying upon, and has not waived, the monetary limitations and all other rights, immunities and protection provided by the Colorado Governmental Act, § 24-10-101, et seq., C.R.S. Nothing in this Agreement is, or shall be construed to be, a waiver, in whole or part, by Gunnison County of governmental immunity provided by the Colorado Governmental Immunity Act or otherwise.

d. LEGAL AUTHORITY. Contractor represents and warrants that it possesses the legal authority, pursuant to any proper, appropriate and official motion, resolution or action passed or taken, to enter into the Agreement. Each person signing and executing the Agreement on behalf of Contractor represents and warrants that he has been fully authorized by Contractor to execute the Agreement on behalf of Contractor and to validly and legally bind Contractor to all the terms, performances and provisions of the Agreement. The County shall have the right, in its sole discretion, to either temporarily suspend or permanently terminate the Agreement if there is a dispute as to the legal authority of either Contractor or the person signing the Agreement to enter into the Agreement.

e. NO CONSTRUCTION AGAINST DRAFTING PARTY. The parties and their respective counsel have had the opportunity to review the Agreement, and the Agreement will not be construed against any party merely because any provisions of the Agreement were prepared by a particular party.

f. ORDER OF PRECEDENCE. In the event of any conflicts between the language of the Agreement and any exhibits to it, the language of the Agreement controls.

g. SURVIVAL OF CERTAIN PROVISIONS. The terms of the Agreement and any exhibits and attachments that by reasonable implication contemplate continued performance, rights, or compliance beyond expiration or termination of the Agreement survive the Agreement and will continue to be enforceable. Without limiting the generality of this provision, the Contractor's obligations to provide insurance and to indemnify the County will survive for a period equal to any and all relevant statutes of limitation, plus the time necessary to fully resolve any claims, matters, or actions begun within that period.

h. INUREMENT. The rights and obligations of the parties herein set forth shall inure to the benefit of and be binding upon the parties hereto and their respective successors and assigns permitted under this Agreement.

i. TIME IS OF THE ESSENCE. The parties agree that in the performance of the terms, conditions, and requirements of this Agreement, time is of the essence.

j. PARAGRAPH HEADINGS. The captions and headings set forth herein are for convenience of reference only and shall not be construed so as to define or limit the terms and provisions hereof.

11. DELEGATION AND ASSIGNMENT.

Contractor shall not delegate or assign its duties under this Agreement without the prior written consent of Gunnison County which consent Gunnison County may withhold in its discretion. Subject to the foregoing, the terms, covenants and conditions of this Agreement shall be binding on the successors and assigns of either party.

12. TERMINATION.

Either party shall have the right to terminate this Agreement at any time, with or without cause, upon thirty (30) days prior written notice to the other. Upon termination, Contractor shall be entitled to compensation for Services performed prior to the date of termination, per the compensation terms provided in this Agreement. Termination shall not affect or prejudice any rights or other remedy that a party may have with respect to the event giving rise to termination or any other rights or other remedy a party may have with respect to breach of this Agreement which existed at or before the date of termination.

13. OWNERSHIP OF PROPERTY.

Any work product, information, materials, goods, or intellectual property generated as a result of the Services shall become the sole and exclusive property of the County, and Contractor

agrees to relinquish any rights, implied or otherwise, to such property, including but not limited to any resulting intellectual property rights.

14. WARRANTIES.

Contractor represents and warrants to the County as follows:

a. The Services shall conform to applicable specifications and will be free from deficiencies and defects in materials, workmanship, design or performance, as applicable.

b. All Services shall be performed by qualified personnel in a professional and workmanlike manner, consistent with industry standards.

c. Contractor has the requisite ownership, rights and licenses to perform its obligations under this Agreement and to perform the Services free and clear from all liens, adverse claims, encumbrances and interests of any third party.

d. There are no pending or threatened lawsuits, claims, disputes or actions adversely affecting the Services or Contractor's ability to perform its obligations under this Agreement.

e. Performance of the Services shall not violate, infringe, or misappropriate any patent, copyright, trademark, trade secret, or other intellectual property or proprietary right of any third party.

f. Contractor has the right to and shall assign to County all third-party warranties and indemnities that Contractor receives in connection with any of the Services provided to County. To the extent that Contractor is not permitted to assign any warranties or indemnities to the County, Contractor agrees to specifically identify and enforce those warranties and indemnities on behalf of County to the extent Contractor is permitted to do so under the terms of the applicable third-party agreements.

15. WHEN RIGHTS AND REMEDIES NOT WAIVED.

In no event shall any action by either party constitute or be construed to be a waiver by the other party of any breach of covenant or default which may then exist on the part of the party alleged to be in breach, and the non-breaching party's action or inaction when any such breach or default shall exist shall not impair or prejudice any right or remedy available to that party with respect to such breach or default; and no assent, expressed or implied, to any breach of any one or more covenants, provisions or conditions of the Agreement shall be deemed or taken to be a waiver of any other breach.

16. NO THIRD-PARTY BENEFICIARY.

Enforcement of the terms of the Agreement and all rights of action relating to enforcement are strictly reserved to the parties. Nothing contained in the Agreement gives or allows any claim or right of action to any third person or entity. Any person or entity other than the County or the Contractor receiving services or benefits pursuant to the Agreement is an incidental beneficiary only.

17. CONFLICT OF INTEREST.

The signatories to this Agreement aver to their knowledge, no employee of the County has any personal or beneficial interest whatsoever in the Services. Contractor has no beneficial interest, direct or indirect, that would conflict in any manner or degree with the performance of the Services, and Contractor shall not employ any person having such known interests. The Contractor shall also not engage in any transaction, activity or conduct that would result in a conflict of interest under the Agreement. The Contractor represents that it has disclosed any and all current or potential conflicts of interest. A conflict of interest shall include transactions, activities or conduct that would affect the judgment, actions or work of the Contractor by placing the Contractor's own interests, or the interests of any party with whom the Contractor has a contractual arrangement, in conflict with those of the County. The County, in its sole discretion, will determine the existence of a conflict of interest and may terminate the Agreement in the event it determines a conflict exists, after it has given the Contractor written notice describing the conflict.

18. FORCE MAJEURE.

Neither party shall be responsible for failure to fulfill its obligations hereunder or liable for damages resulting from delay in performance as a result of an unforeseeable event outside the control of such party, and not caused by such party's negligence, including war or armed conflict, fire, flood, strike, riot or insurrection, terrorist attack, nuclear, chemical or biological attack, federal immigration enforcement action, federal armed forces deployment, federal or state government failure or refusal to provide grant or other funding to the County, natural disaster, martial law, unreasonable delay of carriers, governmental order or regulation; PROVIDED, HOWEVER, the any delay caused by a communicable disease pandemic or endemic, shall NOT be considered a force majeure event. If a force majeure event occurs, the time for performance shall be extended by mutual agreement of the parties for a period of time as may be reasonably necessary to compensate for such delay, provided that if such performance still cannot be completed within such extended period of time, either party may terminate this Agreement and both parties will be released from any further obligation to the other.

19. NOTICES.

Any notice, demand or communication which either party may desire or be required to give to the other party shall be in writing and shall be deemed sufficiently given or rendered if delivered personally, by commercial courier or sent by certified first class US mail, postage prepaid, addressed as follows:

Gunnison County: County Manager
Gunnison County
200 E. Virginia
Gunnison, Colorado 81230

With a copy to: Gunnison County Attorney
200 E. Virginia
Gunnison, Colorado 81230

Contractor: Raymond Alspach
116 South Taylor Street
Gunnison CO 81230

Either party has the right to designate in writing, served as provided above, a different address to which any notice, demand or communication is to be mailed.

20. GOVERNING LAW.

This Agreement shall be governed by and interpreted in accordance with the laws of the State of Colorado. Jurisdiction and venue for any legal proceedings related to this Agreement shall exclusively lie in the State of Colorado District Court located in Gunnison County, Colorado.

21. COUNTERPARTS: FACSIMILE AND ELECTRONIC TRANSMISSION.

This Agreement may be executed by facsimile and/or in any number of counterparts, any or all of which my contain the signatures of less than all the parties, and all of which shall be construed together as but a single instrument and shall be binding on the parties as though originally executed on one originally executed document. All facsimile counterparts shall be promptly followed with delivery of original executed counterparts.

This Agreement may also be executed by electronic means or signatures. Accordingly, the Agreement, and any other documents requiring a signature hereunder, may be signed electronically by the County in the manner specified by the County. The Parties agree not to

deny the legal effect or enforceability of the Agreement solely because it is in electronic form or because an electronic record was used in its formation. The Parties agree not to object to the admissibility of the Agreement in the form of an electronic record, or a paper copy of an electronic document, or a paper copy of a document bearing an electronic signature, on the ground that it is an electronic record or electronic signature or that it is not in its original form or is not an original.

The parties agree that: (i) any notice or communication transmitted by electronic transmission, as defined below, shall be treated in all manner and respects as an original written document; (ii) any such notice or communication shall be considered to have the same binding and legal effect as an original document; and (iii) at the request of either party, any such notice or communication shall be re-delivered or re-executed, as appropriate, by the party in its original form. For purposes of this Agreement, the term "electronic transmission" means any form of communication not directly involving the physical transmission of paper, that creates a record that may be retained, retrieved and reviewed by a recipient thereof, and that may be directly reproduced in paper form by such a recipient through an automated process, but specifically excluding text or instant messages.

22. ENTIRE AGREEMENT.

This Agreement comprises the entire agreement between County and Contractor and supersedes all prior or contemporaneous negotiations, discussions or agreements, whether written or oral, between the parties regarding the subject matter contained herein. No amendment to or modification of this Agreement will be binding unless in writing and signed by an authorized representative of each party.

Notwithstanding anything to the contrary herein, the County shall not be subject to any provision included in any terms, conditions, or agreements appearing on Contractor's or a subcontractor's website or any provision incorporated into any click-through or online agreements related to the work unless that provision is specifically referenced in this Agreement.

23. RECORDS.

Contractor shall maintain for a minimum of three (3) years, adequate financial and other records for reporting to County. Contractor shall be subject to financial audit by federal, state or county auditors or their designees. Contractor authorizes such audits and inspections of records during normal business hours, upon forty-eight (48) hours' notice to Contractor. Contractor shall fully cooperate during such audit or inspections.

24. PUBLIC RECORD.

To the extent not prohibited by state or federal law, this Agreement is potentially subject to public release through the Colorado Open Records Act. The parties further acknowledge and understand that all work product or materials provided or produced under this Agreement, including items marked Proprietary or Confidential, may be subject to the Colorado Open Records Act., § 24-72-201, *et seq.*, C.R.S.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date above written.

BOARD OF COUNTY COMMISSIONERS
OF THE COUNTY OF GUNNISON, COLORADO

By: _____
Laura Puckett Daniels, Chairperson

ATTEST:

_____
Deputy Clerk

GUNNISON COUNTY SEAL COLORADO

☐ If this box is checked, the parties stipulate and agree that the County Manager has the authority to execute this Agreement on behalf of Gunnison County
COUNTY OF GUNNISON, COLORADO

By: _____
Matthew Birnie, County Manager

CONTRACTOR

By: _____
Its: _____Raymond Alspach_____

APPENDIX “A”

SCOPE OF SERVICES

Contractor shall perform and provide the following Services:
Appliance Ordering, Delivery and Installation.

AGENDA ITEM or FINAL CONTRACT REVIEW SUBMITTAL FORM

Agenda Item: Small Dollar Grant Award; 25EM25-26-05; Emergency

Action Requested: Other County Manager/BOCC Acknowledgement

Parties to the Agreement:

Term Begins: 10/1/2025 **Term Ends:** **Grant Contract #:** 24EM25-26-05

Summary:

Small Dollar Grant Award for the 2025-2026 Emergency Management Performance Grant from the CO DHSEM. Award amount of $109,886, made up of a $54,943 federal share and a $54,943 local match.

Fiscal Impact: grant award

Submitted by: Lisa Bickford **Submitter's Email Address:** LBickford@gunnisoncounty.org

Finance Review: (●) Required ( ) Not Required

Comments:

Reviewed by: GUNCOUNTY1\mlamonica Discharge Date: 2/20/2026

County Attorney Review: (●) Required ( ) Not Required

Comments:
Legally sufficient. SO 2/20/26

Reveiwed by: GUNCOUNTY1\sobaid Discharge Date: 2/20/2026 Certificate of Insurance Required

Yes ( ) No (●)

County Manager Review:

Comments:

Reveiwed by: GUNCOUNTY1\mbirnie Discharge Date: 2/25/2026

(●) Consent Agenda ( ) Regular Agenda ( ) Worksession Time Allotted: 0

Agenda Date: 3/3/2026

Revised April 2015

STATE OF COLORADO

Department of Public Safety

ORDER

Number: POGG1,RFAA,202600002938
Date: 2/3/26
Description:
Gunnison County - EMPG25-26 24EM25-26-05 - New

Effective Date: 10/01/25
Expiration Date: 09/30/26

BUYER

Buyer:
Email:

VENDOR

County of Gunnison
Finance
200 E VIRGINIA AVE
GUNNISON, CO 81230-2248

Contact: Lisa Bickford, Emergency
Phone:

*****IMPORTANT*****

The order number and line number must appear on all invoices, packing slips, cartons, and correspondence.

BILL TO

DIVISION OF HOMELAND SECURITY
9195 E MINERAL AVE. SUITE 200
CENTENNIAL, CO 80112

SHIP TO

DIVISION OF HOMELAND SECURITY
9195 E MINERAL AVE. SUITE 200
CENTENNIAL, CO 80112

SHIPPING INSTRUCTIONS

Delivery/Install Date:
FOB:

VENDOR INSTRUCTIONS

EXTENDED DESCRIPTION

02/03/2026 Gunnison County - EMPG25-26 24EM25-26-05 - New

Line Item	Commodity/Item Code	UOM	QTY	Unit Cost	Total Cost	MSDS Req.
1			0	0.00	$54,943.00	☐

Description: Grant Commodity - Federal

Actual Expiration is 06/30/2026

Service From: 10/01/25 Service To: 06/30/26

TERMS AND CONDITIONS

https://www.colorado.gov/osc/purchase-order-terms-conditions

DOCUMENT TOTAL = $54,943.00

COLORADO
Division of Homeland Security
& Emergency Management
Department of Public Safety
Office of Grants Management
8000 South Chester Street, Suite 575
Centennial, CO 80112

Lisa Bickford
Emergency Management Director
Gunnison County
510 West Bidwell Avenue
Gunnison, CO 81230

January 13, 2026 24EM25-26-05

Dear Lisa Bickford,

The Colorado Division of Homeland Security & Emergency Management (DHSEM) is pleased to inform you that your application for funding pursuant to the 2025-2026 Emergency Management Performance Grant Program (EMPG) is approved and awarded in the amount of $109,886.00 (funding sources: $54,943.00 of Federal, and $54,943.00 of Local).

Please take note of the following requirements. All supporting documentation will accompany Requests for Reimbursement (RFRs) for EMPG awards as outlined in the attached Statement of Work (SOW) §§5.2.1 and 5.2.2, and as described on page 7 in the 2025-2026 EMPG Guidance document. Delays to reimbursements as a result of missing documentation will occur until documentation requirements are satisfied.

1) EMPG funded staff
   a) For 100% EMPG funded staff, a signed job description on file or for partially EMPG funded staff, a certified time card with proof of payment
   b) Print out from the accounting system (i.e. General Ledger) or payroll system
2) All other costs, backup documents will be required with proof of payment
   a) Invoice
   b) Print out from the accounting system (i.e. General Ledger)

COLORADO
Division of Homeland Security
& Emergency Management
Department of Public Safety
Office of Grants Management
8000 South Chester Street, Suite 575
Centennial, CO 80112

The requirements of part one (1) above are found in the Federal Regulations under Title 2 Code of Federal Regulations (CFR) Part 200.430 *Compensation-Personal Services*.

Project funding award is based on the project description provided in the application and is outlined in the following table:

Project Activity/Line Item	*Federal Share*	*Local Share*	*Total Project*
EMPG Activities	$ 54,943.00	$ 54,943.00	$ 109,886.00

DHSEM will issue your grant award as a Small Dollar Grant Award (SDGA). The issuance of the SDGA functions like a 'purchase order' for RFRs in the State financial system and does not require original signatures on a formal agreement from your approving authorities.

Included with this Award Letter is the completed SDGA, SOW, and terms and conditions of your grant award. If your organization has updated or changed W-9 or banking information, new forms are required to update our financial system.

The period of performance for the 2025-2026 EMPG SDGA is from **October 1, 2025 to June 30, 2026**. All requests for reimbursements must cover work completed, or expenditures claimed, within this period of performance as outlined in the SOW.

For questions regarding your SDGA or the 2025-2026 EMPG, please contact your assigned Field Manager or Field Operations Specialists at cdps_dhsem_empg-admin@state.co.us.

Sincerely,

Kevin F. Kuretich
Chief of Field Operations
Colorado Department of Public Safety
Division of Homeland Security and Emergency Management

CC: File

Small Dollar Grant Award (SDGA)
Statement of Work

State Agency

Department of Public Safety, Division of Homeland Security and Emergency Management

Grantee

Board of County Commissioners of Gunnison County

Grantee UEI

NSN9FAGKEDJ9

Agreement Number

24EM25-26-05

Agreement Performance Beginning Date

October 1, 2025

Current Agreement Expiration Date

June 30, 2026

Current Agreement Maximum Amount

$54,943.00

Current Agreement Match Amount

$54,943.00

1. Federal Award Information

Federal Award ID # (FAIN)

EMD-2024-EP-05002

Federal Award Date

September 24, 2024

Federal Awarding Agency

DHS / FEMA

Assistance Listing (CFDA)

97.042

Emergency Management Performance Grants (EMPG)

Identification if the Award is for R&D:

No

2. Grant Authority

A. Federal Authority to enter into this Grant exists in the Section 662 of the Post-Katrina Emergency Management Reform Act of 2006 (PKEMRA), as amended, (Pub. L. No. 109-295) (6 U.S.C. §762); the Robert T. Stafford Disaster Relief and Emergency Assistance Act, as amended (Pub. L. No. 93-288) (42 U.S.C. §§5121 et seq.); the Earthquake Hazards Reduction Act of 1977, as amended (Pub. L. No. 95-124) (42 U.S.C. §§7701 et seq.); and the National Flood Insurance Act of 1968, as amended (Pub. L. No. 90448) (42 U.S.C. §§4001 et seq.);

B. State Authority: to enter this Grant exists in CRS §24-1-128.6.

3. General Description of the Project(s).

3.1. Project Description. Work Plan – Grantee will carry-out and work diligently to complete the tasks in their approved annual work plan. These tasks are listed by Emergency Management Function in the work plan document and are part of the annual Emergency Management Performance Grant/Local Emergency Management

Support (EMPG/LEMS) Program Application along with the Staffing Pattern/Personnel, Program Budget and other required forms. Subrecipient will execute and complete the projects as specified and outlined in their approved 2025-2026 application.

3.2. Project Period of Performance. This 2025-2026 Emergency Management Performance Grant (EMPG) Small Dollar Grant Award (SDGA) is funded with 2024 EMPG funds for the period of performance from October 1, 2025 to June 30, 2026 exclusively for the reimbursement of eligible project expenditures during the performance period only. All requests for reimbursements must cover work completed, or expenditures claimed, within this period of performance.

3.3. Project Expenses. Eligible project expenses for the EMPG award for reimbursement are allowable by Federal authority beginning on the Agreement Performance Beginning Date and ending on the Current Agreement Expiration Date outlined in this Statement of Work (SOW). All eligible expenses are listed in the budget agreement amount table in §9 of this SOW.

Project expenses include the costs for salaries and benefits for Grantee's emergency manager and emergency management staff, travel, emergency management office operating costs, and the costs associated with emergency management exercises, training, and planning activities. Eligible project expenses are reimbursed upon submission and approval of the quarterly request for reimbursement form and supporting documentation in the EMGrants Pro system. No more than 5% of this Grant may be used for Management and Administration (M&A) costs.

Note: This 2025-2026 EMPG SDGA is funded with 2024 EMPG funds. Salaries of local emergency managers are not typically categorized as M&A, unless the local Emergency Management Agency (EMA) chooses to assign personnel to specific M&A activities. Additional specific eligible and ineligible cost information is listed in the FY 2024 EMPG Notice of Funding Opportunity.

3.4. Non-Federal Match: This non-federal match section does apply to this Grant. If applicable the match may include in-kind match. This Grant requires a non-federal match contribution of **50%** of the total Grant budget. Documentation of expenditures for the non-federal match contribution is required with each drawdown request.

4. Principal Representatives

For the State:

Kevin F. Kuretich, Chief of Field Operations
Department of Public Safety, Division of
Homeland Security & Emergency Management
9195 East Mineral Avenue, Suite 200
Centennial, CO 80112
Kevin.Kuretich@state.co.us

For Grantee:

Lisa Bickford, Emergency Management Director
Gunnison County
510 West Bidwell Avenue
Gunnison, CO 81230
LBickford@gunnisoncounty.org

5. Administrative Requirements:

5.1. The Grantee must request approval in advance for any change to this Grant Award, using the forms and procedures established by the Colorado Department of Public Safety, Division of Homeland Security and Emergency Management (DHSEM).

5.2. Required Documentation: Grantees shall retain all procurement, payment, and award documentation on site for inspection for three years after the Federal Award is closed by the DHSEM. The DHSEM anticipates the minimum retention date for the EMPG program of December 30, 2029, or thereafter, and is subject to change. Compliance with the Office of Management and Budget (OMB) regulations, Title 2 Code of Federal Regulations (2 CFR), Subpart D, Part 200.334 Retention requirements for records, is required under this subaward.

Retained records include, but not be limited to, purchase orders, receiving documents, invoices, vouchers, equipment/services identification, time and effort reports, grant award documents, letters from DHSEM, and requests for reimbursement (RFR) forms.

Sufficient detail shall be provided with RFRs to demonstrate that expenses are allowable and appropriate as detailed in the following sections.

5.2.1 Detailed backup documentation for salaries and benefits. In accordance with the OMB regulations, 2 CFR Part 200.430 "Compensation—personal services" the signed job descriptions for 100% EMPG funded staff or certified time cards for partially EMPG funded personnel, with proof of payment, must accompany RFRs under this award. For further reference, please visit the OMB Guidance link above.

5.2.2 Supporting documentation for all expenses requested for reimbursement. Grantee shall ensure all proper supporting documentation is provided to validate expenses requested for reimbursement. Delays to reimbursements, as

a result of missing documentation, will occur until documentation requirements are satisfied. The DHSEM reserves the right to request additional documentation and information as needed and necessary for processing requests. Supporting documentation should include, but is not limited to:

5.2.2.1. Invoices, receipts, approved travel reimbursement forms, or forms showing prior approval obtained for specified expenses, attendance forms, after action reports/process improvement plans, etc., and

5.2.2.2. Proof of payment for all expenses requested for reimbursement, such as credit card statements; general ledgers which show payee name, date paid, check numbers (if applicable), transaction number, and amount; cancelled check copies; bank statements; printed receipts showing payment method used; etc. All proof of payment documents containing sensitive information should be redacted if not applicable to the expenses being supported. The DHSEM maintains sensitive documents on secured servers to protect information.

5.2.3 Equipment or tangible goods. When requesting reimbursement for equipment items with a purchase price of or exceeding $10,000, and a useful life of more than one year, the Grantee shall provide a unique identifying number for the equipment, with a copy of the Grantee's invoice and proof of payment. The unique identifying number can be the manufacturer's serial number or, if the Grantee has its own existing inventory numbering system, that number may be used. The location of the equipment shall also be provided. In addition to ongoing tracking requirements, Grantee shall ensure that equipment items with per unit cost of $10,000 or more are prominently marked in a manner similar to the following:

Purchased with funds provided by the U.S. Department of Homeland Security.

5.2.4 Services. Grantees shall include contract/purchase order number(s) or employee names, the date(s) the services were provided and the nature of the services.

5.3. Non-Supplanting Requirement: Grantees receiving federal financial assistance awards made under programs that prohibit supplanting by law must ensure that federal funds

do not replace (supplant) funds that have been budgeted for the same purpose through non-federal sources.

5.4. **Procurement:** A Grantee shall ensure its procurement policies meet or exceed local, state, and federal requirements. Grantees should refer to local, state, and federal guidance prior to making decisions regarding competitive bids, sole source or other procurement issues. In addition:

5.4.1 Any sole source transaction shall be approved in advance by the DHSEM.

5.4.2 Grantees shall ensure that: (a) All procurement transactions, whether negotiated or competitively bid, and without regard to dollar value, are conducted in a manner that provides maximum open and free competition; (b) Grantee shall be alert to organizational conflicts of interest and/or non-competitive practices among contractors that may restrict or eliminate competition or otherwise restrain trade; (c) Contractors who develop or draft specifications, requirements, statements of work, and/or Requests for Proposals (RFPs) for a proposed procurement shall be excluded from bidding or submitting a proposal to compete for the award of such procurement; and (d) Any request for exemption of item a-c within this subsection shall be submitted in writing to, and be approved by the authorized Grantee official.

5.4.3 Grantee shall verify Contractor(s) is/are not debarred from participation in state and federal programs by reviewing contractor debarment information on SAM.gov.

5.4.4 When issuing requests for proposals, bid solicitations, and other published documents describing projects or programs funded in whole or in part with these grant funds, Grantee and Subgrantees shall use the following phrase in the request listing:

"*This project was supported by grant #24EM25-26-05, issued by the Colorado Division of Homeland Security and Emergency Management.*"

5.4.5 Grantee shall ensure that no rights or duties exercised under this grant, or equipment purchased with Grant Funds having a purchase value of $10,000 or more, are assigned without the prior written consent of the DHSEM.

5.5. Prohibitions on Expending FEMA Award Funds for Covered Telecommunications Equipment or Services: Recipients and subrecipients of FEMA federal financial

assistance are subject to the prohibitions described in section 889 of the John S. McCain National Defense Authorization Act for Fiscal Year 2019 (FY 2019 NDAA), Pub. L. No. 115-232 John S. McCain National Defense Authorization Act for Fiscal Year 2019 (FY 2019 NDAA), Pub. L. No. 115-232 (2018) and 2 C.F.R. §§ 200.216, 200.327, 200.471, and Appendix II to 2 C.F.R. Part 200. Beginning August 13, 2020, the statute–as it applies to FEMA recipients, subrecipients, and their contractors and subcontractors–prohibits obligating or expending federal award funds on certain telecommunications and video surveillance products and contracting with certain entities for national security reason.

5.6. Additional Administrative Requirements:

5.6.1 All of the instructions, guidance, limitations, terms and conditions, scope of work, and other conditions set forth in the Notice of Funding Opportunity (NOFO) and the Notice of Award (NOA) for this federal award are incorporated by reference. See also DHS Standard Terms and Conditions.

5.6.2 Grantees of FEMA financial assistance for programs that are subject to the Build America, Buy America Act (BABAA) must include a Buy America preference contract provision as noted in 2 C.F.R. § 184.4 and a and self-certification as required by the FEMA Buy America Preference in FEMA Financial Assistance Programs for Infrastructure (FEMA Interim Policy #207-22-0001). This requirement applies to all subawards, contracts, and purchase orders for work performed or products supplied under the FEMA award subject to BABAA.

5.6.3 Environmental Planning and Historic Preservation (EHP) Review: DHS/FEMA funded activities that may require an EHP review are subject to the FEMA Environmental Planning and Historic Preservation (EHP) review process. This review does not address all federal, state, and local requirements. Acceptance of federal funding requires recipient to comply with all federal, state, and local laws.

DHS/FEMA is required to consider the potential impacts to natural and cultural resources of all projects funded by DHS/FEMA grant funds, through its EHP Review process, as mandated by the National Environmental Policy Act; National Historic Preservation Act of 1966, as amended; National Flood Insurance Program regulations; and, any other applicable laws and Executive Orders. Click this link to access the FEMA EHP screening form and instructions.

In order to initiate EHP review of the project(s) requires completion of all relevant sections of the EHP form and submit it to DHSEM, along with all other pertinent project information. The EHP review process must be completed and approved by DHS/FEMA before funds are released to carry out the proposed project; otherwise, DHS/FEMA and DHSEM may not be able to fund the project due to noncompliance with EHP laws, executive order, regulations, and policies.

If ground disturbing activities occur during construction, Grantee will monitor ground disturbance, and if any potential archeological resources are discovered, Grantee will immediately cease work in that area and notify DHSEM, which will immediately notify DHS/FEMA for further action.

5.6.3.1. Expenses related to capital projects, construction, renovation or any modifications to existing buildings, structures, facilities, or ground disturbance activities that require compliance with the FEMA Environmental Planning and Historic Preservation (EHP) are ineligible under this SDGA or award.

5.6.4 All applicant agencies that own resources that could deploy must be on a Colorado Resource Rate Form in WebEOC.

5.6.5 Regardless of exercise type or scope, After Action Reports/Improvement Plans are due to the DHSEM within 45 days of the exercise. All funding related to exercises must be managed and executed in accordance with the Homeland Security Exercise and Evaluation Program (HSEEP), and must be National Incident Management System (NIMS) compliant.

5.6.6 Any funds used to support emergency communications activities should comply with the FY SAFECOM Guidance on Emergency Communication Grants.

6. Reporting Requirements:

6.1. The project(s) approved in this Grant are to be completed on or before the termination date stated on the agreement's Grant Award Letter of this grant agreement. Grantee shall submit quarterly progress reports for each project identified in this agreement using the format provided by the DHSEM throughout the life of the grant.

Grantee shall submit narrative and financial reports describing project progress and accomplishments, and/or any delays in meeting project objectives and expenditures, to date as described in this §6.

Reports shall be submitted in accordance with the schedule table below. The order of the reporting period quarters below is irrelevant to the grant. Reports for the respective period are due on or before the due dates listed below if the grant is open during the "report period" time, and for every quarter that the grant remains open.

Report Period	Due Date
January, February, March	due April 10th
April, May, June	due July 10th
July, August, September	due October 10th
October, November, December	due January 10th

6.2. Final Reports: Grantee shall submit final progress reports that provide final financial reconciliation and final cumulative grant/project accomplishments within 45 days of the end of the project/grant period of performance. The final report may not include unliquidated obligations and must indicate the exact balance of unobligated funds. The final reports may substitute for the quarterly reports for the final quarter of the grant period.

If all projects are completed before the end of the grant period, the final report may be submitted at any time during the period of performance. Further reports are not due after the DHSEM has received, and sent notice of acceptance, of the final grant report.

7. Payment:

7.1. **Payment Schedule**: Grantee shall submit RFRs using the DHSEM's provided form, submission preference, and quarterly at minimum. One original or electronically signed/submitted copy of the RFR is due as outlined in the following schedule table.

Report Period	Due Date
January, February, March	due April 30th
April, May, June	due July 31st
July, August, September	due October 31st
October, November, December	due January 31st

All requests shall be for eligible actual expenses incurred by Grantee, and as described in detail in the budget table(s) in §9 of this SOW. Requests shall be accompanied by supporting documentation totaling at least the amount requested for reimbursement

and any required non-federal match contribution as outlined in §3.3 and §5.2 of this SOW. If any progress reports are delinquent at the time of a payment request, the DHSEM may withhold such reimbursement until the required reports have been submitted. Additionally, the DHSEM may issue a notice of delinquency to the Grantee for any overdue progress reports and/or RFRs.

7.2. Payment Amount: If non-federal match is required, such match shall be documented with every payment request. Excess match documented and submitted with one reimbursement request shall be applied to subsequent requests as necessary to maximize the allowable reimbursement.

7.3. Payment Returns: Any grant funds from this award not expended by the Agreement Expiration Date, or deemed ineligible under the grant program, must be returned to the State within 10 days of the Agreement Expiration Date, or notification from the DHSEM of ineligibility. Such grant funds returned to the State must be via check repayment issued to 'Colorado Department of Public Safety' with a memo line stating 'refund for [encumbrance number*]' and remit to:

Colorado Department of Public Safety
Attn: EDO Accountant
700 Kipling Street, Suite 4000
Lakewood, CO 80215

*Encumbrance number for this award is found at the bottom of each page of the SOW.

8. Testing and Acceptance Criteria:

The DHSEM shall evaluate Project(s) through the review of Grantee submitted financial and progress reports, and may also conduct on-site monitoring to determine whether the Grantee is meeting/has met the performance goals, administrative standards, financial management, and other requirements of this grant. The DHSEM will notify Grantee in advance of such on-site monitoring.

9. Budget Agreement Amount Table:

The following budget table contains amounts for the categories and/or project activities for this grant award.

Project Activity/Line Item	*Federal Share*	*Local Share*	*Total Project*
EMPG Activities	$ 54,943.00	$ 54,943.00	$ 109,886.00

10. Modifications

Any changes requested by the Grantee, or by the DHSEM, shall be made in writing. The DHSEM, in good faith and sole discretion, can modify this agreement and shall notify Grantee in writing with a letter of modification outlining any changes to this agreement with a modified SOW, and accompanied with an Acceptance Letter of Modification for the Grantee to sign as approval of such changes and/or modifications.

Only upon returning the Acceptance Letter of Modification, or further drawdowns of funds by the Grantee after notification of modification is made in writing by the DHSEM, will the modifications be deemed accepted by the Grantee in accordance with §3 of the attached Terms and Conditions of this Small Dollar Grant Award (SDGA). Examples of the modification notification letter, modified SOW, and Acceptance Letter of Modification are included.

State of Colorado Small Dollar Grant Award Terms and Conditions

1. **Offer/Acceptance.** This Small Dollar Grant Award, together with these terms and conditions (including, if applicable, Addendum 1: Additional Terms and Conditions for Information Technology below), and any other attachments, exhibits, specifications, or appendices, whether attached or incorporated by reference (collectively the "Agreement") shall represent the entire and exclusive agreement between the State of Colorado, by and through the agency identified on the face of the Small Dollar Grant Award ("State") and the Subrecipient identified on the face of the Small Dollar Grant Award ("Grantee"). If this Agreement refers to Grantee's bid or proposal, this Agreement is an ACCEPTANCE of Grantee's OFFER TO PERFORM in accordance with the terms and conditions of this Agreement. If a bid or proposal is not referenced, this Agreement is an OFFER TO ENTER INTO AGREEMENT, subject to Grantee's acceptance, demonstrated by Grantee's beginning performance or written acceptance of this Agreement. Any COUNTER-OFFER automatically CANCELS this Agreement, unless a change order is issued by the State accepting a counter-offer. Except as provided herein, the State shall not be responsible or liable for any Work performed prior to issuance of this Agreement. The State's financial obligations to the Grantee are limited by the amount of Grant Funds awarded as reflected on the face of the Small Dollar Grant Award.
2. **Order of Precedence.** In the event of a conflict or inconsistency within this Agreement, such conflict or inconsistency shall be resolved by giving preference to the documents in the following order of priority: (1) the Small dollar Grant Award document; (2) these terms and conditions (including, if applicable, Addendum 1 below); and (3) any attachments, exhibits, specifications, or appendices, whether attached or incorporated by reference. Notwithstanding the above, if this Agreement has been funded, in whole or in part, with a Federal Award, in the event of a conflict between the Federal Grant and this Agreement, the provisions of the Federal Grant shall control. Grantee shall comply with all applicable Federal provisions at all times during the term of this Agreement. Any terms and conditions included on Grantee's forms or invoices not included in this Agreement are void.
3. **Changes.** Once accepted in accordance with §1, this Agreement shall not be modified, superseded or otherwise altered, except in writing by the State and accepted by Grantee.

4. **Definitions.** The following terms shall be construed and interpreted as follows: (a) "Award" means an award of Federal financial assistance, and the grant setting forth the terms and conditions of that financial assistance, that a Non-Federal Entity receives or administers.;(b) "Budget" means the budget for the Work described in this Agreement; (c) "Business Day" means any day in which the State is open and conducting business, but shall not include Saturday, Sunday or any day on which the State observes one of the holidays listed in CRS §24-11- 101(1); (d) "UCC" means the Uniform Commercial Code in CRS Title 4; (e) "Effective Date" means the date on which this Agreement is issued as shown on the face of the Small Dollar Grant Award; (f) "Federal Award" means an award of federal financial assistance or a cost-reimbursement contract, , by a Federal Awarding Agency to the Recipient. "Federal Award" also means an agreement setting forth the terms and conditions of the Federal Award, which terms and conditions shall flow down to the Award unless such terms and conditions specifically indicate otherwise. The term does not include payments to a contractor or payments to an individual that is a beneficiary of a Federal program; (g) "Federal Awarding Agency" means a Federal agency providing a Federal Award to a Recipient as described in 2 CFR 200.1; (h) "Grantee" means the party or parties identified as such in the Grant to which these Terms and Conditions apply. Grantee also means Subrecipient; (i) "Grant Funds" means the funds that have been appropriated, designated, encumbered, or otherwise made available for payment by the State under this Agreement; (j) "Matching Funds" mean the funds provided by the Grantee to meet cost sharing requirements described in this Agreement; (k) "Non-Federal Entity" means a State, local government, Indian tribe, institution of higher education, or nonprofit organization that carries out a Federal Award as a Recipient or Subrecipient; (l) "Recipient" means the State agency identified on the face of the Small Dollar Grant Award; (m) "Subcontractor" means third parties, if any, engaged by Grantee to aid in performance of the Work; (n) "Subrecipient" means an entity that receives a subaward from a pass-through entity to carry out part of a Federal award. The term subrecipient does not include a beneficiary or participant. A subrecipient may also be a recipient of other Federal awards directly from a Federal agency; (o) "Uniform Guidance" means the Office of Management and Budget Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards. The terms and conditions of the Uniform Guidance flow down to awards to Subrecipients unless the Uniform Guidance or the terms and conditions of the Federal Award specifically indicate otherwise; and (p) "Work" means the goods delivered or services, or both, performed pursuant to this Agreement and identified as Line Items on the face of the Small Dollar Grant Award.

5. **Delivery.** Grantee shall furnish the Work in strict accordance with the specifications and price set forth in this Agreement. The State shall have no liability to compensate Grantee for the performance of any Work not specifically set forth in the Agreement.

6. **Rights to Materials.** [*Not Applicable to Agreements issued either in whole in part for Information Technology, as defined in CRS § 24-37.5-102(2); in which case Addendum 1 §2 applies in lieu of this section.*] Unless specifically stated otherwise in this Agreement, all materials, including without limitation supplies, equipment, documents, content, information, or other material of any type, whether tangible or intangible (collectively "Materials"), furnished by the State to Grantee or delivered by Grantee to the State in performance of its obligations under this Agreement shall be the exclusive property the State. Grantee shall return or deliver all Materials to the State upon completion or termination of this Agreement.

7. **Grantee Records.** Grantee shall make, keep, maintain, and allow inspection and monitoring by the State of a complete file of all records, documents, communications, notes and other written materials, electronic media files, and communications, pertaining in any manner to the Work (including, but not limited to the operation of programs) performed under this Agreement (collectively "Grantee Records"). Grantee must collect, transmit, and store information related to this Agreement in open and machine-readable formats (2 CFR 200.336). Unless otherwise specified by the State, the Grantee shall retain Grantee Records for a period (the "Record Retention Period") of three years following the date of submission to the State of the final expenditure report, or if this Award is renewed quarterly or annually, from the date of the submission of each quarterly or annual report, respectively. If any litigation, claim, or audit related to this Award starts before expiration of the Record Retention Period, the Record Retention Period shall extend until all litigation, claims or audit finding have been resolved and final action taken by the State or Federal Awarding Agency. The Federal Awarding Agency, a cognizant agency for audit, oversight, or indirect costs, and the State, may notify Grantee in writing that the Record Retention Period shall be extended. For records for real property and equipment, the Record Retention Period shall extend three years following final disposition of such property. Grantee shall permit the State, the federal government, and any other duly authorized agent of a governmental agency to audit, inspect, examine, excerpt, copy and transcribe Grantee Records during the Record Retention Period. Grantee shall make Grantee Records available during normal business hours at Grantee's office or place of business, or at other mutually agreed upon times or locations, upon no fewer than two Business Days' notice from the State, unless the State determines that a shorter period of notice, or no notice, is necessary to protect the interests of the State. The State, in its discretion, may monitor Grantee's performance of its obligations under this Agreement

using procedures as determined by the State. The federal government and any other duly authorized agent of a governmental agency, in its discretion, Grantee shall allow the State to perform all monitoring required by the Uniform Guidance, based on the State's risk analysis of Grantee and this Agreement, and the State shall have the right, in its discretion, to change its monitoring procedures and requirements at any time during the term of this Agreement. The State will monitor Grantee's performance in a manner that does not unduly interfere with Grantee's performance of the Work. Grantee shall promptly submit to the State a copy of any final audit report of an audit performed on Grantee Records that relates to or affects this Agreement or the Work, whether the audit is conducted by Grantee, a State agency or the State's authorized representative, or a third party. If applicable, the Grantee may be required to perform a single audit under 2 CFR 200.501, *et seq*. Grantee shall submit a copy of the results of that audit to the State within the same timelines as the submission to the federal government.

8. **Reporting.** If Grantee is served with a pleading or other document in connection with an action before a court or other administrative decision- making body, and such pleading or document relates to this Agreement or may affect Grantee's ability to perform its obligations under this Agreement, Grantee shall, within 10 days after being served, notify the State of such action and deliver copies of such pleading or document to the State. Grantee shall disclose, in a timely manner, in writing to the State and the Federal Awarding Agency, all violations of federal or State criminal law involving fraud, bribery, or gratuity violations potentially affecting the Award. The State or the Federal Awarding Agency may impose any penalties for noncompliance allowed under 2 CFR Part 180 and 31 U.S.C. 3321, which may include, without limitation, suspension or debarment.

9. **Conflicts of Interest.** Grantee acknowledges that with respect to this Agreement, even the appearance of a conflict of interest is harmful to the State's interests. Absent the State's prior written approval, Grantee shall refrain from any practices, activities, or relationships that reasonably may appear to be in conflict with the full performance of Grantee's obligations to the State under this Agreement. If a conflict or appearance of a conflict of interest exists, or if Grantee is uncertain as to such, Grantee shall submit to the State a disclosure statement setting forth the relevant details for the State's consideration. Failure to promptly submit a disclosure statement or to follow the State's direction in regard to the actual or apparent conflict constitutes a breach of this Agreement. Grantee certifies that, to their knowledge, no employee of the State has any personal or beneficial interest whatsoever in the service or property described in this Agreement. Grantee has no interest and shall not acquire any interest, direct or indirect, that would conflict in any manner or degree with the performance of Grantee's Services and Grantee shall not employ any person having such known interests.

10. **Taxes.** The State is exempt from federal excise taxes and from State and local sales and use taxes.

11. **Payment.** Payments to Grantee are limited to the unpaid, obligated balance of the Grant Funds. The State shall not pay Grantee any amount under this Agreement that exceeds the Document Total shown on the face of the Small Dollar Grant Award. The State shall pay Grantee in the amounts and in accordance with the schedule and other conditions set forth in this Agreement. Grantee shall initiate payment requests by invoice to the State, in a form and manner approved by the State. The State shall pay Grantee for all amounts due within 45 days after receipt of an Awarding Agency's approved invoicing request, or in instances of reimbursement grant programs a request for reimbursement, compliant with Generally Accepted Accounting Principles (GAAP) and, if applicable Government Accounting Standards Board (GASB) of amount requested. Amounts not paid by the State within 45 days of the State's acceptance of the invoice shall bear interest on the unpaid balance beginning on the 45th day at the rate set forth in CRS §24-30-202(24) until paid in full. Interest shall not accrue if a good faith dispute exists as to the State's obligation to pay all or a portion of the amount due. Grantee shall invoice the State separately for interest on delinquent amounts due, referencing the delinquent payment, number of day's interest to be paid, and applicable interest rate. The acceptance of an invoice shall not constitute acceptance of any Work performed under this Agreement. Except as specifically agreed in this Agreement, Grantee shall be solely responsible for all costs, expenses, and other charges it incurs in connection with its performance under this Grantee.

12. **Term.** The parties' respective performances under this Agreement shall commence on the "Service From" date identified on the face of the Small Dollar Grant Award, unless otherwise specified, and shall terminate on the "Service To" date identified on the face of the Small Dollar Grant Award unless sooner terminated in accordance with the terms of this Agreement.

13. **Payment Disputes.** If Grantee disputes any calculation, determination or amount of any payment, Grantee shall notify the State in writing of its dispute within 30 days following the earlier to occur of Grantee's receipt of the payment or notification of the determination or calculation of the payment by the State. The State will review the information presented by Grantee and may make changes to its determination based on this review. The calculation, determination or payment amount that results from the State's review shall not be subject to additional dispute under this subsection. No payment subject to a dispute under this subsection shall be due until after the State has concluded its review, and the State shall not pay any interest on any amount during the period it is subject to dispute under this subsection.

14. **Matching Funds.** Grantee shall provide Matching Funds, if required by this Agreement. If permitted under the terms of the grant and per this Agreement, Grantee may be permitted to provide Matching Funds prior to or during the course of the project or the match will be an in-kind match. Grantee shall report to the State regarding the status of such funds upon request. Grantee's obligation to pay all or any part of any Matching Funds, whether direct or contingent, only extend to funds duly and lawfully appropriated for the purposes of this Agreement by the authorized representatives of Grantee and paid into Grantee's treasury or bank account. Grantee represents to the State that the amount designated "Grantee's Matching Funds" pursuant to this Agreement, has been legally appropriated for the purposes of this Agreement by its authorized representatives and paid into its treasury or bank account. Grantee does not by this Agreement irrevocably pledge present cash reserves for payments in future fiscal years, and this Agreement is not intended to create a multiple-fiscal year debt of Grantee. Grantee shall not pay or be liable for any claimed interest, late charges, fees, taxes or penalties of any nature, except as required by Grantee's laws or policies.

15. **Reimbursement of Grantee Costs.** If applicable, the State shall reimburse Grantee's allowable costs, not exceeding the maximum total amount described in this Agreement for all allowable costs described in the grant except that Grantee may adjust the amounts between each line item of the Budget without formal modification to this Agreement as long as the Grantee provides notice to, and received approval from the State of the change, the change does not modify the total maximum amount of this Agreement, and the change does not modify any requirements of the Work. If applicable, the State shall reimburse Grantee for the properly documented allowable costs related to the Work after review and approval thereof, subject to the provisions of this Agreement. However, any costs incurred by Grantee prior to the Effective Date shall not be reimbursed absent specific allowance of pre-award costs. Grantee's costs for Work performed after the "Service To" date identified on the face of the Small Dollar Grant Award, or after any phase performance period end date for a respective phase of the Work, shall not be reimbursable. The State shall only reimburse allowable costs described in this Agreement and shown in the Budget if those costs are (a) reasonable and necessary to accomplish the Work, and (b) equal to the actual net cost to Grantee (i.e. the price paid minus any items of value received by Grantee that reduce the costs actually incurred).

16. **Close-Out.** Grantee shall close out this Award within 45 days after the "Service To" date identified on the face of the Small Dollar Grant Award, including any modifications. To complete close-out, Grantee shall submit to the State all deliverables (including documentation) as defined in this Agreement and Grantee's final reimbursement request or invoice. In accordance with the Agreement, the State may withhold a percentage of

allowable costs until all final documentation has been submitted and accepted by the State as substantially complete.

17. **Assignment.** Grantee's rights and obligations under this Agreement may not be transferred or assigned without the prior, written consent of the State and execution of a new agreement. Any attempt at assignment or transfer without such consent and new agreement shall be void. Any assignment or transfer of Grantee's rights and obligations approved by the State shall be subject to the provisions of this Agreement.

18. **Subcontracts.** Grantee shall not enter into any subcontract in connection with its obligations under this Agreement without the prior, written approval of the State. Grantee shall submit to the State a copy of each subcontract upon request by the State. All subcontracts entered into by Grantee in connection with this Agreement shall comply with all applicable federal and state laws and regulations, shall provide that they are governed by the laws of the State of Colorado, and shall be subject to all provisions of this Agreement.

19. **Severability.** The invalidity or unenforceability of any provision of this Agreement shall not affect the validity or enforceability of any other provision of this Agreement, which shall remain in full force and effect, provided that the Parties can continue to perform their obligations in accordance with the intent of the Agreement.

20. **Survival of Certain Agreement Terms.** Any provision of this Agreement that imposes an obligation on a party after termination or expiration of the Agreement shall survive the termination or expiration of the Agreement and shall be enforceable by the other party.

21. **Third Party Beneficiaries.** Except for the parties' respective successors and assigns, this Agreement does not and is not intended to confer any rights or remedies upon any person or entity other than the Parties. Enforcement of this Agreement and all rights and obligations hereunder are reserved solely to the parties. Any services or benefits which third parties receive as a result of this Agreement are incidental to the Agreement, and do not create any rights for such third parties.

22. **Waiver.** A party's failure or delay in exercising any right, power, or privilege under this Agreement, whether explicit or by lack of enforcement, shall not operate as a waiver, nor shall any single or partial exercise of any right, power, or privilege preclude any other or further exercise of such right, power, or privilege.

23. **Indemnification.** [*Not Applicable to Inter-governmental agreements*] Grantee shall indemnify, save, and hold harmless the State, its employees, agents and assignees (the "Indemnified Parties"), against any and all costs, expenses, claims, damages, liabilities, court awards and other amounts (including attorneys' fees and related costs) incurred by

any of the Indemnified Parties in relation to any act or omission by Grantee, or its employees, agents, Subcontractors, or assignees in connection with this Agreement. This shall include, without limitation, any and all costs, expenses, claims, damages, liabilities, court awards and other amounts incurred by the Indemnified Parties in relation to any claim that any work infringes a patent, copyright, trademark, trade secret, or any other intellectual property right or any claim for loss or improper disclosure of any confidential information or personally identifiable information. If Grantee is a public agency prohibited by applicable law from indemnifying any party, then this section shall not apply.

24. **Notice.** All notices given under this Agreement shall be in writing, and shall be delivered to the contacts for each party listed on the face of the Small Dollar Grant Award. Either party may change its contact or contact information by notice submitted in accordance with this section without a formal modification to this Agreement.

25. **Insurance.** Except as otherwise specifically stated in this Agreement or any attachment or exhibit to this Agreement, Grantee shall obtain and maintain insurance as specified in this section at all times during the term of the Agreement: (a) workers' compensation insurance as required by state statute, and employers' liability insurance covering all Grantee employees acting within the course and scope of their employment, (b) Commercial general liability insurance written on an Insurance Services Office occurrence form, covering premises operations, fire damage, independent contractors, products and completed operations, blanket contractual liability, personal injury, and advertising liability with minimum limits as follows: $1,000,000 each occurrence; $1,000,000 general aggregate; $1,000,000 products and completed operations aggregate; and $50,000 any one fire, and (c) Automobile liability insurance covering any auto (including owned, hired and non-owned autos) with a minimum limit of $1,000,000 each accident combined single limit. If Grantee will or may have access to any protected information, then Grantee shall also obtain and maintain insurance covering loss and disclosure of protected information and claims based on alleged violations of privacy right through improper use and disclosure of protected information with limits of $1,000,000 each occurrence and $1,000,000 general aggregate at all times during the term of the Small Dollar Grant Award. Additional insurance may be required as provided elsewhere in this Agreement or any attachment or exhibit to this Agreement. All insurance policies required by this Agreement shall be issued by insurance companies with an AM Best rating of A-VIII or better. If Grantee is a public agency within the meaning of the Colorado Governmental Immunity Act, then this section shall not apply and Grantee shall instead comply with the Colorado Governmental Immunity Act.

26. **Termination Prior to Grantee Acceptance.** If Grantee has not begun performance under this Agreement, the State may cancel this Agreement by providing written notice to the Grantee.

27. **Termination for Cause.** If Grantee refuses or fails to timely and properly perform any of its obligations under this Agreement with such diligence as will ensure its completion within the time specified in this Agreement, the State may notify Grantee in writing of non-performance and, if not corrected by Grantee within the time specified in the notice, terminate Grantee's right to proceed with the Agreement or such part thereof as to which there has been delay or a failure. Grantee shall continue performance of this Agreement to the extent not terminated. Grantee shall be liable for excess costs incurred by the State in procuring similar Work and the State may withhold such amounts, as the State deems necessary. If after rejection, revocation, or other termination of Grantee's right to proceed under the Colorado Uniform Commercial Code (CUCC) or this clause, the State determines for any reason that Grantee was not in default or the delay was excusable, the rights and obligations of the State and Grantee shall be the same as if the notice of termination had been issued pursuant to termination under §28.

28. **Termination in Public Interest.** The State is entering into this Agreement for the purpose of carrying out the public interest of the State, as determined by its Governor, General Assembly, Courts, or Federal Awarding Agency. If this Agreement ceases to further the public interest of the State as determined by its Governor, General Assembly, Courts, or Federal Awarding Agency, the State, in its sole discretion, may terminate this Agreement in whole or in part and such termination shall not be deemed to be a breach of the State's obligations hereunder. This section shall not apply to a termination for cause, which shall be governed by §27. A determination that this Small Dollar Grant Award should be terminated in the public interest shall not be equivalent to a State right to terminate for convenience. The State shall give written notice of termination to Grantee specifying the part of the Agreement terminated and when termination becomes effective. Upon receipt of notice of termination, Grantee shall not incur further obligations except as necessary to mitigate costs of performance. The State shall pay the Agreement price or rate for Work performed and accepted by State prior to the effective date of the notice of termination. The State's termination liability under this section shall not exceed the total Agreement price.

29. **Termination for Funds Availability.** The State is prohibited by law from making commitments beyond the term of the current State Fiscal Year. Payment to Grantee beyond the current State Fiscal Year is contingent on the appropriation and continuing availability of Grant Funds in any subsequent year (as provided in the Colorado Special

Provisions). If federal funds or funds from any other non-State funds constitute all or some of the Grant Funds, the State's obligation to pay Grantee shall be contingent upon such non-State funding continuing to be made available for payment. Payments to be made pursuant to this Agreement shall be made only from Grant Funds, and the State's liability for such payments shall be limited to the amount remaining of such Grant Funds. If State, federal or other funds are not appropriated, or otherwise become unavailable to fund this Agreement, the State may, upon written notice, terminate this Agreement, in whole or in part, without incurring further liability. The State shall, however, remain obligated to pay for Work performed and accepted prior to the effective date of notice of termination, and this termination shall otherwise be treated as if this Agreement were terminated in the public interest as described in §28.

30. **Grantee's Termination Under Federal Requirements.** If the Grant Funds include any federal funds, then Grantee may request termination of this Grant by sending notice to the State, or to the Federal Awarding Agency with a copy to the State, which includes the reasons for the termination and the effective date of the termination. If this Grant is terminated in this manner, then Grantee shall return any advanced payments made for Work that will not be performed prior to the effective date of the termination.

31. **Governmental Immunity.** Liability for claims for injuries to persons or property arising from the negligence of the State, its departments, boards, commissions committees, bureaus, offices, employees and officials shall be controlled and limited by the provisions of the Colorado Governmental Immunity Act, CRS §24-10-101, *et seq.*, the Federal Tort Claims Act, 28 U.S.C. Pt. VI, Ch. 171 and 28 U.S.C. 1346(b), and the State's risk management statutes, CRS §§24-30-1501, *et seq.* No term or condition of this Agreement shall be construed or interpreted as a waiver, express or implied, of any of the immunities, rights, benefits, protections, or other provisions, contained in these statutes.

32. **Grant Recipient.** Grantee shall perform its duties hereunder as a grant recipient and not as an employee. Neither Grantee nor any agent or employee of Grantee shall be deemed to be an agent or employee of the State. Grantee shall not have authorization, express or implied, to bind the State to any agreement, liability or understanding, except as expressly set forth herein. Grantee and its employees and agents are not entitled to unemployment insurance or workers compensation benefits through the State and the State shall not pay for or otherwise provide such coverage for Grantee or any of its agents or employees. Grantee shall pay when due all applicable employment taxes and income taxes and local head taxes incurred pursuant to this Agreement. Grantee shall (a) provide and keep in force workers' compensation and unemployment compensation insurance in the amounts required by law, (b) provide proof thereof when requested by the State, and

(c) be solely responsible for its acts and those of its employees and agents.

33. **Compliance with Law.** Grantee shall comply with all applicable federal and State laws, rules, and regulations in effect or hereafter established, including, without limitation, laws applicable to discrimination and unfair employment practices.

34. **Choice of Law, Jurisdiction and Venue.** [*Not Applicable to Inter-governmental agreements*] Colorado law, and rules and regulations issued pursuant thereto, shall be applied in the interpretation, execution, and enforcement of this Agreement. Any provision included or incorporated herein by reference which conflicts with said laws, rules, and regulations shall be null and void. All suits or actions related to this Agreement shall be filed and proceedings held in the State of Colorado and exclusive venue shall be in the City and County of Denver. Any provision incorporated herein by reference which purports to negate this or any other provision in this Agreement in whole or in part shall not be valid or enforceable or available in any action at law, whether by way of complaint, defense, or otherwise. Any provision rendered null and void by the operation of this provision or for any other reason shall not invalidate the remainder of this Agreement, to the extent capable of execution. Grantee shall exhaust administrative remedies in CRS §24-109-106, prior to commencing any judicial action against the State regardless of whether the Colorado Procurement Code applies to this Agreement.

35. **Prohibited Terms.** Nothing in this Agreement shall be construed as a waiver of any provision of CRS §24-106-109. Any term included in this Agreement that requires the State to indemnify or hold Grantee harmless; requires the State to agree to binding arbitration; limits Grantee's liability for damages resulting from death, bodily injury, or damage to tangible property; or that conflicts with that statute in any way shall be void ab initio.

36. **Public Contracts for Services.** [*Not Applicable to offer, issuance, or sale of securities, investment advisory services, fund management services, sponsored projects, intergovernmental grant agreements, or information technology services or products and services*] Grantee certifies, warrants, and agrees that it does not knowingly employ or contract with an illegal alien who will perform work under this Agreement and will confirm the employment eligibility of all employees who are newly hired for employment in the United States to perform work under this Agreement, through participation in the E-Verify Program or the Department program established pursuant to CRS §8-17.5- 102(5)(c), Grantee shall not knowingly employ or contract with an illegal alien to perform work under this Agreement or enter into a contract or agreement with a Subcontractor that fails to certify to Grantee that the Subcontractor shall not knowingly employ or contract with an illegal alien to perform work under this Agreement. Grantee shall (a) not use E-Verify Program or Department program procedures to undertake pre- employment

screening of job applicants during performance of this Agreement, (b) notify Subcontractor and the State within three days if Grantee has actual knowledge that Subcontractor is employing or contracting with an illegal alien for work under this Agreement, (c) terminate the subcontract if Subcontractor does not stop employing or contracting with the illegal alien within three days of receiving notice, and (d) comply with reasonable requests made in the course of an investigation, undertaken pursuant to CRS §8-17.5-102(5), by the Colorado Department of Labor and Employment. If Grantee participates in the Department program, Grantee shall deliver to the State a written, notarized affirmation that Grantee has examined the legal work status of such employee, and shall comply with all of the other requirements of the Department program. If Grantee fails to comply with any requirement of this provision or CRS §8-17.5-101 et seq., the State may terminate this Agreement for breach and, if so terminated, Grantee shall be liable for damages.

37. **Public Contracts with Natural Persons.** Grantee, if a natural person 18 years of age or older, hereby swears and affirms under penalty of perjury that the person (a) is a citizen or otherwise lawfully present in the United States pursuant to federal law, (b) shall comply with the provisions of CRS §24-76.5-101 et seq., and (c) has produced a form of identification required by CRS §24-76.5-103 prior to the date Grantee begins Work under terms of the Agreement.

38. **Whistle Blower Protections.** An employee of a grantee must not be discharged, demoted, or otherwise discriminated against as a reprisal for disclosing to a person or body described in paragraph (a)(2) of 41 U.S.C. 4712 information that the employee reasonably believes is evidence of gross mismanagement of a Federal contract or grant, a gross waste of Federal funds, an abuse of authority relating to a Federal contract or grant, a substantial and specific danger to public health or safety, or a violation of law, rule, or regulation related to a Federal contract (including the competition for or negotiation of a contract) or grant. The subrecipient must inform their employees in writing of employee whistleblower rights and protections under 41 U.S.C. 4712. See statutory requirements for whistleblower protections at 10 U.S.C. 4701, 41 U.S.C. 4712, 41 U.S.C. 4304, and 10 U.S.C. 4310.

ADDENDUM 1:

Additional Terms & Conditions for Information Technology

IF ANY PART OF THE SUBJECT MATTER OF THIS AGREEMENT IS INFORMATION TECHNOLOGY, AS DEFINED IN CRS § 24-37.5-102 (2), THE FOLLOWING PROVISIONS ALSO APPLY TO THIS AGREEMENT.

A. **Definitions.** The following terms shall be construed and interpreted as follows: (a) "CJI" means criminal justice information collected by criminal justice agencies needed for the performance of their authorized functions, including, without limitation, all information defined as criminal justice information by the U.S. Department of Justice, Federal Bureau of Investigation, Criminal Justice Information Services Security Policy, as amended, and all Criminal Justice Records as defined under CRS §24-72-302; (b) "Incident" means any accidental or deliberate event that results in or constitutes an imminent threat of the unauthorized access, loss, disclosure, modification, disruption, or destruction of any communications or information resources of the State, pursuant to CRS §§24-37.5-401 et seq.; (c) "PCI" means payment card information including any data related to credit card holders' names, credit card numbers, or the other credit card information as may be protected by state or federal law; (d) "PHI" means any protected health information, including, without limitation any information whether oral or recorded in any form or medium that relates to the past, present or future physical or mental 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 that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual including, without limitation, any information defined as Individually Identifiable Health Information by the federal Health Insurance Portability and Accountability Act; (e) "PII" means personally identifiable information including, without limitation, any information maintained by the State about an individual that can be used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, or biometric records, including, without limitation, all information defined as personally identifiable information in CRS §24-72-501; (f) "State

Confidential Information" means any and all State Records not subject to disclosure under the Colorado Open Records Act and includes, without limitation, PII, PHI, PCI, Tax Information, CJI, and State personnel records not subject to disclosure under the Colorado Open Records Act, (g) "State Fiscal Rules" means those fiscal rules promulgated by the Colorado State Controller pursuant to CRS §24-30-202(13)(a); (h) "State Fiscal Year" means a 12 month period beginning on July 1 of each calendar year and ending on June 30 of the following calendar year; (i) "State Records" means any and all State data, information, and records, regardless of physical form; (j) "Tax Information" means federal and State of Colorado tax information including, without limitation, federal and State tax returns, return information, and such other tax-related information as may be protected by federal and State law and regulation, including, without limitation all information defined as federal tax information in Internal Revenue Service Publication 1075; and (k) "Work Product" means the tangible and intangible results of the delivery of goods and performance of services, whether finished or unfinished, including drafts. Work Product includes, but is not limited to, documents, text, software (including source code), research, reports, proposals, specifications, plans, notes, studies, data, images, photographs, negatives, pictures, drawings, designs, models, surveys, maps, materials, ideas, concepts, know-how, information, and any other results of the Work, but does not include any material that was developed prior to the Effective Date that is used, without modification, in the performance of the Work.

B. **Intellectual Property.** Except to the extent specifically provided elsewhere in this Agreement, any State information, including without limitation pre-existing State software, research, reports, studies, data, photographs, negatives or other documents, drawings, models, materials; or Work Product prepared by Grantee in the performance of its obligations under this Agreement shall be the exclusive property of the State (collectively, "State Materials"). All State Materials shall be delivered to the State by Grantee upon completion or termination of this Agreement. The State's exclusive rights in any Work Product prepared by Grantee shall include, but not be limited to, the right to copy, publish, display, transfer, and prepare derivative works. Grantee shall not use, willingly allow, cause or permit any State Materials to be used for any purpose other than the performance of Grantee's obligations hereunder without the prior written

consent of the State. The State shall maintain complete and accurate records relating to **(a)** its use of all Grantee and third party software licenses and rights to use any Grantee or third party software granted under this Agreement and its attachments to which the State is a party and **(b)** all amounts payable to Grantee pursuant to this Agreement and its attachments and the State's obligations under this Agreement or any amounts payable to Grantee in relation to this Agreement, which records shall contain sufficient information to permit Grantee to confirm the State's compliance with the use restrictions and payment obligations under this Agreement or to any third party use restrictions to which the State is a party. Grantee retains the exclusive rights, title and ownership to any and all pre-existing materials owned or licensed to Grantee including, but not limited to all pre-existing software, licensed products, associated source code, machine code, text images, audio, video, and third-party materials, delivered by Grantee under the Agreement, whether incorporated in a deliverable or necessary to use a deliverable (collectively, "Grantee Property"). Grantee Property shall be licensed to the State as set forth in a State-approved license agreement **(a)** entered into as exhibits or attachments to this Agreement, **(b)** obtained by the State from the applicable third-party Grantee, or **(c)** in the case of open source software, the license terms set forth in the applicable open source license agreement. Notwithstanding anything to the contrary herein, the State shall not be subject to any provision incorporated in any exhibit or attachment attached hereto, any provision incorporated in any terms and conditions appearing on any website, any provision incorporated into any click through or online agreements, or any provision incorporated into any other document or agreement between the parties that **(a)** requires the State or the State to indemnify Grantee or any other party, **(b)** is in violation of State laws, regulations, rules, State Fiscal Rules, policies, or other State requirements as deemed solely by the State, or **(c)** is contrary to this Agreement.

C. **Information Confidentiality.** Grantee shall keep confidential, and cause all Subcontractors to keep confidential, all State Records, unless those State Records are publicly available. Grantee shall not, without prior written approval of the State, use, publish, copy, disclose to any third party, or permit the use by any third party of any State Records, except as otherwise stated in this Agreement, permitted by law, or approved in writing by the State. If Grantee will or may have access to any State

Confidential Information or any other protected information, Grantee shall provide for the security of all State Confidential Information in accordance with all applicable laws, rules, policies, publications, and guidelines. Grantee shall comply with all Colorado Office of Information Security ("OIS") policies and procedures which OIS has issued pursuant to CRS §§24- 37.5-401 through 406 and 8 CCR §1501-5 and posted at http://oit.state.co.us/ois, all information security and privacy obligations imposed by any federal, state, or local statute or regulation, or by any industry standards or guidelines, as applicable based on the classification of the data relevant to Grantee's performance under this Agreement. Such obligations may arise from: Health Information Portability and Accountability Act (HIPAA); IRS Publication 1075; Payment Card Industry Data Security Standard (PCI-DSS); FBI Criminal Justice Information Service Security Addendum; Centers for Medicare & Medicaid Services (CMS) Minimum Acceptable Risk Standards for Exchanges; and Electronic Information Exchange Security Requirements and Procedures for State and Local Agencies Exchanging Electronic Information with The Social Security Administration. Grantee shall immediately forward any request or demand for State Records to the State's principal representative.

D. **Other Entity Access and Nondisclosure Agreements.** Grantee may provide State Records to its agents, employees, assigns and Subcontractors as necessary to perform the work, but shall restrict access to State Confidential Information to those agents, employees, assigns, and Subcontractors who require access to perform their obligations under this Agreement. Grantee shall ensure all such agents, employees, assigns, and Subcontractors sign agreements containing nondisclosure provisions at least as protective as those in this Agreement, and that the nondisclosure provisions are in force at all times the agent, employee, assign, or Subcontractors has access to any State Confidential Information. Grantee shall provide copies of those signed nondisclosure provisions to the State upon execution of the nondisclosure provisions if requested by the State.

E. **Use, Security, and Retention.** Grantee shall use, hold, and maintain State Confidential Information in compliance with any and all applicable laws and regulations only in facilities located within the United States, and shall maintain a secure environment that

ensures confidentiality of all State Confidential Information. Grantee shall provide the State with access, subject to Grantee's reasonable security requirements, for purposes of inspecting and monitoring access and use of State Confidential Information and evaluating security control effectiveness. Upon the expiration or termination of this Agreement, Grantee shall return State Records provided to Grantee or destroy such State Records and certify to the State that it has done so, as directed by the State. If Grantee is prevented by law or regulation from returning or destroying State Confidential Information, Grantee warrants it will guarantee the confidentiality of, and cease to use, such State Confidential Information.

F. **Incident Notice and Remediation.** If Grantee becomes aware of any Incident, it shall notify the State immediately and cooperate with the State regarding recovery, remediation, and the necessity to involve law enforcement, as determined by the State. Unless Grantee can establish none of Grantee or any of its agents, employees, assigns or Subcontractors are the cause or source of the Incident, Grantee shall be responsible for the cost of notifying each person who may have been impacted by the Incident. After an Incident, Grantee shall take steps to reduce the risk of incurring a similar type of Incident in the future as directed by the State, which may include, but is not limited to, developing and implementing a remediation plan that is approved by the State at no additional cost to the State. The State may adjust or direct modifications to this plan, in its sole discretion and Grantee shall make all modifications as directed by the State. If Grantee cannot produce its analysis and plan within the allotted time, the State, in its sole discretion, may perform such analysis and produce a remediation plan, and Grantee shall reimburse the State for the reasonable actual costs thereof.

G. **Data Protection and Handling.** Grantee shall ensure that all State Records and Work Product in the possession of Grantee or any Subcontractors are protected and handled in accordance with the requirements of this Agreement at all times. Upon request by the State made any time prior to 60 days following the termination of this Agreement for any reason, whether or not this Agreement is expiring or terminating, Grantee shall make available to the State a complete and secure download file of all data that is encrypted and appropriately authenticated. This download file shall be made available to the State within 10 Business Days following the State's request, and shall contain,

without limitation, all State Records, Work Product, and any other information belonging to the State. Upon the termination of Grantee's services under this Agreement, Grantee shall, as directed by the State, return all State Records provided by the State to Grantee, and the copies thereof, to the State or destroy all such State Records and certify to the State that it has done so. If legal obligations imposed upon Grantee prevent Grantee from returning or destroying all or part of the State Records provided by the State, Grantee shall guarantee the confidentiality of all State Records in Grantee's possession and will not actively process such data. The State retains the right to use the established operational services to access and retrieve State Records stored on Grantee's infrastructure at its sole discretion and at any time.

H. **Compliance.** If applicable, Grantee shall review, on a semi-annual basis, all OIS policies and procedures which OIS has promulgated pursuant to CRS §§ 24-37.5-401 through 406 and 8 CCR § 1501-5 and posted at http://oit.state.co.us/ois, to ensure compliance with the standards and guidelines published therein. Grantee shall cooperate, and shall cause its Subcontractors to cooperate, with the performance of security audit and penetration tests by OIS or its designee.

I. **Safeguarding PII.** If Grantee or any of its Subcontractors will or may receive PII under this Agreement, Grantee shall provide for the security of such PII, in a manner and form acceptable to the State, including, without limitation, all State requirements relating to non-disclosure, use of appropriate technology, security practices, computer access security, data access security, data storage encryption, data transmission encryption, security inspections, and audits. Grantee shall take full responsibility for the security of all PII in its possession or in the possession of its Subcontractors, and shall hold the State harmless for any damages or liabilities resulting from the unauthorized disclosure or loss thereof. Grantee shall be a "Third-Party Service Provider" as defined in CRS §24-73-103(1)(i) and shall maintain security procedures and practices consistent with CRS §§24-73-101 *et seq*.

J. **Software Piracy Prohibition.** The State or other public funds payable under this Agreement shall not be used for the acquisition, operation, or maintenance of computer software in violation of federal copyright laws or applicable licensing restrictions. Grantee hereby certifies and warrants that, during the term of this Agreement and any

extensions, Grantee has and shall maintain in place appropriate systems and controls to prevent such improper use of public funds. If the State determines that Grantee is in violation of this provision, the State may exercise any remedy available at law or in equity or under this Agreement, including, without limitation, immediate termination of this Agreement and any remedy consistent with federal copyright laws or applicable licensing restrictions.

K. **Information Technology.** To the extent that Grantee provides physical or logical storage of State Records; Grantee creates, uses, processes, discloses, transmits, or disposes of State Records; or Grantee is otherwise given physical or logical access to State Records in order to perform Grantee's obligations under this Agreement, the following terms shall apply. Grantee shall, and shall cause its Subcontractors, to: Provide physical and logical protection for all hardware, software, applications, and data that meets or exceeds industry standards and the requirements of this Agreement; Maintain network, system, and application security, which includes, but is not limited to, network firewalls, intrusion detection (host and network), annual security testing, and improvements or enhancements consistent with evolving industry standards; Comply with State and federal rules and regulations related to overall security, privacy, confidentiality, integrity, availability, and auditing; Provide that security is not compromised by unauthorized access to workspaces, computers, networks, software, databases, or other physical or electronic environments; Promptly report all Incidents, including Incidents that do not result in unauthorized disclosure or loss of data integrity, to a designated representative of the OIS; Comply with all rules, policies, procedures, and standards issued by the Governor's Office of Information Technology (OIT), including project lifecycle methodology and governance, technical standards, documentation, and other requirements posted at www.oit.state.co.us/about/policies. Grantee shall not allow remote access to State Records from outside the United States, including access by Grantee's employees or agents, without the prior express written consent of OIS. Grantee shall communicate any request regarding non-U.S. access to State Records to the State. The State, acting by and through OIS, shall have sole discretion to grant or deny any such request.

COLORADO
Division of Homeland Security & Emergency Management
Department of Public Safety

Office of Grants Management
8000 South Chester Street, Suite 575
Centennial, CO 80112

Insert Name
Insert Title
Insert Agency Name
Insert Agency Address
City, CO ZipCode

Insert Full Date

Re: Grant Award ##XXX##XXX Modification Notification

Dear Insert Last Name,

This letter is to inform you that your award under the Insert Year Insert Grant Program Name Grant Program is modified from the original issuance of your Small Dollar Grant Award (SDGA). The modification for this letter is accompanied by the modified Statement of Work (SOW). This modification includes:

1. The period of performance for this SDGA modification is extended from the Original Expiration date of Insert Full Date to the Current Expiration date of Insert Full Date.

2. The Increase/Decrease or Budget Line Adjustment of the award amount of $00,000.00 (funding source: $00,000.00 of Federal, and $00,000.00 of State, Local or Both Funds) as outlined in the attached Statement of Work (SOW).

For questions regarding your SDGA or the Insert Year Insert Grant Program Name Grant Program, please contact Insert Name at (###) ###-#### or Email Address@state.co.us, or Insert Name (###) ###-#### or Email Address@state.co.us and thank you for your assistance in managing this grant award.

Sincerely,

DHSEM Full Name
DHSEM Title
Colorado Department of Public Safety
Division of Homeland Security and Emergency Management

CC: File

STATE OF COLORADO
SMALL DOLLAR GRANT AWARD (SDGA) MODIFICATION
STATEMENT OF WORK

State Agency
Department of Public Safety, Division of Homeland Security and Emergency Management

Grantee
Board of County Commissioners of [County Name] County

Grantee UEI
XXXabcXXXz12

Agreement Number
YYxxxYYxxxx

Agreement Performance Beginning Date
Month dd, YYYY

Current Agreement Expiration Date
Month dd, YYYY

Current Agreement Maximum Amount
$00,000.00

Current Agreement Match Amount
$00,000.00

1. FEDERAL AWARD INFORMATION

Federal Award ID # (FAIN)
AWARD No.

Federal Award Date
Month dd, YYYY

Federal Awarding Agency
ex.: DHS / FEMA

Assistance Listing (CFDA)
00.000
Grant Program Name

Identification if the Award is for R&D:
No

2. GRANT AUTHORITY

A. Federal Authority to enter into this Grant exists in the Briefly describe the Authority to enter into the Agreement;

B. State Authority: to enter this Grant exists in CRS §24-1-128.6.

3. GENERAL DESCRIPTION OF THE PROJECT(S).

3.1. Project Description. Sample Text Only - Grantee will hire a contractor to complete a multi-hazard risk analysis for XXX County. The analysis will meet all FEMA's requirements. Subrecipient will execute and complete the projects as specified and outlined in their approved Insert Appropriate Reference.

3.2. Project Expenses. Project expenses include the costs to Sample Text Only - hire the contractor to complete the project as described in this §3 Statement of Work (SOW). All eligible expenses are listed in the budget agreement amount table of §9 of this SOW.

3.3. Non-Federal Match: This non-federal match section applies to or does not apply to this Grant. If it applies, this Grant requires a non-federal match contribution of Number% of the total Grant budget. Documentation of expenditures for the non-federal match contribution is required with each drawdown request. If applicable the match may or may not include in-kind match.

4. PRINCIPAL REPRESENTATIVES

For the State:
Name, Title
Department of Public Safety,
Division of Homeland Security &
Emergency Management
8000 South Chester Street, Suite 575
Centennial, CO 80112
Name.Name@state.co.us

For Grantee:
Name, Title
Agency Name
Physical Address
Mailing or PO Address
City, CO ZIP Code
Email Address

5. ADMINISTRATIVE REQUIREMENTS:

5.1. The Grantee must request approval in advance for any change to this Grant Agreement, using the forms and procedures established by the Colorado Department of Public Safety, Division of Homeland Security and Emergency Management (DHSEM).

5.2. Required Documentation: Grantees shall retain all procurement and payment documentation on site for inspection. This shall include, but not be limited to, purchase orders, receiving documents, invoices, vouchers, equipment/services identification, and time and effort reports.

5.2.1 Sufficient detail shall be provided with reimbursement requests to demonstrate that expenses are allowable and appropriate as detailed below:

5.2.2 Equipment or tangible goods. When requesting reimbursement for equipment items with a purchase price of or exceeding $5,000, and a useful life of more than one year, the Grantee shall provide a unique identifying number for the equipment, with a copy of the Grantee's invoice and proof of payment. The unique identifying number can be the manufacturer's serial number or, if the Grantee has its own existing inventory numbering system, that number may be used. The location of the equipment shall also be provided. In addition to ongoing tracking requirements, Grantee shall ensure that equipment items with per unit cost of $5,000 or more are prominently marked in a manner similar to the following:

Purchased with funds provided by the U.S. Department of Homeland Security.

5.2.3 Services. Grantees shall include contract/purchase order number(s) or employee names, the date(s) the services were provided and the nature of the services.

5.3. Non-Supplanting Requirement: Grantees receiving federal financial assistance awards made under programs that prohibit supplanting by law must ensure that federal funds do not replace (supplant) funds that have been budgeted for the same purpose through non-federal sources.

5.4. Procurement: A Grantee shall ensure its procurement policies meet or exceed local, state, and federal requirements. Grantees should refer to local, state, and federal guidance prior to making decisions regarding competitive bids, sole source or other procurement issues.

In addition:

5.4.1 Any sole source transaction in excess of $100,000 shall be approved in advance by the DHSEM.

5.4.2 Grantees shall ensure that: (a) All procurement transactions, whether negotiated or competitively bid, and without regard to dollar value, are conducted in a manner that provides maximum open and free competition; (b) Grantee shall be alert to organizational conflicts of interest and/or non-competitive practices among contractors that may restrict or eliminate competition or otherwise restrain trade; (c) Contractors who develop or draft specifications, requirements, statements of work, and/or Requests for Proposals (RFPs) for a proposed procurement shall be excluded from bidding or submitting a proposal to compete for the award of such procurement; and (d) Any request for exemption of item a-c within this subsection shall be submitted in writing to, and be approved by the authorized Grantee official.

5.4.3 Grantee shall verify Contractor(s) is/are not debarred from participation in state and federal programs by reviewing contractor debarment information on SAM.gov.

5.4.4 When issuing requests for proposals, bid solicitations, and other published documents describing projects or programs funded in whole or in part with these grant funds, Grantee and Subgrantees shall use the following phrase in the request listing:

"*This project was supported by grant #YYxxxYYxxxx, issued by the Colorado Division of Homeland Security and Emergency Management.*"

5.4.5 Grantee shall ensure that no rights or duties exercised under this grant, or equipment purchased with Grant Funds having a purchase value of $5,000 or more, are assigned without the prior written consent of the DHSEM.

5.5. Additional Administrative Requirements:

5.5.1 All of the instructions, guidance, limitations, terms and conditions, scope of work, and other conditions set forth in the Notice of Funding Opportunity (NOFO) and the Notice of Award (NOA) for this federal award are incorporated by reference. See also DHS Standard Terms and Conditions.

5.5.2 Grantees of FEMA financial assistance for programs that are subject to the Build America, Buy America Act (BABAA) must include a Buy America preference contract provision as noted in 2 C.F.R. § 184.4 and a and self-certification as required by the FEMA Buy America Preference in FEMA Financial Assistance Programs for Infrastructure (FEMA Interim Policy #207-22-0001). This requirement applies to all subawards, contracts, and purchase orders for work performed or products supplied under the FEMA award subject to BABAA.

5.5.3 All applicant agencies that own resources currently covered by the Colorado Resource Typing Standards must agree to participate in the State's Emergency Resource Inventory Report and update their information on a quarterly basis.

5.5.4 Regardless of exercise type or scope, After Action Reports/Improvement Plans are due to the State Training and Exercise Program Manager within 45 days of the exercise. All funding related to exercises must be managed and executed in accordance with the Homeland Security Exercise and Evaluation Program (HSEEP), and must be National Incident Management System (NIMS) compliant.

6. REPORTING REQUIREMENTS:

6.1. The project(s) approved in this Grant are to be completed on or before the termination date stated on the agreement's Grant Award Letter of this grant agreement. Grantee shall submit quarterly progress reports for each project identified in this agreement using the format provided by the DHSEM throughout the life of the grant.

Grantee shall submit narrative and financial reports describing project progress and accomplishments, and/or any delays in meeting project objectives and expenditures, to date as described in this §6.

Reports shall be submitted in accordance with the schedule table below. The order of the reporting period quarters below is irrelevant to the grant. Reports for the respective period are due on or before the due dates listed below if the grant is open during the "report period" time, and for every quarter that the grant remains open.

Report Period	Due Date
January, February, March	due April 30th
April, May, June	due July 30th
July, August, September	due October 30th
October, November, December	due January 30th

6.2. Final Reports: Grantee shall submit final progress reports that provide final financial reconciliation and final cumulative grant/project accomplishments within 45 days of the end of the project/grant period of performance. The final report may not include unliquidated obligations and must indicate the exact balance of unobligated funds. The final reports may substitute for the quarterly reports for the final quarter of the grant period.

If all projects are completed before the end of the grant period, the final report may be submitted at any time during the period of performance. Further reports are not due after the DHSEM has received, and sent notice of acceptance, of the final grant report.

7. PAYMENT:

7.1. **Payment Schedule**: Grantee shall submit requests for reimbursement using the DHSEM's provided form, submission preference, and quarterly at minimum. One original or electronically signed/submitted copy of the reimbursement request is due on the same dates as the required progress reports outlined in §6.1 of this SOW.

All requests shall be for eligible actual expenses incurred by Grantee, and as described in detail in the budget table(s) in §9 of this SOW. Requests shall be accompanied by supporting documentation totaling at least the amount requested for reimbursement and any required non-federal match contribution as outlined in §3.3 of this SOW.

If any progress reports are delinquent at the time of a payment request, the DHSEM may withhold such reimbursement until the required reports have been submitted.

7.2. Payment Amount: If non-federal match is required, such match shall be documented with every payment request. Excess match documented and submitted with one reimbursement request shall be applied to subsequent requests as necessary to maximize the allowable reimbursement.

8. TESTING AND ACCEPTANCE CRITERIA:

The DHSEM shall evaluate Project(s) through the review of Grantee submitted financial and progress reports, and may also conduct on-site monitoring to determine whether the Grantee is meeting/has met the performance goals, administrative standards, financial management, and other requirements of this grant. The DHSEM will notify Grantee in advance of such on-site monitoring.

9. BUDGET AGREEMENT AMOUNT TABLE:

The following budget table contains amounts for the categories and/or project activities for this grant award.

Project Activity/Line Item	*Federal Share*	*Local Share*	*Total Project*
Planning	$ 000,000.00	$ 000,000.00	$ 000,000.00
Equipment	$ 000,000.00	$ 000,000.00	$ 000,000.00
Training	$ 000,000.00	$ 000,000.00	$ 000,000.00
Exercise	$ 000,000.00	$ 000,000.00	$ 000,000.00
PROJECT ACTIVITY SUBTOTAL	**$ 000,000.00**	**$ 000,000.00**	**$ 000,000.00**
Management & Admin	$ 000,000.00	$ 000,000.00	$ 000,000.00
TOTAL AWARD AMOUNT	**$ 000,000.00**	**$ 000,000.00**	**$ 000,000.00**

10. MODIFICATIONS

Any changes requested by the Grantee, or by the DHSEM, shall be made in writing. The DHSEM, in good faith and sole discretion, can modify this agreement and shall notify Grantee in writing with a letter of modification outlining any changes to this agreement with a modified SOW, and accompanied with an Acceptance Letter of Modification for the Grantee to sign as approval of such changes and/or modifications.

Only upon returning the Acceptance Letter of Modification, or further drawdowns of funds by the Grantee after notification of modification is made in writing by the DHSEM, will the modifications be deemed accepted by the Grantee in accordance with §3 of the attached Terms and Conditions of this Small Dollar Grant Award (SDGA). Examples of the modification notification letter, modified SOW, and Acceptance Letter of Modification are included.

SDGA Grant Federal Provisions

1. Applicability of Provisions.

1.1. The Grant to which these Federal Provisions are attached has been funded, in whole or in part, with an Award of Federal funds. In the event of a conflict between the provisions of these Federal Provisions, the Special Provisions, the body of the Grant, or any attachments or exhibits incorporated into and made a part of the Grant, the provisions of these Federal Provisions shall control.

These Federal Provisions are subject to the Award as defined in §2 of these Federal Provisions, as may be revised pursuant to ongoing guidance from the relevant Federal or State of Colorado agency or institutions of higher education.

2. Definitions.

2.1. For the purposes of these Federal Provisions, the following terms shall have the meanings ascribed to them below. For a full list of definitions (as of October 1, 2024) under the Uniform Guidance, see 2 CFR 200.1.

2.1.1. "Award" means an award of Federal financial assistance, and the Grant setting forth the terms and conditions of that financial assistance, that a non-Federal Entity receives or administers.

2.1.2. "Entity" means:

2.1.2.1 a non-federal entity;

2.1.2.2 a non-profit organization or for-profit organization;

2.1.3. "Executive" means an officer, managing partner or any other employee in a management position.

2.1.4. "Federal Awarding Agency" means a Federal agency providing a Federal Award to a Recipient as described in 2 CFR 200.1

2.1.5. "Grant" means the Grant to which these Federal Provisions are attached.

2.1.6. "Grantee" means the party or parties identified as such in the Grant to which these Federal Provisions are attached. Grantee also means Subrecipient.

2.1.7. "Non-Federal Entity" means a State, local government, Indian tribe, institution of higher education, or nonprofit organization that carries out a Federal Award as a Recipient or a Subrecipient.

2.1.8. "Nonprofit Organization" organization, that:

2.1.8.1 Is operated primarily for scientific, educational, service, charitable, or similar purposes in the public interest;

2.1.8.2 Is not organized primarily for profit; and

2.1.8.3 Uses net proceeds to maintain, improve, or expand the organization's operations; and

2.1.8.4 Is not an IHE.

2.1.9. "OMB" means the Executive Office of the President, Office of Management and Budget.

2.1.10. "Pass-through Entity" means a recipient or subrecipient that provides a Subaward to a Subrecipient (including lower tier subrecipients) to carry out part of a Federal program. The authority of the pass-through entity under this part flows through the Subaward agreements between the pass-through entity and subrecipient.

2.1.11. "Recipient" means the Colorado State agency or institution of higher education identified as the Grantor in the Grant to which these Federal Provisions are attached.

2.1.12. "Subaward" means an award provided by a pass-through entity to a Subrecipient to contribute to the goals and objectives of the project by carrying out part of a Federal award received by the pass-through entity. The term does not include payments to a contractor, beneficiary or participant.

2.1.13. "Subrecipient" means an entity that receives a subaward from a pass-through entity to carry out part of a Federal award. The term subrecipient does not include a beneficiary or participant. A subrecipient may also be a recipient of other Federal awards directly from a Federal agency. Subrecipient also means Grantee.

2.1.14. "System for Award Management (SAM)" means the Federal repository into which an Entity must enter the information required under the Transparency Act, which may be found at SAM.gov.

2.1.15. "Total Compensation" means the cash and noncash dollar value an Executive earns during the entity's preceding fiscal year. This includes all items of compensation as prescribed in 17 CFR 229.402(c)(2).

2.1.16. "Transparency Act" means the Federal Funding Accountability and Transparency Act of 2006 (Public Law 109-282), as amended by §6202 of Public Law 110-252.

2.1.17. "Unique Entity ID" (UEI) is the universal identifier for federal financial assistance applicants, as well as recipients and their direct subrecipients (first tier subrecipients).

2.1.18. "Uniform Guidance" means the Office of Management and Budget Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards. The terms and conditions of the Uniform Guidance flow down to Awards to Subrecipients unless the Uniform Guidance or the terms and conditions of the Federal Award specifically indicate otherwise.

3. Compliance.

3.1. Subrecipient shall comply with all applicable provisions of the Transparency Act and the regulations issued pursuant thereto, all applicable provisions of the Uniform Guidance, and all applicable Federal Laws and regulations required by this Federal Award. Any revisions to such provisions or regulations shall automatically become a part of these Federal Provisions, without the necessity of either party executing any further instrument. The State of Colorado, at its discretion, may provide written notification to Subrecipient of such revisions, but such notice shall not be a condition precedent to the effectiveness of such revisions.

4. System for Award Management (SAM) and Unique Entity ID Requirements.

4.1. SAM. Subrecipient must obtain a UEI but are not required to fully register in SAM.gov. Subrecipient shall maintain the currency of its information in SAM until the Subrecipient submits the final financial report required under the Award or receives final payment, whichever is later. Subrecipient shall review and update SAM information at least annually after the initial registration, and more frequently if required by changes in its information.

4.2. Unique Entity ID. Subrecipient shall provide its Unique Entity ID to its Recipient, and shall update Subrecipient's information at SAM.gov at least annually after the initial registration, and more frequently if required by changes in Subrecipient's information.

5. Total Compensation.

5.1. Subrecipient shall include Total Compensation in SAM for each of its five most highly compensated Executives for the preceding fiscal year if:

5.1.1. The total Federal funding authorized to date under the Award is $30,000 or more; and

5.1.2. In the preceding fiscal year, Subrecipient received:

5.1.2.1 80% or more of its annual gross revenues from Federal procurement contracts and subcontracts and/or Federal financial assistance Awards or Subawards subject to the Transparency Act; and

5.1.2.2 $25,000,000 or more in annual gross revenues from Federal procurement contracts and subcontracts and/or Federal financial assistance Awards or Subawards subject to the Transparency Act; and

5.1.2.3 The public does not have access to information about the compensation of such Executives through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. 78m(a), 78o(d) or § 6104 of the Internal Revenue Code of 1986.

6. Reporting.

6.1. Pursuant to the Transparency Act, Subrecipient shall report data elements to SAM and to the Recipient as required in this Exhibit. No direct payment shall be made to Subrecipient for providing any reports required under these Federal Provisions and the cost of producing such reports shall be included in the Grant price. The reporting requirements in this Exhibit are based on guidance from the OMB, and as such are subject to change at any time by OMB. Any such changes shall be automatically incorporated into this Grant and shall become part of Subrecipient's obligations under this Grant.

7. Effective Date and Dollar Threshold for Reporting.

7.1. Reporting requirements in §8 below apply to new Awards as of October 1, 2010, if the initial award is $30,000 or more. If the initial Award is below $30,000 but subsequent Award modifications result in a total Award of $30,000 or more, the Award is subject to the reporting requirements as of the date the Award exceeds $30,000. If the initial Award is $30,000 or more, but funding is subsequently de-obligated such that the total

award amount falls below $30,000, the Award shall continue to be subject to the reporting requirements.

7.2. The procurement standards in §9 below are applicable to new Awards made by Recipient as of December 26, 2015. The standards set forth in §11 below are applicable to audits of fiscal years beginning on or after December 26, 2014.

8. Subrecipient Reporting Requirements.

8.1. Subrecipient shall report as set forth below.

8.1.1. To Recipient. The Recipient must report the following Subrecipient data elements for each Federal Award Identification Number (FAIN) assigned by a Federal agency no later than the end of the month following the month in which the Subaward was made:

8.1.1.1 Subrecipient Unique Entity ID;

8.1.1.2 Subrecipient Unique Entity ID if more than one electronic funds transfer (EFT) account;

8.1.1.3 Subrecipient parent's organization Unique Entity ID;

8.1.1.4 Subrecipient's address, including: Street Address, City, State, Country, Zip + 4, and Congressional District;

8.1.1.5 Subrecipient's top 5 most highly compensated Executives if the criteria in §4 above are met; and Subrecipient's Total Compensation of top 5 most highly compensated Executives if the criteria in §4 above met.

8.1.2. To Recipient. A Subrecipient shall report to its Recipient, upon the effective date of the Grant, the following data elements:

8.1.2.1 Subrecipient's Unique Entity ID as registered in SAM.

8.1.2.2 Primary Place of Performance Information, including: Street Address, City, State, Country, Zip code + 4, and Congressional District.

9. Procurement Standards.

9.1. Procurement Procedures. A Subrecipient shall use its own documented procurement procedures which reflect applicable State, local, and Tribal laws and applicable regulations, provided that the procurements conform to applicable Federal law and the standards identified in the Uniform Guidance, including without limitation, 2 CFR 200.318 through 200.327 thereof.

9.2. Domestic preference for procurements (2 CFR 200.322). As appropriate and to the extent consistent with law, the non-Federal entity should, to the greatest extent practicable under a Federal award, provide a preference for the purchase, acquisition, or use of goods, products, or materials produced in the United States (including but not limited to iron, aluminum, steel, cement, and other manufactured products). The requirements of this section must be included in all subawards including all contracts and purchase orders for work or products under this award.

9.3. Procurement of Recovered Materials. If a Subrecipient is a State Agency or an agency of a political subdivision of the State, its contractors must comply with section 6002 of the Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act. The requirements of Section 6002 include procuring only items designated in guidelines of the Environmental Protection Agency (EPA) at 40 CFR part 247, that contain the highest percentage of recovered materials practicable, consistent with maintaining a satisfactory level of competition, where the purchase price of the item exceeds $10,000 or the value of the quantity acquired during the preceding fiscal year exceeded $10,000; procuring solid waste management services in a manner that maximizes energy and resource recovery; and establishing an affirmative procurement program for procurement of recovered materials identified in the EPA guidelines.

9.4. Never contract with the enemy (2 CFR 200.215). Federal awarding agencies and recipients are subject to the regulations implementing "Never contract with the enemy" in 2 CFR part 183. The regulations in 2 CFR part 183 affect covered contracts, grants and cooperative agreements that are expected to exceed $50,000 during the period of performance, are performed outside the United States and its territories, and are in support of a contingency operation in which members of the Armed Forces are actively engaged in hostilities.

9.5. Prohibition on certain telecommunications and video surveillance equipment or services (2 CFR 200.216). Subrecipient is prohibited from obligating or expending loan or grant funds on certain telecommunications and video surveillance services or equipment pursuant to 2 CFR 200.216.

10. Access to Records.

10.1. A Subrecipient shall permit Recipient and its auditors to have access to Subrecipient's records and financial statements as necessary for Recipient to meet the requirements of 2 CFR 200.332 (Requirements for pass-through entities), 2 CFR 200.300 (Statutory and

national policy requirements) through 2 CFR 200.309 (Modification to period of performance), 2 CFR 200.337 (Access to Records) and Subpart F-Audit Requirements of the Uniform Guidance.

10.2. A Subrecipient must collect, transmit, and store information related to this Subaward in open and machine-readable formats (2 CFR 200.336).

11. Single Audit Requirements.

11.1. If a Subrecipient expends $1,000,000 or more in Federal Awards during the Subrecipient's fiscal year, the Subrecipient shall procure or arrange for a single or program-specific audit conducted for that year in accordance with the provisions of Subpart F-Audit Requirements of the Uniform Guidance, issued pursuant to the Single Audit Act Amendments of 1996, (31 U.S.C. 7501-7507). 2 CFR 200.501.

11.1.1. Election. A Subrecipient shall have a single audit conducted in accordance with Uniform Guidance 2 CFR 200.514 (Scope of audit), except when it elects to have a program-specific audit conducted in accordance with 2 CFR 200.507 (Program-specific audits). The Subrecipient may elect to have a program-specific audit if Subrecipient expends Federal Awards under only one Federal program (excluding research and development) and the Federal program's statutes, regulations, or the terms and conditions of the Federal award do not require a financial statement audit of Recipient. A program-specific audit may not be elected for research and development unless all of the Federal Awards expended were received from Recipient and Recipient approves in advance a program-specific audit.

11.1.2. Exemption. If a Subrecipient expends less than $1,000,000 in Federal Awards during its fiscal year, the Subrecipient shall be exempt from Federal audit requirements for that year, except as noted in 2 CFR 200.503 (Relation to other audit requirements), but records shall be available for review or audit by appropriate officials of the Federal agency, the State, and the Government Accountability Office.

11.1.3. Subrecipient Compliance Responsibility. A Subrecipient shall procure or otherwise arrange for the audit required by Subpart F of the Uniform Guidance and ensure it is properly performed and submitted when due in accordance with the Uniform Guidance. Subrecipient shall prepare appropriate financial statements, including the schedule of expenditures of Federal awards in

accordance with 2 CFR 200.510 (Financial statements) and provide the auditor with access to personnel, accounts, books, records, supporting documentation, and other information as needed for the auditor to perform the audit required by Uniform Guidance Subpart F-Audit Requirements.

12. Required Provisions for Subrecipient with Subcontractors.

12.1. In addition to other provisions required by the Federal Awarding Agency or the Recipient, Subrecipients shall include all of the following applicable provisions;

12.1.1. For agreements with Subrecipients – Include the terms in the Grant Federal Provisions Exhibit (this exhibit)

12.1.2. For contracts with Subcontractors – Include the terms in the Contract Federal Provisions Exhibit.

13. Certifications.

13.1. Unless prohibited by Federal statutes or regulations, Recipient may require Subrecipient to submit certifications and representations required by Federal statutes or regulations on an annual basis. 2 CFR 200.415. Submission may be required more frequently if Subrecipient fails to meet a requirement of the Federal award. Subrecipient shall certify in writing to the State at the end of the Award that the project or activity was completed or the level of effort was expended. If the required level of activity or effort was not carried out, the amount of the Award must be adjusted.

14. Exemptions.

14.1. These Federal Provisions do not apply to an individual who receives an Award as a natural person, unrelated to any business or non-profit organization he or she may own or operate in his or her name.

14.2. A Subrecipient with gross income from all sources of less than $300,000 in the previous tax year is exempt from the requirements to report Subawards and the Total Compensation of its most highly compensated Executives.

15. Event of Default and Termination.

15.1. Failure to comply with these Federal Provisions shall constitute an event of default under the Grant and the State of Colorado may terminate the Grant upon 30 days prior written notice if the default remains uncured five calendar days following the termination of the 30-day notice period. This remedy will be in addition to any other remedy available to the State of Colorado under the Grant, at law or in equity.

15.2. Termination (2 CFR 200.340). The Federal Award may be terminated in whole or in part as follows:

15.2.1. By the Federal Awarding Agency or Pass-through Entity, if a Non-Federal Entity fails to comply with the terms and conditions of a Federal Award;

15.2.2. By the Federal awarding agency or Pass-through Entity with the consent of the Non-Federal Entity, in which case the two parties must agree upon the termination conditions, including the effective date and, in the case of partial termination, the portion to be terminated;

15.2.3. By the Non-Federal Entity upon sending to the Federal Awarding Agency or Pass-through Entity written notification setting forth the reasons for such termination, the effective date, and, in the case of partial termination, the portion to be terminated. However, if the Federal Awarding Agency or Pass-through Entity determines in the case of partial termination that the reduced or modified portion of the Federal Award or Subaward will not accomplish the purposes for which the Federal Award was made, the Federal Awarding Agency or Pass-through Entity may terminate the Federal Award in its entirety; or

15.2.4. By the Federal Awarding Agency or Pass-through Entity pursuant to termination provisions included in the Federal Award

16. Additional Federal Requirements.

16.1. Whistle Blower Protections

16.1.1. An employee of a subrecipient must not be discharged, demoted, or otherwise discriminated against as a reprisal for disclosing to a person or body described in paragraph (a)(2) of 41 U.S.C. 4712 information that the employee reasonably believes is evidence of gross mismanagement of a Federal contract or grant, a gross waste of Federal funds, an abuse of authority relating to a Federal contract or grant, a substantial and specific danger to public health or safety, or a violation of law, rule, or regulation related to a Federal contract (including the competition for or negotiation of a contract) or grant. The subrecipient must inform their employees in writing of employee whistleblower rights and protections under 41 U.S.C. 4712. See statutory requirements for whistleblower protections at 10 U.S.C. 4701, 41 U.S.C. 4712, 41 U.S.C. 4304, and 10 U.S.C. 4310.

AGENDA ITEM or FINAL CONTRACT REVIEW SUBMITTAL FORM

Agenda Item: Colorado Division of Aeronatutics Discretionary Av

Action Requested: Board of County Commissioners' Signature

Parties to the Agreement: CDOT - Aeronautics Division and Gunnison County

Term Begins: Execution Date **Term Ends:** **Grant Contract #:** 26-GUC-I01

Summary:

The Airport Internship Program is seeking to hire an individual interested in pursuing a career in Airport Management, Admin and Operations. Under this Grant Award, CDOT will fund 50% of the intern's wages during the 1-year program.

Fiscal Impact: Maximum Amount - CDOT share: $16,949.40; Local share: $16,949.40

Submitted by: Stephanie Petsch **Submitter's Email Address:** spetsch@gunnisoncounty.org

Finance Review: (•) Required ( ) Not Required

Comments:

Reviewed by: GUNCOUNTY1\mlamonica Discharge Date: 2/20/2026

County Attorney Review: (•) Required ( ) Not Required

Comments:
Legally sufficient. SO 2/20/26

Reveiwed by: GUNCOUNTY1\sobaid Discharge Date: 2/20/2026 Certificate of Insurance Required

Yes ( ) No (•)

County Manager Review:

Comments:

Reveiwed by: GUNCOUNTY1\mbirnie Discharge Date: 2/25/2026

(•) Consent Agenda ( ) Regular Agenda ( ) Worksession Time Allotted: 0

Agenda Date: 3/3/2026

Revised April 2015

Colorado Division of Aeronautics
Discretionary Aviation Grant Resolution

RESOLUTION

WHEREAS:

The General Assembly of the State of Colorado declared in Title 43 of the Colorado Revised Statutes, Article 10, 1991 in CRS §43-10-101 (the Act) "… that there exists a need to promote the safe operations and accessibility of general aviation in this state; that improvements to general aviation transportation facilities will promote diversified economic development across the state; and that accessibility to airport facilities for residents of this state is crucial in the event of a medical or other type of emergency…"

The Act created the Colorado Aeronautical Board ("the Board") to establish policy and procedures for distribution of monies in the Aviation Fund and created the Division of Aeronautics ("the Division") to carry out the directives of the Board, including technical and planning assistance to airports and the administration of the state aviation system grant program. SEE CRS §43-10-103 and C.R.S. §43-10-105 and CRS §43-10-108.5 of the Act.

Any eligible entity operating an FAA-designated public-use airport in the state may file an application for and be recipient of a grant to be used solely for aviation purposes. The Division is authorized to assist such airports and request assistance by means of a Resolution passed by the applicant's duly-authorized governing body, which understands that all funds shall be used exclusively for aviation purposes and that it will comply with all grant procedures, grant assurances and requirements as defined in the Division's Programs and Procedures Manual, ("the Manual") and the Airport Sponsor Assurances for Colorado Discretionary Aviation Grant Funding ("Grant Assurances") attached hereto as **Exhibit B** for the project detailed in the Discretionary Aviation Grant Application ("Application") attached hereto as **Exhibit A** and in conjunction with CDOT's Small Dollar Grant Award Terms and Conditions attached hereto as **Exhibit C**.

NOW, THEREFORE, BE IT RESOLVED THAT:

The **Gunnison County,** as a duly authorized governing body of the grant applicant, hereby formally requests assistance from the Colorado Aeronautical Board and the Division of Aeronautics in the form of a state aviation system grant. The **Gunnison County** states that such grant shall be used solely for aviation purposes, as determined by the State, and as generally described in the Application.

By signing this Grant Resolution, the applicant commits to keep open and accessible for public use all grant funded facilities, improvements and services for their useful life, as determined by the Division and stated in the Grant Assurances.

FURTHER BE IT RESOLVED:

That the **Gunnison County** hereby designates **Richard Lamport** as the Project Director, as described in the Manual and authorizes the Project Director to act in all matters relating to the work project proposed in the Application, including execution of any amendments.

FURTHER:

The **Gunnison County** has appropriated or will otherwise make available in a timely manner all funds, if any, that are required to be provided by the applicant as shown on the Application.

FINALLY:

The **Gunnison County** hereby accepts all guidelines, procedures, standards, and requirements described in the Manual as applicable to the performance of the grant work and hereby approves this Grant Resloution, including all terms and conditions contained therein.

By:_____ Date: _____

Print Name and Title:_____

ATTEST (if needed)

By:_____

Print Name and Title:_____

EXHIBIT A

Colorado Division of Aeronautics
Discretionary Aviation Grant Application

APPLICANT INFORMATION		
APPLICANT SPONSOR: Gunnison County	**AIRPORT:** Gunnison-Crested Butte Regional Airport	**IDENTIFIER:** GUC
PROJECT DIRECTOR: Richard Lamport		
MAILING ADDRESS: 519 Rio Grande Ave Gunnison, CO 81230	**EMAIL ADDRESS:**	rlamport@gunnisoncounty.org
	PHONE NUMBER:	9706427388

GRANT NAME AND TERMS		
26-GUC-I01	**TERMS**	
	Execution Date:	Expiration Date: December 31, 2027

FUNDING SUMMARY

Funding Source	Funding Amount
State Aviation Grant:	$16,949.40
Local Cash:	$16,949.40
Local In-Kind:	$0.00
Federal Aviation Grant:	$0.00
Total Project Funding:	$33,898.80

PROJECT SCHEDULE & BUDGET

ELEMENT DESCRIPTION	STATE FUNDING		LOCAL FUNDING		FEDERAL FUNDING		TOTAL
A. Airport Management Internship	$16,949.40	Up to 50.00%	$16,949.40	50.00%	$0.00	0.00%	$33,898.80
TOTALS	**$16,949.40**		**$16,949.40**		**$0.00**		**$33,898.80**

EXHIBIT B, GRANT ASSURANCES

Airport Sponsor Assurances for Colorado Discretionary Aviation Grant Funding

Approved by CAB January 22, 2018

I. APPLICABILITY

a. These assurances shall be complied with by Airport Sponsors in the performance of all projects at airports that receive Colorado Department of Transportation – Division of Aeronautics (Division) Colorado Discretionary Aviation Grant (CDAG) funding for projects including but not limited to: master planning, land acquisition, equipment acquisition or capital improvement projects (Project). It is not the intent of these Assurances to expand existing Federal Aviation Administration (FAA) Grant Assurances for airports included in the National Plan of Integrated Airport Systems (NPIAS); as similar assurances already exist for acceptance of FAA funding.

b. Upon acceptance of this grant agreement these assurances are incorporated in and become a part thereof.

II. DURATION

a. The terms, conditions and assurances of the grant agreement shall remain in full force and effect throughout the useful life of the Project as defined in Table 1 (Useful Life), or if the airport for which the Project is funded ceases to function as a public airport, for twenty (20) years from the date of Project completion, whichever period is greater. However, there shall be no limit on the duration of the assurances with respect to real property acquired with CDAG Project funds.

III. COMPLIANCE

a. Should an Airport Sponsor be notified to be in non-compliance with any terms of this agreement, they may become ineligible for future Division funding until such non-compliance is cured.

b. If any Project is not used for aviation purposes during its Useful Life, or if the airport for which the Project is funded ceases to function as a public airport, for twenty (20) years from the date of Project completion or at any time during the estimated useful life of the Project as defined in Table 1, whichever period is greater, the Airport Sponsor may be liable for repayment to the Division of any or all funds contributed by the Division under this agreement. If the airport at which the Project is constructed is abandoned for any reason, the Division may in its discretion discharge the Airport Sponsor from any repayment obligation upon written request by the Airport Sponsor.

IV. AIRPORT SPONSOR GRANT ASSURANCES

1. **Compatible Land Use.** Compatible land use and planning in and around airports benefits the state aviation system by providing opportunities for safe airport development, preservation of airport and aircraft operations, protection of airport approaches, reduced potential for litigation and compliance with appropriate airport design standards. The airport will take appropriate action, to the extent reasonable, to restrict the use of land adjacent to, in the immediate vicinity of, or on the airport to activities and purposes compatible with normal airport operations, including landing and takeoff of aircraft.

2. **On-Airport Hazard Removal and Mitigation**. The airport will take appropriate action to protect aircraft operations to/from the airport and ensure paths are adequately cleared and protected by removing, lowering, relocating, marking, or lighting or otherwise mitigating existing airport hazards and by preventing the establishment or creation of future airport hazards.

3. **Safe, Efficient Use, and Preservation of Navigable Airspace.** The airport shall comply with 14 CFR Part 77 for all future airport development and anytime an existing airport development is altered.

4. **Operation and Maintenance.** In regards to Projects that receive Division funding, the airport sponsor certifies that it has the financial or other resources that may be necessary for the preventive maintenance, maintenance, repair and operation of such projects during their Useful Life.

The airport and all facilities which are necessary to serve the aeronautical users of the airport shall be operated at all times in a safe and serviceable condition. The airport will also have in effect arrangements for:

a. Operating the airport's aeronautical facilities whenever required;

b. Promptly marking and lighting hazards resulting from airport conditions, including temporary conditions; and

c. Promptly notifying airmen of any condition affecting aeronautical use of the airport.

5. **Airport Revenues.** All revenues generated by the airport will be expended by it for the capital or operating costs of the airport, the local airport system, or other local facilities owned or operated by the owner or operator of the airport for aviation purposes.

6. **Airport Layout Plan (ALP).** Once accomplished and as otherwise may be required to develop, it will keep up-to-date a minimum of an ALP of the airport showing (1) boundaries of the airport and all proposed additions thereto, together with the boundaries of all offsite areas owned or controlled by the sponsor for airport purposes and proposed additions thereto; (2) the location and nature of all existing and proposed airport facilities and structures (such as runways, taxiways, aprons, terminal buildings, hangars and roads), including all proposed extensions and reductions of existing airport facilities; and (3) the location of all existing improvements thereon.

7. **Use for Aviation Purposes.** The Airport Sponsor shall not use runways, taxiways, aprons, seeded areas or any other appurtenance or facility constructed, repaired, renovated or maintained under the terms of this Agreement for activities other than aviation purposes unless otherwise exempted by the Division.

TABLE 1

Project Type	Useful Life
a. All construction projects (unless listed separately below)	20 years
b. All equipment and vehicles	10 years
c. Pavement rehabilitation (not reconstruction, which is 20 years)	10 years
d. Asphalt seal coat, slurry seal, and joint sealing	3 years
e. Concrete joint replacement	7 years
f. Airfield lighting and signage	10 years
g. Navigational Aids	15 years
h. Buildings	40 years
i. Land	Unlimited

STATE CONTROLLER

MODEL SMALL DOLLAR GRANT AWARDS AND CONTENT

This is a State Controller Contract, Grant, and Purchase Order Policy under the State Fiscal Rules. All Small Dollar Grant Awards shall use one of the approved models Small Dollar Grant Award or Grant Agreement forms described in Fiscal Rule 3-4 unless the State Agency or Institution of Higher Education (IHE) has obtained the prior written approval from the Office of the State Controller (OSC).

1) ***Available Model Small Dollar Grant Awards.*** The following model Small Dollar Grant Awards may be used by State Agencies and IHEs without additional approval from the OSC:

   a. **Financial System Generated Small Dollar Grant Awards.** This model is the system-generated document resulting from a Colorado Operations Resource Engine (CORE) POGG1 encumbrance or through another approved state financial system, which also explicitly references a link to the State of Colorado Small Dollar Grant Award Terms and Conditions that are attached to this policy. This model does not include other documents with a similar or the same appearance as one of these documents that is not generated within the financial system

   b. **Other Approved Forms.** A State Agency or IHE, at the discretion of the State Agency's or IHE's Procurement Official or State Controller delegate, may request other approved forms from the OSC.

   c. **Backup Forms.** If CORE or the approved state financial system used by the State Agency or IHE is unavailable for an extended period of time when a Small Dollar Grant Award must be issued, the State Agency or IHE, with the prior approval of the OSC, may use a backup form with the same or substantially similar appearance as one of the documents described in **§1)a.**

2) ***Modifications of Model Small Dollar Grant Awards.*** A State Agency or Institution of Higher Education issuing a Small Dollar Grant Award may not modify the State of Colorado Small Dollar Grant Award Terms and Conditions attached to this policy, including Addendum 1: Additional Terms & Conditions for Information Technology ("Addendum"), in any way without prior written approval of the OSC.

   a. **Exception.** The Office of Information Technology (OIT) may modify the provisions of Addendum for the State of Colorado Small Dollar Grant Awards specifically issued by OIT with the prior written approval of the Procurement Official of OIT or authorized delegate, without obtaining additional approval from OSC.

   b. **Unauthorized Modifications.** Except as described in **§2)a.**, the failure of a State Agency or IHE to obtain approval from the OSC prior to issuing a Small Dollar Grant Award with modified the State of Colorado Small Dollar Grant Award Terms and Conditions shall constitute a violation of Fiscal Rule 3-4, §§ 4.1.7. and 5.1.

3) ***Small Dollar Grant Award Exhibits and References.*** All Small Dollar Grant Awards shall either include or specifically reference the State of Colorado Small Dollar Grant Award Terms and Conditions by hyperlink or, if modified in accordance with **§2)**, attach the modified State of Colorado Small Dollar Grant Award Terms and Conditions and shall clarify on the Small Dollar Grant Award that the attached modified State of Colorado Small Dollar Grant Award Terms and Conditions shall govern the Small Dollar Grant Award in lieu of the State of Colorado Small Dollar Grant Award Terms and Conditions referenced by hyperlink. Small Dollar Grant Awards shall also include any additional exhibits, based on the nature of the work performed under the Small Dollar Grant Award, as required by any other state

and/or federal agency with authority over that type of work or by any entity providing funding for the Small Dollar Grant Award, including, but not limited to, the following:

a. Additional information technology provisions required by OIT.

b. Additional provisions required to comply with the Office of Management and Budget Uniform Guidance, or the Federal Funding Accountability and Transparency Act, or any other applicable federal terms and conditions.

c. Any federally required attachments relating to confidential information, such as a Health Information Portability and Accountability Act (HIPAA) Business Associate Addendum or a Federal Tax Information Exhibit.

Robert Jaros

Robert Jaros, CPA, MBA, JD State Controller

STATE CONTROLLER

State of Colorado Small Dollar Grant Award Terms and Conditions

1. Offer/Acceptance. This Small Dollar Grant Award, together with these terms and conditions (including, if applicable, Addendum 1: Additional Terms and Conditions for Information Technology below), and any other attachments, exhibits, specifications, or appendices, whether attached or incorporated by reference (collectively the "Agreement") shall represent the entire and exclusive agreement between the State of Colorado, by and through the agency identified on the face of the Small Dollar Grant Award ("State") and the Subrecipient identified on the face of the Small Dollar Grant Award ("Grantee"). If this Agreement refers to Grantee's bid or proposal, this Agreement is an ACCEPTANCE of Grantee's OFFER TO PERFORM in accordance with the terms and conditions of this Agreement. If a bid or proposal is not referenced, this Agreement is an OFFER TO ENTER INTO AGREEMENT, subject to Grantee's acceptance, demonstrated by Grantee's beginning performance or written acceptance of this Agreement. Any COUNTER-OFFER automatically CANCELS this Agreement, unless a change order is issued by the State accepting a counter-offer. Except as provided herein, the State shall not be responsible or liable for any Work performed prior to issuance of this Agreement. The State's financial obligations to the Grantee are limited by the amount of Grant Funds awarded as reflected on the face of the Small Dollar Grant Award.

2. Order of Precedence. In the event of a conflict or inconsistency within this Agreement, such conflict or inconsistency shall be resolved by giving preference to the documents in the following order of priority: **(1)** the Small dollar Grant Award document; **(2)** these terms and conditions (including, if applicable, Addendum 1 below); and **(3)** any attachments, exhibits, specifications, or appendices, whether attached or incorporated by reference. Notwithstanding the above, if this Agreement has been funded, in whole or in part, with a Federal Award, in the event of a conflict between the Federal Grant and this Agreement, the provisions of the Federal Grant shall control. Grantee shall comply with all applicable Federal provisions at all times during the term of this Agreement. Any terms and conditions included on Grantee's forms or invoices not included in this Agreement are void.

3. Changes. Once accepted in accordance with **§1**, this Agreement shall not be modified, superseded or otherwise altered, except in writing by the State and accepted by Grantee.

4. Definitions. The following terms shall be construed and interpreted as follows: **(a)** "**Award**" means an award by a Recipient to a Subrecipient; **(b)** "**Budget**" means the budget for the Work described in this Agreement; **(c)** "**Business Day**" means any day in which the State is open and conducting business, but shall not include Saturday, Sunday or any day on which the State observes one of the holidays listed in CRS §24-11-101(1); **(d)** "**UCC**" means the Uniform Commercial Code in CRS Title 4; **(e)** "**Effective Date**" means the date on which this Agreement is issued as shown on the face of the Small Dollar Grant Award; **(f)** "**Federal Award**" means an award of federal financial assistance or a cost-reimbursement contract, , by a Federal Awarding Agency to the Recipient. "Federal Award" also means an agreement setting forth the terms and conditions of the Federal Award, which terms and conditions shall flow down to the Award unless such terms and conditions specifically indicate otherwise. The term does not include payments to a contractor or payments to an individual that is a beneficiary of a Federal program; **(g)** "**Federal Awarding Agency**" means a Federal agency providing a Federal Award to a Recipient; **(h)** "**Grant Funds**" means the funds that have been appropriated, designated, encumbered, or otherwise made available for payment by the State under this Agreement; **(i)** "**Matching Funds**" mean the funds provided by the Grantee to meet cost sharing requirements described in this Agreement; **(j)** "**Recipient**" means the State agency identified on the face of the Small Dollar Grant Award; **(k)** "**Subcontractor**" means third parties, if any, engaged by Grantee to aid in performance of the Work; **(l)** "**Subrecipient**" means a non-Federal entity that receives a sub-award from a Recipient to carry out part of a program, but does not include an individual that is a beneficiary of such program; **(m)** "**Uniform Guidance**" means the Office of Management and Budget Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, identified as the 2 C.F.R. (Code of Federal Regulations) Part 200, commonly known as the "Super Circular," which supersedes requirements from OMB Circulars A-21, A-87, A-110, A-122, A-89, A-102, and A-133, and the guidance in Circular a-50 on Single Audit Act follow-up; and **(n)** "**Work**" means the goods delivered or services, or both, performed pursuant to this Agreement and identified as Line Items on the face of the Small Dollar Grant Award.

5. Delivery. Grantee shall furnish the Work in strict accordance with the specifications and price set forth in this Agreement. The State shall have no liability to compensate Grantee for the performance of any Work not specifically set forth in the Agreement.

6. Rights to Materials. [*Not Applicable to Agreements issued either in whole in part for Information Technology, as defined in CRS § 24-37.5-102(2); in which case Addendum 1 §2 applies in lieu of this section.*] Unless specifically stated otherwise in this Agreement, all materials, including without limitation supplies, equipment, documents, content, information, or other material of any type, whether tangible or intangible (collectively "Materials"), furnished by the State to Grantee or delivered by Grantee to the State in performance of its obligations under this Agreement shall be the exclusive property the State. Grantee shall return or deliver all Materials to the State upon completion or termination of this Agreement.

7. Grantee Records. Grantee shall make, keep, maintain, and allow inspection and monitoring by the State of a complete file of all records, documents, communications, notes and other written materials, electronic media files, and communications, pertaining in any manner to the Work (including, but not limited to the operation of programs) performed under this Agreement (collectively "Grantee Records"). Unless otherwise specified by the State, the Grantee shall retain Grantee Records for a period (the "Record Retention Period") of three years following the date of submission to the State of the final expenditure report, or if this Award is renewed quarterly or annually, from the date of the submission of each quarterly or annual report, respectively. If any litigation, claim, or audit related to this Award starts before expiration of the Record Retention Period, the Record Retention Period shall extend until all litigation, claims or audit finding have been resolved and final action taken by the State or Federal Awarding Agency. The Federal Awarding Agency, a cognizant agency for audit, oversight, or indirect costs, and the State, may notify Grantee in writing that the Record Retention Period shall be extended. For records for real property and equipment, the Record Retention Period shall extend three years following final disposition of such property. Grantee shall permit the State, the federal government, and any other duly authorized agent of a governmental agency to audit, inspect, examine, excerpt, copy and transcribe Grantee Records during the Record Retention Period. Grantee shall make Grantee Records available during normal business hours at Grantee's office or place of business, or at other mutually agreed upon times or locations, upon no fewer than two Business Days' notice from the State, unless the State determines that a shorter period of notice, or no notice, is necessary to protect the interests of the State. The State, in its discretion, may monitor Grantee's performance of its obligations under this Agreement using procedures as determined by the State. The federal government and any other duly authorized agent of a governmental agency, in its discretion, Grantee shall allow the State to perform all monitoring required by the Uniform Guidance, based on the State's risk analysis of Grantee and this Agreement, and the State shall have the right, in its discretion, to change its monitoring procedures and requirements at any time during the term of this Agreement. The State will monitor Grantee's performance in a manner that does not unduly interfere with Grantee's performance of the Work. Grantee shall promptly submit to the State a copy of any final audit report of an audit performed

on Grantee Records that relates to or affects this Agreement or the Work, whether the audit is conducted by Grantee, a State agency or the State's authorized representative, or a third party. If applicable, the Grantee may be required to perform a single audit under 2 CFR 200.501, *et seq.* Grantee shall submit a copy of the results of that audit to the State within the same timelines as the submission to the federal government.

8. Reporting. If Grantee is served with a pleading or other document in connection with an action before a court or other administrative decision making body, and such pleading or document relates to this Agreement or may affect Grantee's ability to perform its obligations under this Agreement, Grantee shall, within 10 days after being served, notify the State of such action and deliver copies of such pleading or document to the State. Grantee shall disclose, in a timely manner, in writing to the State and the Federal Awarding Agency, all violations of federal or State criminal law involving fraud, bribery, or gratuity violations potentially affecting the Award. The State or the Federal Awarding Agency may impose any penalties for noncompliance allowed under 2 CFR Part 180 and 31 U.S.C. 3321, which may include, without limitation, suspension or debarment.

9. Conflicts of Interest. Grantee acknowledges that with respect to this Agreement, even the appearance of a conflict of interest is harmful to the State's interests. Absent the State's prior written approval, Grantee shall refrain from any practices, activities, or relationships that reasonably may appear to be in conflict with the full performance of Grantee's obligations to the State under this Agreement. If a conflict or appearance of a conflict of interest exists, or if Grantee is uncertain as to such, Grantee shall submit to the State a disclosure statement setting forth the relevant details for the State's consideration. Failure to promptly submit a disclosure statement or to follow the State's direction in regard to the actual or apparent conflict constitutes a breach of this Agreement. Grantee certifies that to their knowledge, no employee of the State has any personal or beneficial interest whatsoever in the service or property described in this Agreement. Grantee has no interest and shall not acquire any interest, direct or indirect, that would conflict in any manner or degree with the performance of Grantee's Services and Grantee shall not employ any person having such known interests.

10. Taxes. The State is exempt from federal excise taxes and from State and local sales and use taxes. The State shall not be liable for the payment of any excise, sales, of use taxes imposed on Grantee. A tax exemption certificate will be made available upon Grantee's request. Grantee shall be solely responsible for any exemptions from the collection of excise, sales or use taxes that Grantee may wish to have in place in connection with this Agreement.

11. Payment. Payments to Grantee are limited to the unpaid, obligated balance of the Grant Funds. The State shall not pay Grantee any amount under this Agreement that exceeds the Document Total shown on the face of the Small Dollar Grant Award. The State shall pay Grantee in the amounts and in accordance with the schedule and other conditions set forth in this Agreement. Grantee shall initiate payment requests by invoice to the State, in a form and manner approved by the State. The State shall pay Grantee for all amounts due within 45 days after receipt of an Awarding Agency's approved invoicing request, or in instances of reimbursement grant programs a request for reimbursement, compliant with Generally Accepted Accounting Principles (GAAP) and, if applicable Government Accounting Standards Board (GASB) of amount requested. Amounts not paid by the State within 45 days of the State's acceptance of the invoice shall bear interest on the unpaid balance beginning on the 45th day at the rate set forth in CRS §24-30-202(24) until paid in full. Interest shall not accrue if a good faith dispute exists as to the State's obligation to pay all or a portion of the amount due. Grantee shall invoice the State separately for interest on delinquent amounts due, referencing the delinquent payment, number of day's interest to be paid, and applicable interest rate. The acceptance of an invoice shall not constitute acceptance of any Work performed under this Agreement. Except as specifically agreed in this Agreement, Grantee shall be solely responsible for all costs, expenses, and other charges it incurs in connection with its performance under this Grantee.

12. Term. The parties' respective performances under this Agreement shall commence on the "Service From" date identified on the face of the Small Dollar Grant Award, unless otherwise specified, and shall terminate on the "Service To" date identified on the face of the Small Dollar Grant Award unless sooner terminated in accordance with the terms of this Agreement.

13. Payment Disputes. If Grantee disputes any calculation, determination or amount of any payment, Grantee shall notify the State in writing of its dispute within 30 days following the earlier to occur of Grantee's receipt of the payment or notification of the determination or calculation of the payment by the State. The State will review the information presented by Grantee and may make changes to its determination based on this review. The calculation, determination or payment amount that results from the State's review shall not be subject to additional dispute under this subsection. No payment subject to a dispute under this subsection shall be due until after the State has concluded its review, and the State shall not pay any interest on any amount during the period it is subject to dispute under this subsection.

14. Matching Funds. Grantee shall provide Matching Funds, if required by this Agreement. If permitted under the terms of the grant and per this Agreement, Grantee may be permitted to provide Matching Funds prior to or during the course of the project or the match will be an in-kind match. Grantee shall report to the State regarding the status of such funds upon request. Grantee's obligation to pay all or any part of any Matching Funds, whether direct or contingent, only extend to funds duly and lawfully appropriated for the purposes of this Agreement by the authorized representatives of Grantee and paid into Grantee's treasury or bank account. Grantee represents to the State that the amount designated "Grantee's Matching Funds" pursuant to this Agreement, has been legally appropriated for the purposes of this Agreement by its authorized representatives and paid into its treasury or bank account. Grantee does not by this Agreement irrevocably pledge present cash reserves for payments in future fiscal years, and this Agreement is not intended to create a multiple-fiscal year debt of Grantee. Grantee shall not pay or be liable for any claimed interest, late charges, fees, taxes or penalties of any nature, except as required by Grantee's laws or policies.

15. Reimbursement of Grantee Costs. If applicable, the State shall reimburse Grantee's allowable costs, not exceeding the maximum total amount described in this Agreement for all allowable costs described in the grant except that Grantee may adjust the amounts between each line item of the Budget without formal modification to this Agreement as long as the Grantee provides notice to, and received approval from the State of the change, the change does not modify the total maximum amount of this Agreement, and the change does not modify any requirements of the Work. If applicable, the State shall reimburse Grantee for the properly documented allowable costs related to the Work after review and approval thereof, subject to the provisions of this Agreement. However, any costs incurred by Grantee prior to the Effective Date shall not be reimbursed absent specific allowance of pre-award costs. Grantee's costs for Work performed after the "Service To" date identified on the face of the Small Dollar Grant Award, or after any phase performance period end date for a respective phase of the Work, shall not be reimbursable. The State shall only reimburse allowable costs described in this Agreement and shown in the Budget if those costs are **(a)** reasonable and necessary to accomplish the Work, and **(b)** equal to the actual net cost to Grantee (i.e. the price paid minus any items of value received by Grantee that reduce the costs actually incurred).

16. Close-Out. Grantee shall close out this Award within 45 days after the "Service To" date identified on the face of the Small Dollar Grant Award, including any modifications. To complete close-out, Grantee shall submit to the State all deliverables (including documentation) as defined

in this Agreement and Grantee's final reimbursement request or invoice. In accordance with the Agreement, the State may withhold a percentage of allowable costs until all final documentation has been submitted and accepted by the State as substantially complete.

17. Assignment. Grantee's rights and obligations under this Agreement may not be transferred or assigned without the prior, written consent of the State and execution of a new agreement. Any attempt at assignment or transfer without such consent and new agreement shall be void. Any assignment or transfer of Grantee's rights and obligations approved by the State shall be subject to the provisions of this Agreement.

18. Subcontracts. Grantee shall not enter into any subcontract in connection with its obligations under this Agreement without the prior, written approval of the State. Grantee shall submit to the State a copy of each subcontract upon request by the State. All subcontracts entered into by Grantee in connection with this Agreement shall comply with all applicable federal and state laws and regulations, shall provide that they are governed by the laws of the State of Colorado, and shall be subject to all provisions of this Agreement.

19. Severability. The invalidity or unenforceability of any provision of this Agreement shall not affect the validity or enforceability of any other provision of this Agreement, which shall remain in full force and effect, provided that the Parties can continue to perform their obligations in accordance with the intent of the Agreement.

20. Survival of Certain Agreement Terms. Any provision of this Agreement that imposes an obligation on a party after termination or expiration of the Agreement shall survive the termination or expiration of the Agreement and shall be enforceable by the other party.

21. Third Party Beneficiaries. Except for the parties' respective successors and assigns, this Agreement does not and is not intended to confer any rights or remedies upon any person or entity other than the Parties. Enforcement of this Agreement and all rights and obligations hereunder are reserved solely to the parties. Any services or benefits which third parties receive as a result of this Agreement are incidental to the Agreement, and do not create any rights for such third parties.

22. Waiver. A party's failure or delay in exercising any right, power, or privilege under this Agreement, whether explicit or by lack of enforcement, shall not operate as a waiver, nor shall any single or partial exercise of any right, power, or privilege preclude any other or further exercise of such right, power, or privilege.

23. Indemnification. [***Not Applicable to Inter-governmental agreements***] Grantee shall indemnify, save, and hold harmless the State, its employees, agents and assignees (the "Indemnified Parties"), against any and all costs, expenses, claims, damages, liabilities, court awards and other amounts (including attorneys' fees and related costs) incurred by any of the Indemnified Parties in relation to any act or omission by Grantee, or its employees, agents, Subcontractors, or assignees in connection with this Agreement. This shall include, without limitation, any and all costs, expenses, claims, damages, liabilities, court awards and other amounts incurred by the Indemnified Parties in relation to any claim that any work infringes a patent, copyright, trademark, trade secret, or any other intellectual property right or any claim for loss or improper disclosure of any confidential information or personally identifiable information. If Grantee is a public agency prohibited by applicable law from indemnifying any party, then this section shall not apply.

24. Notice. All notices given under this Agreement shall be in writing, and shall be delivered to the contacts for each party listed on the face of the Small Dollar Grant Award. Either party may change its contact or contact information by notice submitted in accordance with this section without a formal modification to this Agreement.

25. Insurance. Except as otherwise specifically stated in this Agreement or any attachment or exhibit to this Agreement, Grantee shall obtain and maintain insurance as specified in this section at all times during the term of the Agreement: (a) workers' compensation insurance as required by state statute, and employers' liability insurance covering all Grantee employees acting within the course and scope of their employment, (b) Commercial general liability insurance written on an Insurance Services Office occurrence form, covering premises operations, fire damage, independent contractors, products and completed operations, blanket contractual liability, personal injury, and advertising liability with minimum limits as follows: $1,000,000 each occurrence; $1,000,000 general aggregate; $1,000,000 products and completed operations aggregate; and $50,000 any one fire, and (c) Automobile liability insurance covering any auto (including owned, hired and non-owned autos) with a minimum limit of $1,000,000 each accident combined single limit. If Grantee will or may have access to any protected information, then Grantee shall also obtain and maintain insurance covering loss and disclosure of protected information and claims based on alleged violations of privacy right through improper use and disclosure of protected information with limits of $1,000,000 each occurrence and $1,000,000 general aggregate at all times during the term of the Small Dollar Grant Award. Additional insurance may be required as provided elsewhere in this Agreement or any attachment or exhibit to this Agreement. All insurance policies required by this Agreement shall be issued by insurance companies with an AM Best rating of A-VIII or better. If Grantee is a public agency within the meaning of the Colorado Governmental Immunity Act, then this section shall not apply and Grantee shall instead comply with the Colorado Governmental Immunity Act.

26. Termination Prior to Grantee Acceptance. If Grantee has not begun performance under this Agreement, the State may cancel this Agreement by providing written notice to the Grantee.

27. Termination for Cause. If Grantee refuses or fails to timely and properly perform any of its obligations under this Agreement with such diligence as will ensure its completion within the time specified in this Agreement, the State may notify Grantee in writing of non-performance and, if not corrected by Grantee within the time specified in the notice, terminate Grantee's right to proceed with the Agreement or such part thereof as to which there has been delay or a failure. Grantee shall continue performance of this Agreement to the extent not terminated. Grantee shall be liable for excess costs incurred by the State in procuring similar Work and the State may withhold such amounts, as the State deems necessary. If after rejection, revocation, or other termination of Grantee's right to proceed under the Colorado Uniform Commercial Code (CUCC) or this clause, the State determines for any reason that Grantee was not in default or the delay was excusable, the rights and obligations of the State and Grantee shall be the same as if the notice of termination had been issued pursuant to termination under **§28**.

28. Termination in Public Interest. The State is entering into this Agreement for the purpose of carrying out the public interest of the State, as determined by its Governor, General Assembly, Courts, or Federal Awarding Agency. If this Agreement ceases to further the public interest of the State as determined by its Governor, General Assembly, Courts, or Federal Awarding Agency, the State, in its sole discretion, may terminate this Agreement in whole or in part and such termination shall not be deemed to be a breach of the State's obligations hereunder. This section shall not apply to a termination for cause, which shall be governed by **§27**. A determination that this Small Dollar Grant Award should be terminated in the public interest shall not be equivalent to a State right to terminate for convenience. The State shall give written notice of termination to Grantee specifying the part of the Agreement terminated and when termination becomes effective. Upon receipt of notice of termination, Grantee shall not incur further obligations except as necessary to mitigate costs of performance. The State shall pay the Agreement price or rate for Work performed

and accepted by State prior to the effective date of the notice of termination. The State's termination liability under this section shall not exceed the total Agreement price.

29. Termination for Funds Availability. The State is prohibited by law from making commitments beyond the term of the current State Fiscal Year. Payment to Grantee beyond the current State Fiscal Year is contingent on the appropriation and continuing availability of Grant Funds in any subsequent year (as provided in the Colorado Special Provisions). If federal funds or funds from any other non-State funds constitute all or some of the Grant Funds, the State's obligation to pay Grantee shall be contingent upon such non-State funding continuing to be made available for payment. Payments to be made pursuant to this Agreement shall be made only from Grant Funds, and the State's liability for such payments shall be limited to the amount remaining of such Grant Funds. If State, federal or other funds are not appropriated, or otherwise become unavailable to fund this Agreement, the State may, upon written notice, terminate this Agreement, in whole or in part, without incurring further liability. The State shall, however, remain obligated to pay for Work performed and accepted prior to the effective date of notice of termination, and this termination shall otherwise be treated as if this Agreement were terminated in the public interest as described in **§28**.

30. Grantee's Termination Under Federal Requirements. If the Grant Funds include any federal funds, then Grantee may request termination of this Grant by sending notice to the State, or to the Federal Awarding Agency with a copy to the State, which includes the reasons for the termination and the effective date of the termination. If this Grant is terminated in this manner, then Grantee shall return any advanced payments made for Work that will not be performed prior to the effective date of the termination.

31. Governmental Immunity. Liability for claims for injuries to persons or property arising from the negligence of the State, its departments, boards, commissions committees, bureaus, offices, employees and officials shall be controlled and limited by the provisions of the Colorado Governmental Immunity Act, CRS §24-10-101, *et seq*., the Federal Tort Claims Act, 28 U.S.C. Pt. VI, Ch. 171 and 28 U.S.C. 1346(b), and the State's risk management statutes, CRS §§24-30-1501, *et seq*. No term or condition of this Agreement shall be construed or interpreted as a waiver, express or implied, of any of the immunities, rights, benefits, protections, or other provisions, contained in these statutes.

32. Grant Recipient. Grantee shall perform its duties hereunder as a grant recipient and not as an employee. Neither Grantee nor any agent or employee of Grantee shall be deemed to be an agent or employee of the State. Grantee shall not have authorization, express or implied, to bind the State to any agreement, liability or understanding, except as expressly set forth herein. **Grantee and its employees and agents are not entitled to unemployment insurance or workers compensation benefits through the State and the State shall not pay for or otherwise provide such coverage for Grantee or any of its agents or employees. Grantee shall pay when due all applicable employment taxes and income taxes and local head taxes incurred pursuant to this Agreement. Grantee shall (a) provide and keep in force workers' compensation and unemployment compensation insurance in the amounts required by law, (b) provide proof thereof when requested by the State, and (c) be solely responsible for its acts and those of its employees and agents.**

33. Compliance with Law. Grantee shall comply with all applicable federal and State laws, rules, and regulations in effect or hereafter established, including, without limitation, laws applicable to discrimination and unfair employment practices.

34. Choice of Law, Jurisdiction and Venue. [***Not Applicable to Inter-governmental agreements***] Colorado law, and rules and regulations issued pursuant thereto, shall be applied in the interpretation, execution, and enforcement of this Agreement. Any provision included or incorporated herein by reference which conflicts with said laws, rules, and regulations shall be null and void. All suits or actions related to this Agreement shall be filed and proceedings held in the State of Colorado and exclusive venue shall be in the City and County of Denver. Any provision incorporated herein by reference which purports to negate this or any other provision in this Agreement in whole or in part shall not be valid or enforceable or available in any action at law, whether by way of complaint, defense, or otherwise. Any provision rendered null and void by the operation of this provision or for any other reason shall not invalidate the remainder of this Agreement, to the extent capable of execution. Grantee shall exhaust administrative remedies in CRS §24-109-106, prior to commencing any judicial action against the State regardless of whether the Colorado Procurement Code applies to this Agreement.

35. Prohibited Terms. Nothing in this Agreement shall be construed as a waiver of any provision of CRS §24-106-109. Any term included in this Agreement that requires the State to indemnify or hold Grantee harmless; requires the State to agree to binding arbitration; limits Grantee's liability for damages resulting from death, bodily injury, or damage to tangible property; or that conflicts with that statute in any way shall be void ab initio.

36. Public Contracts for Services. [***Not Applicable to offer, issuance, or sale of securities, investment advisory services, fund management services, sponsored projects, intergovernmental grant agreements, or information technology services or products and services***] Grantee certifies, warrants, and agrees that it does not knowingly employ or contract with an illegal alien who will perform work under this Agreement and will confirm the employment eligibility of all employees who are newly hired for employment in the United States to perform work under this Agreement, through participation in the E-Verify Program or the Department program established pursuant to CRS §8-17.5-102(5)(c), Grantee shall not knowingly employ or contract with an illegal alien to perform work under this Agreement or enter into a contract or agreement with a Subcontractor that fails to certify to Grantee that the Subcontractor shall not knowingly employ or contract with an illegal alien to perform work under this Agreement. Grantee shall (a) not use E-Verify Program or Department program procedures to undertake pre- employment screening of job applicants during performance of this Agreement, (b) notify Subcontractor and the State within three days if Grantee has actual knowledge that Subcontractor is employing or contracting with an illegal alien for work under this Agreement, (c) terminate the subcontract if Subcontractor does not stop employing or contracting with the illegal alien within three days of receiving notice, and (d) comply with reasonable requests made in the course of an investigation, undertaken pursuant to CRS §8-17.5-102(5), by the Colorado Department of Labor and Employment. If Grantee participates in the Department program, Grantee shall deliver to the State a written, notarized affirmation that Grantee has examined the legal work status of such employee, and shall comply with all of the other requirements of the Department program. If Grantee fails to comply with any requirement of this provision or CRS §8-17.5-101 et seq., the State may terminate this Agreement for breach and, if so terminated, Grantee shall be liable for damages.

37. Public Contracts with Natural Persons. Grantee, if a natural person 18 years of age or older, hereby swears and affirms under penalty of perjury that the person (a) is a citizen or otherwise lawfully present in the United States pursuant to federal law, (b) shall comply with the provisions of CRS §24-76.5-101 et seq., and (c) has produced a form of identification required by CRS §24-76.5-103 prior to the date Grantee begins Work under terms of the Agreement.

STATE CONTROLLER

ADDENDUM 1:
Additional Terms & Conditions for Information Technology

IF ANY PART OF THE SUBJECT MATTER OF THIS AGREEMENT IS INFORMATION TECHNOLOGY, AS DEFINED IN CRS § 24-37.5-102 (2), THE FOLLOWING PROVISIONS ALSO APPLY TO THIS AGREEMENT.

A. Definitions. The following terms shall be construed and interpreted as follows: **(a)** "**CJI**" means criminal justice information collected by criminal justice agencies needed for the performance of their authorized functions, including, without limitation, all information defined as criminal justice information by the U.S. Department of Justice, Federal Bureau of Investigation, Criminal Justice Information Services Security Policy, as amended, and all Criminal Justice Records as defined under CRS §24-72-302; **(b)** "**Incident**" means any accidental or deliberate event that results in or constitutes an imminent threat of the unauthorized access, loss, disclosure, modification, disruption, or destruction of any communications or information resources of the State, pursuant to CRS §§24-37.5-401 *et seq*.; **(c)** "**PCI**" means payment card information including any data related to credit card holders' names, credit card numbers, or the other credit card information as may be protected by state or federal law; **(d)** "**PHI**" means any protected health information, including, without limitation any information whether oral or recorded in any form or medium that relates to the past, present or future physical or mental 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 that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual including, without limitation, any information defined as Individually Identifiable Health Information by the federal Health Insurance Portability and Accountability Act; **(e)** "**PII**" means personally identifiable information including, without limitation, any information maintained by the State about an individual that can be used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, or biometric records, including, without limitation, all information defined as personally identifiable information in CRS §24-72-501; **(f)** "**State Confidential Information**" means any and all State Records not subject to disclosure under the Colorado Open Records Act and includes, without limitation, PII, PHI, PCI, Tax Information, CJI, and State personnel records not subject to disclosure under the Colorado Open Records Act, **(g)** "**State Fiscal Rules**" means those fiscal rules promulgated by the Colorado State Controller pursuant to CRS §24-30-202(13)(a); **(h)** "**State Fiscal Year**" means a 12 month period beginning on July 1 of each calendar year and ending on June 30 of the following calendar year; **(i)** "**State Records**" means any and all State data, information, and records, regardless of physical form; **(j)** "**Tax Information**" means federal and State of Colorado tax information including, without limitation, federal and State tax returns, return information, and such other tax-related information as may be protected by federal and State law and regulation, including, without limitation all information defined as federal tax information in Internal Revenue Service Publication 1075; and **(k)** "**Work Product**" means the tangible and intangible results of the delivery of goods and performance of services, whether finished or unfinished, including drafts. Work Product includes, but is not limited to, documents, text, software (including source code), research, reports, proposals, specifications, plans, notes, studies, data, images, photographs, negatives, pictures, drawings, designs, models, surveys, maps, materials, ideas, concepts, know-how, information, and any other results of the Work, but does not include any material that was developed prior to the Effective Date that is used, without modification, in the performance of the Work.

B. Intellectual Property. Except to the extent specifically provided elsewhere in this Agreement, any State information, including without limitation pre-existing State software, research, reports, studies, data, photographs, negatives or other documents, drawings, models, materials; or Work Product prepared by Grantee in the performance of its obligations under this Agreement shall be the exclusive property of the State (collectively, "State Materials"). All State Materials shall be delivered to the State by Grantee upon completion or termination of this Agreement. The State's exclusive rights in any Work Product prepared by Grantee shall include, but not be limited to, the right to copy, publish, display, transfer, and prepare derivative works. Grantee shall not use, willingly allow, cause or permit any State Materials to be used for any purpose other than the performance of Grantee's obligations hereunder without the prior written consent of the State. The State shall maintain complete and accurate records relating to **(a)** its use of all Grantee and third party software licenses and rights to use any Grantee or third party software granted under this Agreement and its attachments to which the State is a party and **(b)** all amounts payable to Grantee pursuant to this Agreement and its attachments and the State's obligations under this Agreement or any amounts payable to Grantee in relation to this Agreement, which records shall contain sufficient information to permit Grantee to confirm the State's compliance with the use restrictions and payment obligations under this Agreement or to any third party use restrictions to which the State is a party. Grantee retains the exclusive rights, title and ownership to any and all pre-existing materials owned or licensed to Grantee including, but not limited to all pre-existing software, licensed products, associated source code, machine code, text images, audio, video, and third party materials, delivered by Grantee under the Agreement, whether incorporated in a deliverable or necessary to use a deliverable (collectively, "Grantee Property"). Grantee Property shall be licensed to the State as set forth in a State-approved license agreement **(a)** entered into as exhibits or attachments to this Agreement, **(b)** obtained by the State from the applicable third party Grantee, or **(c)** in the case of open source software, the license terms set forth in the applicable open source license agreement. Notwithstanding anything to the contrary herein, the State shall not be subject to any provision incorporated in any exhibit or attachment attached hereto, any provision incorporated in any terms and conditions appearing on any website, any provision incorporated into any click through or online agreements, or any provision incorporated into any other document or agreement between the parties that **(a)** requires the State or the State to indemnify Grantee or any other party, **(b)** is in violation of State laws, regulations, rules, State Fiscal Rules, policies, or other State requirements as deemed solely by the State, or **(c)** is contrary to this Agreement.

C. Information Confidentiality. Grantee shall keep confidential, and cause all Subcontractors to keep confidential, all State Records, unless those State Records are publicly available. Grantee shall not, without prior written approval of the State, use, publish, copy, disclose to any third party, or permit the use by any third party of any State Records, except as otherwise stated in this Agreement, permitted by law, or approved in writing by the State. If Grantee will or may have access to any State Confidential Information or any other protected information, Grantee shall provide for the security of all State Confidential Information in accordance with all applicable laws, rules, policies, publications, and guidelines. Grantee shall comply with all Colorado Office of Information Security ("OIS") policies and procedures which OIS has issued pursuant to CRS §§24-37.5-401 through 406 and 8 CCR §1501-5 and posted at http://oit.state.co.us/ois, all information security and privacy obligations imposed by any federal, state, or local statute or regulation, or by any industry standards or guidelines, as applicable based on the classification of the data relevant to Grantee's performance under this Agreement. Such obligations may arise from: Health Information Portability and Accountability Act (HIPAA); IRS Publication 1075; Payment Card Industry Data Security Standard (PCI-DSS); FBI Criminal Justice Information Service Security Addendum; Centers for Medicare & Medicaid Services (CMS) Minimum Acceptable Risk Standards for Exchanges; and Electronic Information Exchange

Security Requirements and Procedures for State and Local Agencies Exchanging Electronic Information with The Social Security Administration. Grantee shall immediately forward any request or demand for State Records to the State's principal representative.

D. Other Entity Access and Nondisclosure Agreements. Grantee may provide State Records to its agents, employees, assigns and Subcontractors as necessary to perform the work, but shall restrict access to State Confidential Information to those agents, employees, assigns, and Subcontractors who require access to perform their obligations under this Agreement. Grantee shall ensure all such agents, employees, assigns, and Subcontractors sign agreements containing nondisclosure provisions at least as protective as those in this Agreement, and that the nondisclosure provisions are in force at all times the agent, employee, assign, or Subcontractors has access to any State Confidential Information. Grantee shall provide copies of those signed nondisclosure provisions to the State upon execution of the nondisclosure provisions if requested by the State.

E. Use, Security, and Retention. Grantee shall use, hold, and maintain State Confidential Information in compliance with any and all applicable laws and regulations only in facilities located within the United States, and shall maintain a secure environment that ensures confidentiality of all State Confidential Information. Grantee shall provide the State with access, subject to Grantee's reasonable security requirements, for purposes of inspecting and monitoring access and use of State Confidential Information and evaluating security control effectiveness. Upon the expiration or termination of this Agreement, Grantee shall return State Records provided to Grantee or destroy such State Records and certify to the State that it has done so, as directed by the State. If Grantee is prevented by law or regulation from returning or destroying State Confidential Information, Grantee warrants it will guarantee the confidentiality of, and cease to use, such State Confidential Information.

F. Incident Notice and Remediation. If Grantee becomes aware of any Incident, it shall notify the State immediately and cooperate with the State regarding recovery, remediation, and the necessity to involve law enforcement, as determined by the State. Unless Grantee can establish none of Grantee or any of its agents, employees, assigns or Subcontractors are the cause or source of the Incident, Grantee shall be responsible for the cost of notifying each person who may have been impacted by the Incident. After an Incident, Grantee shall take steps to reduce the risk of incurring a similar type of Incident in the future as directed by the State, which may include, but is not limited to, developing and implementing a remediation plan that is approved by the State at no additional cost to the State. The State may adjust or direct modifications to this plan, in its sole discretion and Grantee shall make all modifications as directed by the State. If Grantee cannot produce its analysis and plan within the allotted time, the State, in its sole discretion, may perform such analysis and produce a remediation plan, and Grantee shall reimburse the State for the reasonable actual costs thereof.

G. Data Protection and Handling. Grantee shall ensure that all State Records and Work Product in the possession of Grantee or any Subcontractors are protected and handled in accordance with the requirements of this Agreement at all times. Upon request by the State made any time prior to 60 days following the termination of this Agreement for any reason, whether or not this Agreement is expiring or terminating, Grantee shall make available to the State a complete and secure download file of all data that is encrypted and appropriately authenticated. This download file shall be made available to the State within 10 Business Days following the State's request, and shall contain, without limitation, all State Records, Work Product, and any other information belonging to the State. Upon the termination of Grantee's services under this Agreement, Grantee shall, as directed by the State, return all State Records provided by the State to Grantee, and the copies thereof, to the State or destroy all such State Records and certify to the State that it has done so. If legal obligations imposed upon Grantee prevent Grantee from returning or destroying all or part of the State Records provided by the State, Grantee shall guarantee the confidentiality of all State Records in Grantee's possession and will not actively process such data. The State retains the right to use the established operational services to access and retrieve State Records stored on Grantee's infrastructure at its sole discretion and at any time.

H. Compliance. If applicable, Grantee shall review, on a semi-annual basis, all OIS policies and procedures which OIS has promulgated pursuant to CRS §§ 24-37.5-401 through 406 and 8 CCR § 1501-5 and posted at http://oit.state.co.us/ois, to ensure compliance with the standards and guidelines published therein. Grantee shall cooperate, and shall cause its Subcontractors to cooperate, with the performance of security audit and penetration tests by OIS or its designee.

I. Safeguarding PII. If Grantee or any of its Subcontractors will or may receive PII under this Agreement, Grantee shall provide for the security of such PII, in a manner and form acceptable to the State, including, without limitation, all State requirements relating to non-disclosure, use of appropriate technology, security practices, computer access security, data access security, data storage encryption, data transmission encryption, security inspections, and audits. Grantee shall take full responsibility for the security of all PII in its possession or in the possession of its Subcontractors, and shall hold the State harmless for any damages or liabilities resulting from the unauthorized disclosure or loss thereof. Grantee shall be a "Third-Party Service Provider" as defined in CRS §24-73-103(1)(i) and shall maintain security procedures and practices consistent with CRS §§24-73-101 *et seq*.

J. Software Piracy Prohibition. The State or other public funds payable under this Agreement shall not be used for the acquisition, operation, or maintenance of computer software in violation of federal copyright laws or applicable licensing restrictions. Grantee hereby certifies and warrants that, during the term of this Agreement and any extensions, Grantee has and shall maintain in place appropriate systems and controls to prevent such improper use of public funds. If the State determines that Grantee is in violation of this provision, the State may exercise any remedy available at law or in equity or under this Agreement, including, without limitation, immediate termination of this Agreement and any remedy consistent with federal copyright laws or applicable licensing restrictions.

K. Information Technology. To the extent that Grantee provides physical or logical storage of State Records; Grantee creates, uses, processes, discloses, transmits, or disposes of State Records; or Grantee is otherwise given physical or logical access to State Records in order to perform Grantee's obligations under this Agreement, the following terms shall apply. Grantee shall, and shall cause its Subcontractors, to: Provide physical and logical protection for all hardware, software, applications, and data that meets or exceeds industry standards and the requirements of this Agreement; Maintain network, system, and application security, which includes, but is not limited to, network firewalls, intrusion detection (host and network), annual security testing, and improvements or enhancements consistent with evolving industry standards; Comply with State and federal rules and regulations related to overall security, privacy, confidentiality, integrity, availability, and auditing; Provide that security is not compromised by unauthorized access to workspaces, computers, networks, software, databases, or other physical or electronic environments; Promptly report all Incidents, including Incidents that do not result in unauthorized disclosure or loss of data integrity, to a designated representative of the OIS; Comply with all rules, policies, procedures, and standards issued by the Governor's Office of Information Technology (OIT), including project lifecycle methodology and governance, technical standards, documentation, and other requirements posted at www.oit.state.co.us/about/policies. Grantee shall not allow remote access to State Records from outside the United States, including access by

Grantee's employees or agents, without the prior express written consent of OIS. Grantee shall communicate any request regarding non-U.S. access to State Records to the State. The State, acting by and through OIS, shall have sole discretion to grant or deny any such request.

AGENDA ITEM or FINAL CONTRACT REVIEW SUBMITTAL FORM

Agenda Item: Grant Application; Choose When 2026 Application; C

Action Requested: Discussion

Parties to the Agreement: Caring for Colorado- Choose When

Term Begins: July 1 2026 **Term Ends:** **Grant Contract #:**

Summary:

Open to Colorado-based safety net clinics, public health agencies, school-based health centers, and rural health clinics that fit the eligibility criteria, this funding opportunity will provide financial support to cover the costs of contraception, especially long-acting methods, to improve access to this

Fiscal Impact:

Submitted by: Blair Burgess **Submitter's Email Address:** bburgess@gunnisoncouty.org

Finance Review: (●) Required ( ) Not Required

Comments:

Reviewed by: GUNCOUNTY1\mrozman Discharge Date: 2/25/2026

County Attorney Review: (●) Required ( ) Not Required

Comments:
Legally sufficient. SO 2/24/26

Reveiwed by: GUNCOUNTY1\sobaid Discharge Date: 2/24/2026 Certificate of Insurance Required

Yes ( ) No (●)

County Manager Review:

Comments:

Reveiwed by: GUNCOUNTY1\mbirnie Discharge Date: 2/25/2026

(●) Consent Agenda ( ) Regular Agenda ( ) Worksession Time Allotted: 0

Agenda Date: 3/3/2026

Revised April 2015

Gunnison County Department of Health and Human Services

R-17135-26 | Choose When Supports Gunnison Health and Human Services Family Planning Clinic

Amelia Meyer
Requested: $50,000
Created: 2/4/2026

Choose When

▼Table of Contents

Required fields are in bold

Choose When Supports Gunnison Health and Human Services Family Planning Clinic

Grant Contact:
Amelia Meyer
Family Planning Coordinator
ameyer@gunnisoncounty.org

Signatory Contact
Matthew Birnie
County Manager
mbirnie@gunnisoncounty.org

Related User 1
Joni Reynolds
Deputy County Manager
jreynolds@gunnisoncounty.org

IMPORTANT: Please save your work! The portal logs users out after 15 minutes, so save your work as you complete the application. The save and submit buttons are at the bottom right corner of the application.

1. **While you are entering information in your application, click Save to save and continue working on it.**
2. **When you are finished with the application, click Save and Close.**
3. **After clicking Save and Close, you must click the Submit button. You will not be able to edit your application after you click submit.**

Introduction: Choose When Application

The Application is due Thursday, March 12, 2026, by 5 pm MDT.

Please note: you must be a Colorado-based safety net clinic, public health agency, school-based health center, and/or rural health clinic to be eligible for this funding opportunity.

Applicants must submit the complete application by the deadline, including the required attachments, to be considered for funding. You will notice some information below has been pre-populated. Additional guidance for this opportunity can be found here.

Please review and follow each step below before applying:

1. Required questions are in bold in the form below and must be answered. We do not evaluate proposals based on formatting, grammar, writing style, sentence structure, etc.
2. Review your contact information and responses. Please note: Your submission cannot be modified or changed after clicking "Submit" so please review your information carefully.
3. Click “Submit Request.”

Next Steps:

- **The Primary Contact and Executive Director/CEO listed below will receive an email acknowledging receipt of submission within hours. After submitting, your application status will appear as "Under Review" in the Fluxx portal.**
- **After receiving a complete application, the philanthropy team member assigned to your proposal may request a call during the review process to clarify an applicant’s proposal.**
- **Applicants will be notified of a decision in late June 2026.**

ORGANIZATION

Organization	**Gunnison County Department of Health and Human Services**
Location	**Gunnison ,CO**
Proposal Primary Contact	**Amelia Meyer**
Primary Signatory (ED)	**Matthew Birnie**
Additional Grant Contact	**Joni Reynolds**

▼Section 1: Organizational Profile

Please review the following organization and contact information in your Fluxx profile and note any updates in the fields below. *Updates submitted in this section will be processed and new users will be set up after application submission.*

Organization Name:	Gunnison County Department of Health and Human Services
Legal Name:	Gunnison County Health and Human Services
Tax ID:	84-6000770
Tax Class:	Governmental Entity
Address 1:	220 N. Spruce St
Address 2:	
City, State Zip:	Gunnison, Colorado 81230
County where primary office is located:	Gunnison
Phone:	970-641-3244
Website Address:	http://www.gunnisoncounty.org/

Does any organization information above need to be updated?	**No**

Organization Total Annual Budget:	**$9,531,845.00**
Fiscal Year End Date (mm/dd):	**12/31**
Number of years the organization has been in operation (if less than 1 year, type 0).	**30**
Does the organization have an approved anti-discrimination policy?	**Yes**

Mission Statement:

The mission of Gunnison County Health and Human Services is to provide "culturally-competent advocacy, prevention, protection and support services to our community.

Include the number of paid full-time and part-time staff in the entire organization, not just the proposed work.

Number of Part-Time Staff:	**14**
Number of Full-Time Staff:	**38**

▼Section 2: Contact Information

Executive Director

Name: Matthew Birnie
Title: County Manager
Address: 220 N. Spruce St, , Gunnison, Colorado 81230
Email: mbirnie@gunnisoncounty.org
Office Phone: 970-641-3244
Direct Phone: 970-641-7940

Does any of the ED information need to be updated? **Yes**

	Executive Director Updated Contact Information
Full Name	Matthew Birnie
Address 1	220 N Spruce
Address 2	
City, State Zip	Gunnison CO 81230
E-Mail	mbirnie@gunnisoncounty.org
Office Phone (xxx-xxx-xxxx)	970-641-3244
Direct Phone (xxx-xxx-xxxx)	970-641-7940

Proposal Primary Contact

Name: Amelia Meyer
Title Family Planning Coordinator
Address: 220 N. Spruce St, , Gunnison, Colorado 81230
E-Mail ameyer@gunnisoncounty.org
Office Phone: 970-641-3244
Direct Phone: 970-641-7952

If you wish to update any of the Proposal Primary Contact information below OR if the field below is blank and you wish to add a Primary Proposal Contact different from the Executive Director, select Yes.

Does any of the contact information need to be updated? **Yes**

If yes, please enter the information for the main point of contact below.
NOTE: This person will receive all correspondence related to the proposal.

	Proposal Primary Contact Information
Full Name	Amelia Meyer
Title	Family Planning Coordinator
Address 1	220 N Spruce
Address 2	
City, State Zipcode	Gunnison CO 81230
E-mail Address	ameyer@gunnisoncounty.org
Phone (xxx-xxx-xxxx)	970-641-7952

▼Section 3: General Information

Has the organization ever applied to CFC for funding?	**Yes**
Did you receive funding?	**Yes**
Will a fiscal sponsor be used in conjunction with this proposal?	**No**

▼Section 4: Proposal Overview

Proposal Title:	**Choose When Supports Gunnison Health and Human Services Family Planning Clinic**
Amount Requested:	**$50,000.00**
Proposal Summary :	
Proposal Start Date:	**7/1/2026**
Proposal Term in Months:	**12**
Proposal End Date:	**6/30/2027**
Anticipated Number Reached:	**427**
Describe how Anticipated Number Reached is calculated:	**This is the number of unduplicated patients seen last year. We hope to use this funding to increase the sustainability of our clinic which would impact all our patients.**
Geography:	**Rural**
Geographical Area Served:	**Multi-County**

Please select all counties that are served

County or Counties Served by Project:	**Gunnison, Hinsdale**

Guidance: Please only select the age ranges for the proposed work. Do not select every age group served by your organization.

Age Group(s) Served by Proposed work: Select all applicable ages:	**15 to 18 years old , 19 to 21 years old, 22 to 25 years old, 26 years or older, Parents/Caregivers of Adolescents**

Demographic Questions

What percentage of the people you serve self-identify as a person of color?

Less than 25%

What percentage of the people you serve live with low incomes? (Common income eligibility percentages: CHP+ = 260% FPL, SNAP = 200% FPL, Reduced lunch = 185% FPL, MCD = 133% FPL, Free lunch = 130% FPL).

75-100%

Is serving or representing a specific community part of your organization's mission?

Yes

If yes, please answer the question below for each of CFC's priority populations.

Do at least 90% of the people served by the proposed work self-identify as:

a person of color?	**No**
2SLGBTQIA+? :	**No**
living with visible or invisible disabilities?	**No**
living with newly arrived, immigrant, or refugee families?	**Yes**
experiencing housing insecurity? :	**No**
experiencing interpersonal or family violence or abuse? :	**No**
experiencing the child welfare system? :	**No**
being involved in the juvenile justice system? :	**No**

experiencing family instability or separation due to parents or caregivers' involvement in the justice or immigration system? :	**No**
being raised by grandparents or other family caregivers? :	**No**
young parents (under 26 years old)? :	**Yes**
young people and families living with low incomes?	**Yes**

Section 5: Budget Overview

Budget:

Total Reproductive Health Program Budget:

$50,000.00

Amount requested for the purchase and stocking of all methods of contraception to ensure that people with financial barriers to care can access the method of their choice, ideally on the same day that they access healthcare:

$15,000.00

Narrative of request:

Over 30% of our total patient population opt for Long Acting Contraceptives such as the implant or IUD's. This statistic also includes our patients who don't have uteruses. This percentage would be significantly higher if we only looked at our patients with uteruses. These are also our most costly contraceptives to have available, and it is important to our clinic for choices to be patient driven. This funding would help us have all options available so that patients regardless of ability to pay can choose the contraception option most desirable to them.

Amount requested for the cost of office visits to provide person-centered contraceptive care:

$6,250.00

Narrative of request:

One of the costs associated with office visits is lab testing. We have some assistance from the state for lab testing, but it is limited to gonorrhea and chlamydia only. The amount of assistance only covers a quarter of our patients. We have a multitude of STI related test along with pap smear and colposcopy. We make all these services available to our patients regardless of their insurance status or ability to pay. This funding would help offset the cost that we absorb on behalf of our patients.

Amount requested for the cost of health educators who work in partnership with healthcare providers to provide one-on-one or small group education on reproductive and sexual health that is inclusive of cultural or identity-based factors in reproductive health:

$12,500.00

Narrative of request:

Currently we participate in the local school districts health program and co-teach the sexual and reproductive health sections starting in 5th grade all the way through high school. We also participate with our community partners in bringing a sexual assault awareness education program called "Stay Safe Out There" to our high school students. This funding would be used to help support our bilingual staff to participate and reach our LEP students and also help us put on some LiFT courses. We already have LiFT trained community partners, but struggle financially to put on events for families that encourage and educate about conversations at home about sexual and reproductive health. We also partner with our local university to bring education to campus. We are very proud that we partner closely with the students who help direct the education so they are getting the information they want.

Amount requested for provider training to ensure that people can access the contraceptive method of their choice:

$3,750.00

Narrative of request:

We are located very rurally which makes attending training and conferences a financial challenge. The extra resources would allow some of our small staff to attend some of these important opportunities.

Amount requested for focused outreach to populations with barriers to healthcare to help bring down disparities in access to contraceptive care:

$12,500.00

Narrative of request:

We have in person interpretation available to all our LEP patients whose primary language is Spanish. Our team of interpreters are also county employees whose work often includes health navigation for the LEP community. We partner closely with them in both patient care and in outreach. This funding would be used to help support the cost of their services and also support more outreach directed to our LEP community especially those who identify and asylum seekers and refugees.

After you have entered all five budget amounts, click Save (not Save and Close), which will total what you have entered.

$50,000.00

Budget Request:

Contraceptive Methods:	$15,000.00	Over 30% of our total patient population opt for Long Acting Contraceptives such as the implant or IUD's. This statistic also includes our patients who don't have uteruses. This percentage would be significantly higher if we only looked at our patients with uteruses. These are also our most costly contraceptives to have available, and it is important to our clinic for choices to be patient driven. This funding would help us have all options available so that patients regardless of ability to pay can choose the contraception option most desirable to them.
Office Visits:	$6,250.00	One of the costs associated with office visits is lab testing. We have some assistance from the state for lab testing, but it is limited to gonorrhea and chlamydia only. The amount of assistance only covers a quarter of our patients. We have a multitude of STI related test along with pap smear and colposcopy. We make all these services available to our patients regardless of their insurance status or ability to pay. This funding would help offset the cost that we absorb on behalf of our patients.
Reproductive and Sexual Health Educators:	$12,500.00	Currently we participate in the local school districts health program and co-teach the sexual and reproductive health sections starting in 5th grade all the way through high school. We also participate with our community partners in bringing a sexual assault awareness education program called "Stay Safe Out There" to our high school students. This funding would be used to help support our bilingual staff to participate and reach our LEP students and also help us put on some LiFT courses. We already have LiFT trained community partners, but struggle financially to put on events for families that encourage and educate about conversations at home about sexual and reproductive health. We also partner with our local university to bring education to campus. We are very proud that we partner closely with the students who help direct the education so they are getting the information they want.
Provider Training:	$3,750.00	We are located very rurally which makes attending training and conferences a financial challenge. The extra resources would allow some of our small staff to attend some of these important opportunities.
Focused Outreach:	$12,500.00	We have in person interpretation available to all our LEP patients whose primary language is Spanish. Our team of interpreters are also county employees

whose work often includes health navigation for the LEP community. We partner closely with them in both patient care and in outreach. This funding would be used to help support the cost of their services and also support more outreach directed to our LEP community especially those who identify and asylum seekers and refugees.

Section 6: Learning and Assessment

The Caring for Colorado team has identified the pre-populated outcome below as part of this grant award. This will be included in the final report for all grantees. If you have any questions or concerns, please let our team know at grants@caringforcolorado.org.

Universal Outcome: Increase access to free-of-cost contraceptive methods -- including long-acting reversible contraceptives (LARCs) and equitable, person-centered contraceptive care -- to Choose When's priority populations.

Define at least one objective:

Increase focused outreach to young people and those with financial barriers to accessing person centered contraceptive care.

Do you have another objective?	**No**

Section 7: Narrative Questions

Please answer the following narrative questions about your organization. There are no character or word limits in this section, but brevity is encouraged.

1. Describe how your organization provides contraceptive care in your community.

Guidance: Begin by describing your organization, how person-centered contraceptive care aligns with your organization's mission, and how contraceptive care fits within your overall services. Please include the number of people of reproductive age your community serves. Explain how patients access contraceptive care through your organization (e.g., through walk-in appointments, same-day scheduling, telehealth, community outreach, or pharmacy partnerships). Share the most significant barriers patients experience when trying to access their preferred contraceptive methods and describe how your team aims to reduce these barriers. Discuss any challenges or capacity gaps that limit your ability to provide fully person-centered contraceptive care, and how additional resources could strengthen access and quality. Finally, highlight any specific approaches or challenges

related to serving key populations, including individuals in rural or frontier communities, those living in areas with limited access to affordable care, uninsured or underinsured individuals, adolescents, and people seeking confidential services.

The Gunnison Health and Human Services Family Planning Clinic is a Title X clinic that strives to provide culturally-competent advocacy, prevention, protection and support services to all in our community. Based on the 2023-2024 census data we have approximately 7,700 individuals in our community of reproductive age. We strongly believe in the tenants of patients centered care and focus on treating individuals with dignity, compassion, and respect, making them equal partners in decisions about their health, and tailoring support to their unique needs, values, and strengths to promote independence. Our staff regularly engages in trainings and participates in different work groups with other community partners such as our "Health Equity Work Force" and our SART/DVRT. We focus our outreach toward young people and those with financial barriers to care, and make huge efforts to ensure the confidentiality and financial accessibility of our services. Our attempts to make access to care as unencumbered as possible include same-day scheduling, strong community partnerships, off site pop up clinics, and sliding scale billing which also includes full financial coverage if the patient needs.

One of our biggest obstacles currently is ensuring we have an adequate budget to purchase all the contraceptive options our patient population is interested in. As previously mentioned a significant portion of our patient population show interest in LARCs which also are the most costly to have in stock. Because we charge on a sliding scale basis, and also waive bills if patients are unable to pay we regularly assume the financial costs of our contraceptives. Additional funding will help us continue to have all contraceptive option available in clinic so that our patients can select the method of their choice. Provider coverage has be an ongoing challenge due to our rural location. We are looking at some turnover in providers which will hopefully result in some more consistent coverage and availability for patients to start the contraceptive method of their choice. Additional funding will help us offer our new providers opportunities for education for both clinical practices such as LARC initiation, and also patient centered care specifically in regard to sexual and reproductive health care. Additional funding will allow us to provide opportunities for growth and development that will help us sustain more consistent provider coverage.

One of the barriers to care that we try to address is our rural location. We are a rural and frontier community. Some of our patients have to travel over an hour to access care, and there is very limited public transportation. We try to offset these challenges by offering gas cards to help with transportation costs, and grocery cards for those who need financial assistance if they have to take off from work. Within this rural community we focus our outreach to our young people, and those with limited access to affordable care due to insurance status, income, language barriers and citizenship. Along with active outreach in our schools and university we partner with other entities such as the food pantry, local immigration advocacy groups and juvenile support organizations to educate people on the care available through our

clinic. We work with patients to provide high level of care at whatever cost they can afford, and have engrained policies in place to ensure patient confidentiality. We want our patients to feel respected, safe and prioritized.

2. Describe your organization's patient payer mix, and what it reveals about access to contraceptive care in your community.

Guidance: Provide approximate numbers of patients or visits for each payer category (Medicaid, CHP+, Medicare, Private Insurance, Uninsured, Other) for a recent 12-month period, noting the specific period and whether these figures represent visits, encounters, or unique patients. Briefly describe what this mix indicates about community access and affordability, including any significant gaps, trends, or unmet needs related to contraceptive care, and provide any notes or limitations on the data provided.

In 2025, 368 of our visits served patients who had no insurance, 268 visits for patients who carried private insurance, and 94 visits for patients who were covered by Medicaid or CHP+. These numbers are representative of visits not unique patients.

What this mix suggests to me is that over half of our visits serve clients who carry no insurance. This clients group is likely made up of those who don't qualify for Medicaid but can not afford private insurance, and those who don't have residential status that would make them eligible for either Medicaid or private insurance. A small number of these clients may also be young people who for confidentiality purposes are opting not to use the coverage they may have from their caregivers.

In our community there are a few primary care practices and one women's health clinic that offer contraceptive services. These practices are all owned by the local hospital that does not offer specific financial assistance for those seeking contraceptive care. In contrast we provide all our care on a sliding scale basis and frequently absorb all associated cost of care for our patients regardless of insurance coverage. We have approximated that roughly 80% of our patients receive care in our clinic at no cost to themself. In circumstances when our patients carry private insurance we often absorb their copays or fees not covered by insurance. I feel that the above mentioned numbers reflet that a our clinic makes contraceptive options available without creating financial burden for our patients.

Section 8: Demographics

Caring for Colorado collects demographic data to help us better understand our grantmaking and evaluate the effectiveness of our work in reflecting our guiding principles and advancing our mission. We aligned these questions with the Candid/GuideStar model for demographic data collection because it was created specifically for the mission-focused nonprofit sector.

We recognize that requesting this information adds to the amount of time it takes to complete the application. We appreciate your willingness to share these details about your board, staff and communities served.

Answering these questions will not affect your eligibility for funding. If you do not collect demographic data, you may indicate that below. If you collect some demographic data, please fill out those sections below.

Important Note: All demographic data questions, including those about communities served, should reflect your entire organization, even if your proposed work focuses on a specific program and/or population. You will have the opportunity to explain how the data for your organization's community served differs from the proposed communities served in this proposal.

If you are using a fiscal sponsor, the demographic data questions should represent the entity leading the work, not the fiscal sponsor organization.

Additionally, only include data that your organization collects—do not use general population data for the communities served section.

Please contact us at grants@caringforcolorado.org if you have questions or need assistance in answering
We want to assure you that your application data is secure and confidential. Data from applicants or grantees is shared only in an aggregated form across all applicants or grantees.

Do you collect demographic data for your organization and the communities you serve?	**Yes**

Community Served Demographic Information

Race and Ethnicity - Community

Do you collect race and ethnicity demographics for your community?	**Yes**

Select the race/ethnicity group(s) represented in your community. For each selected item, enter the <u>total number</u> of individuals for the category selected.

Race and Ethnicity Categories Selected:

Hispanic/Latina/Latine/Latino/Latinx,

White/Caucasian/European, Different Identity

Hispanic / Latina / Latine / Latino / Latinx:	**130**
White / Caucasian / European:	**278**
Different Identity:	**19**
Please Specify:	
Total:	**427**

Gender Identity - Community

Do you collect gender identity demographics for your community?	**No**

Sexual Orientation - Community

Do you collect sexual orientation demographics for your community?	**No**

People Living With a Disability - Community

Do you collect demographics about living with a disability for your community?	**No**

Income Below Federal Poverty Level - Community

Do you collect income demographics for your community?	**Yes**

Select the group(s) represented in your community. For each selected item, enter the total number of individuals for the category selected.

CFC defines "living with low income" as incomes at or below 260% of the federal poverty level (FPL), 80% of Area Median Income, or TANF eligibility.

For reference, here are some common income-related indicators for young people and their families: CHP+ = 260% of the FPL, SNAP = 200% of the FPL, Reduced lunch = 185% of the FPL, Free lunch = 130% of the FPL, and Medicaid = 138% of the FPL.

Income data can be self-reported by young people or families and does not require formal documentation.

Income Categories Selected:

Lives with low incomes, Does not live with low incomes

Lives with incomes BELOW 260% of the federal poverty level:	**380**
Lives with incomes ABOVE 260% of the federal poverty level:	**47**
Total:	**427**

Is there any other demographic information on people served by your organization and program or project that you'd like to share? If so, please note here.

Some of the demographic information such as Gender Identity and Sexual Orientation are asked, but currently we don't have the ability through our EHR to extract it. We plan to continue gathering this data in our new EHR and will be able to extract that data in the future.

If the target communities of this proposal are different from your current communities served, please explain.

If you selected "do not collect" for any of the above information, please tell us more about why you do not collect this information (capacity, organization priorities, documentation status, etc.)?

Section 9: Financial Information

Please provide the most current fiscal year-end financial statement of your organization for the requested items below.

Do you have audited financial statements? **Yes**

Please attached audited financial statements under the document section.

Select the end date of the financial period for the financial document referenced above:

If Guidestar is used, profile seal:

Section 10: Documentation

Please be sure to SAVE this form before uploading attachments.

Please consolidate any optional information into one PDF and attach as one file. Only one additional attachment is allowed.

Contact **grants@caringforcolorado.org** to request removal or deletion of any attachments uploaded in error.

List of Required Documentation

- **Annual Financials – Please provide audited financials for the most recently completed fiscal year end. If this is unavailable, please provide IRS Form 990/990EZ or internal year-end balance sheet and income statement.**
- **YTD Financial Statements – Attach most current year-to-date internal financial statements (Statement of Activities and Balance Sheet), including budget-to-actual data, if available.**
- **Operating Budget – Attach current-year annual operating budget.**
- **Optional additional attachment (not required) – Please consolidate any additional materials into a PDF and attach as one file. Additional attachments are NOT required.**

CW_Annual Financials

CW_Operating Budget

CW_YTD Financial Statements

K_Optional Attachment

UPLOADED APPLICATION DOCUMENTS

By submitting this application, the organization affirms the information provided is accurate and understands that misrepresentation of information will disqualify the application.

Select one:

If awarded funding, the organization agrees to execute the Caring for Colorado Foundation grant agreement. Click here to view a sample grant agreement.

Select One:

Caring for Colorado FOUNDATION

Choose When 2026 Application Guide

Introduction:

This document is a **resource** to help you prepare and complete the **online application** for the *2026 Choose When* funding opportunity. It includes all the application questions along with helpful guidance. You will also find the same guidance within the **Fluxx online application**. Please also refer to the FAQ as an additional resource.

The **Appendix** includes an optional template that may make preparing your application easier:

- **Demographics Template:** Use this as a simple tool to collect and organize demographic information before entering it into Fluxx. You will not upload this template; it's just for your reference.

Sections of the Application:

Appendix A: **Optional** Template Links

- CFC Demographics Template

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Application Questions

SECTION 1: ORGANIZATIONAL PROFILE

Organization Name:
Legal Name:
Tax ID:
Tax Class:
Address 1:
Address 2:
City:
County where primary office is located (drop-down selection):
State/Province (drop-down selection):
Zip code:
Organization Phone:
Website Address:

Organization Total Annual Budget:
Fiscal Year End Date:
Number of years the organization has been in operation (if less than 1 year, type 0):
Does the organization have an approved anti-discrimination policy?

SECTION 2: CONTACT INFORMATION

The executive director/CEO listed in the application will receive an email acknowledging receipt of application submission within one business day.

Executive Director Information

First Name:
Last Name:
Title:
E-mail:
Address 1:
Address 2:
City:
State:
Postal Code (Zip):
Office Phone:
Direct Phone:

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The primary project contact will be notified via email about the next steps in the review process.

Proposal Primary Contact (if different than ED)

Primary Contact First Name:
Primary Contact Last Name:
Primary Contact Suffix:
Primary Contact Title:
Primary Contact Address (enter Address, City, State, Zip if different from Organization address):
Primary Contact Email:
Primary Contact Office Phone:
Primary Contact Direct Phone:

SECTION 3: Organization Information

This question helps us identify if you are a first-time applicant, a returning applicant, or a previous grantee. If you are unsure if your organization has applied or been funded in the past, please select "no."

Has the organization previously applied for CFC funding?

☐ Yes
☐ No

If yes, Did the organization receive funding?

☐ Yes
☐ No

Will a fiscal sponsor be used in conjunction with this proposal?

☐ Yes
☐ No

If yes: Select one of the prepopulated fiscal agents or select "Other"

If "Other," Please type the Full Name, Address, City, State, Zip, Full Name of the Primary Contact (Signs Contracts), and the Primary Contact's email.

SECTION 4: PROPOSAL OVERVIEW

Please limit to seven words and do not include your organization's name in the title.

Proposal Title:

You can request up to $50,000. Please refer to the FAQ on our website for more guidance.

Amount Requested:

Caring for Colorado FOUNDATION

Proposal Summary

Here are considerations for the Proposal Summary:

- *Format is brief and should not exceed 15 words.*
- *To start the description, use an active verb.*
- *Please detail the anticipated number and types of contraceptive methods that will be purchased with the grant award.*
- *Use keywords to add context, such as rural, urban, contraceptive access, prevention, youth, providers, etc.*

Proposal Details

All proposal start dates should be July 1, 2026.

Proposal Start Date:

Please input a number up to 12.

Proposal Term in Grant Months:

The value should represent the estimated number of patients who are uninsured, underinsured, or seeking confidential services that will be served by Choose When.

Anticipated Number Reached:

Describe how the number listed above is calculated.

Describe how Anticipated Number Reached is calculated:

If your proposed work serves multiple counties that include both rural and urban counties, select the option that best defines the work. Your organization does not have to work in all 64 counties to be considered "statewide."

Geography:

Geographical Area Served:

County or Counties Served by Project: (Option to add counties in the online application)

Please only select age ranges for the proposed work. Do not select every age group served by your organization.

Age Group(s) Served by Proposed work:

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PEOPLE SERVED

This question asks about the demographics of your entire organization, not just the proposed work in your application.

What percentage of the people you serve self-identify as a person of color?

If "Do not track":

Select the primary reason for not tracking this information:

This question asks about the demographics of your entire organization, not just the proposed work in your application.

What percentage of the people you serve live with low income?

If "Do not track":

Select the primary reason for not tracking this information:

This question asks about the demographics of your entire organization, not just the proposed work in your application.

Is serving or representing a specific community part of your organization's mission?

☐ Yes

☐ No

We recognize that many young people hold multiple, intersecting identities and may experience overlapping forms of inequity. However, explicit focus means that an organization was established to meet the unique needs of a specific population. It is very rare for any organization to select "yes" to more than two priority populations.

If yes, please answer the question below for each of CFC's priority populations.

Do at least 90% of the people served self-identify as: *(answer yes or no)*

- → **a person of color?**
- → **2SLGBTQIA+?**
- → **living with visible or invisible disabilities in low-income families and/or under-resourced communities?**
- → **living with newly arrived, immigrant, or refugee families?**
- → **experiencing housing insecurity?**
- → **experiencing interpersonal or family violence or abuse?**
- → **experiencing the child welfare system?**
- → **being involved in the juvenile justice system?**
- → **experiencing family instability or separation due to parents or caregivers' involvement in the justice system?**
- → **being raised by grandparents or other family caregivers?**
- → **young parents (under 26 years old)?**

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SECTION 5: Budget Overview

Applicants must include the amount requested for each allowable cost and provide a brief narrative (200 words). Applicants may request up to $50,000 for a 12-month grant period (total).

To support budget development, clinics may use the following guidance based on the number of patients of reproductive age served annually:
Recommended Grant Amounts Based on Clinic Volume

- **Small clinics (serving fewer than 300 patients of reproductive age/year): $25,000–$30,000**
- **Medium clinics (serving 300–800 patients of reproductive age/year): $31,000–$40,000**
- **Large clinics (serving more than 800 patients of reproductive age/year): $41,000–$50,000**

Question	Guidance for Budget Figures	Guidance for Narrative
Total Reproductive Health Program Budget:	Please include the total operating budget for your organization's reproductive health program. This is NOT the total amount you're applying for from Choose When.	n/a
Amount requested for the purchase and stocking of all methods of contraception to ensure that people with financial barriers to care can access the method of their choice, ideally on the same day that they access healthcare:	Applicants should enter the total dollar amount requested to support the purchase and ongoing stocking of a full range of contraceptive methods so that patients with financial barriers can access their method of choice, ideally on the same day they receive care. Please note: Choose When will also cover the costs of vasectomy care as a contraceptive method.	Describe how funds will be used to reduce or eliminate cost barriers for patients, including those who are uninsured, underinsured, or in need of confidential services.
Amount requested for the cost of office visits to provide person-centered contraceptive care:	Include costs associated with contraceptive-related visits, such as provider time for counseling, method initiation, method switching, follow-up visits, LARC insertions, LARC removals, vasectomy care, and visits that support same-day access to contraception. Base the request on projected visit volume for patients who are uninsured, underinsured, or in need of confidential services.	Describe how funds will offset patient costs for Choose When's priority populations. Consider a person-centered care approach, ensuring that visits allow adequate time for health education and respectful, non-coercive counseling.
Amount requested for health educators who work in partnership with healthcare providers on	Include costs for health educators directly involved in reproductive and sexual health education, such as time for health educator staff to provide	Describe how funds supporting health education will improve access for Choose When's priority populations.

one-on-one or small group education on reproductive and sexual health that is inclusive of cultural or 2SLGBTQIA+ needs:	one-on-one or small group education on reproductive and sexual health.	
Amount requested for provider training to ensure that people can access the contraceptive method of their choice:	Include training costs directly related to contraceptive care, such as clinical skill-building (e.g., insertion and removal of IUDs and implants), counseling techniques, and updates on contraceptive methods. Please note: Provider training on insertion and removal of LARCs and vasectomy care will be prioritized.	Specify who will be trained, such as doctors, nurse practitioners, physician assistants, , nurses, medical assistants, or other staff involved in contraceptive service delivery, and describe their role in improving access. Provide detail on registration fees, trainer costs, materials, and/or travel.
Amount requested for focused outreach to populations with barriers to healthcare to help bring down disparities in access to contraceptive care:	Base the request on realistic outreach plans, including anticipated reach, frequency of activities, staffing support, over the project period.	Describe the populations the outreach is intended to reach, such as individuals who are uninsured or underinsured, adolescents and young adults, rural communities, communities of color, immigrants and refugees, 2SLGBTQIA+ individuals, or others facing structural or systemic barriers to contraceptive care.

SECTION 6: Learning and Assessment

The Choose When team has identified the pre-populated outcome as part of this grant award. The outcome for all grantees is:
Increase access to free-of-cost contraceptive methods -- including long-acting reversible contraceptives (LARCs) and equitable, person-centered contraceptive care -- to Choose When's priority populations.

All grantees will be required to report on this outcome in their final reports.
Applicants must identify at least one objective (up to three).

Question	Guidance
Define at least one objective:	**If funded, all reports will be based on the objectives that you have identified in your application.** **OBJECTIVE: How are we going to achieve the outcome?** Objectives define the steps you will take to achieve the outcomes. Objectives should be specific, measurable, achievable, relevant, and time-bound. *Example #1:* Expand access to person-centered contraceptive care for at least 100 young people, ages 9 to 18, through increased patient visits, focused outreach in partnership with the local school districts, and training more providers on insertions and removals of LARCs.

	Example #2: Train all three clinic providers on insertions and removals of LARCs to increase patient volume by 25% and provide access to all methods of contraception, same day. *Example #3:* Increase access to affordable and person-centered vasectomy services by supporting the delivery of counseling, referrals, and procedures for at least 2 individuals without insurance seeking vasectomy care. This includes training one provider in vasectomy counseling and procedure.
Do you have another objective for this strategy?	**The applicant does NOT have to submit more than one objective.** If you answer "yes" to this question, you will be prompted to answer the questions again.

SECTION 7: Narrative Questions	
Question	**Guidance**
Describe how your organization provides contraceptive care in your community.	Begin by describing your organization, how person-centered contraceptive care aligns with your organization's mission, and how contraceptive care fits within your overall services. Please include the number of people of reproductive age your organization serves. Explain how patients access contraceptive care through your organization (e.g., through walk-in appointments, same-day scheduling, telehealth, community outreach, or pharmacy partnerships). Share the most significant barriers patients experience when trying to access their preferred contraceptive methods and describe how your team aims to reduce these barriers. Discuss any challenges or capacity gaps that limit your ability to provide fully person-centered contraceptive care, and how additional resources could strengthen access and quality. Finally, highlight any specific approaches or challenges related to serving key populations, including individuals in rural or frontier communities, those living in areas with limited access to affordable care, uninsured or underinsured individuals, adolescents, and people seeking confidential services.
Describe your organization's patient payer mix, and what it reveals about access to contraceptive care in your community.	Provide approximate numbers of patients or visits for each payer category (Medicaid, CHP+, Medicare, Private Insurance, Uninsured, Other) for a recent 12-month period, noting the specific period and whether these figures represent visits, encounters, or unique patients. Briefly describe what this mix indicates about community access and affordability, including any significant gaps, trends, or unmet needs related to contraceptive care, and provide any notes or limitations on the data provided.

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SECTION 8: Demographics

Caring for Colorado collects demographic data to help us better understand our grantmaking and evaluate the effectiveness of our work in reflecting our guiding principles and advancing our mission. We aligned these questions with the Candid/GuideStar model for demographic data collection because it was created specifically for the mission-focused nonprofit sector.

We recognize that requesting this information adds to the amount of time it takes to complete the application. We appreciate your willingness to share these details about your board, staff, and communities served.

Answering these questions will not affect your eligibility for funding. **If you do not collect demographic data, you may indicate that below. If you collect some demographic data, please fill out those sections below.** Considering our current environment, we want to assure you that your application data is secure and confidential. Data from applicants or grantees is shared only in an aggregated form across all applicants or grantees.

Important Note: All demographic data questions, including those about communities served, should reflect your **entire organization**, even if your proposed work focuses on a specific program and/or population. You will have the opportunity to explain how the data for your organization's community served differs from the proposed communities served in this proposal.

If you are using a fiscal sponsor, the demographic data questions should represent the entity leading the work, not the fiscal sponsor organization.

Additionally, **only include data that your organization collects—do not use general population data for the communities served section.**

Question	Guidance
IMPORTANT NOTE: Caring for Colorado has provided a demographic template to help you collect the data needed for this section. This is optional, and not a required attachment. You can find the template in Appendix B.	
Do you collect demographic data for your organization and the communities you serve?	If you answer "yes" then you will be led to the next question. If you answer "no" you will be prompted to answer "If your organization does not collect demographic information, please tell us more about why (e.g., capacity, organization priorities, documentation status, etc.)"
Community Served Demographics • Do you collect race and ethnicity demographics for your community? • Do you collect gender identity demographics for your community? • Do you collect sexual orientation demographics for your community? • Do you collect demographics about living with a disability for your community? • Do you collect income demographics for your community?	For each question you answer "yes" to, you'll be prompted to enter the relevant information and confirm the total number of people. Please do not use percentages. Use the total number of people representing each category. Important Reminder: This data should reflect your entire organization, even if your proposed work focuses on a specific program and/or population. You will have the opportunity to explain how the data for your organization's community served differs from the proposed communities served in this proposal.

	***This question is optional**
Is there any other demographic information on people served by your organization and program or project that you'd like to share? If so, please note here.	Please provide any further context needed for the community you serve here. ***This question is optional**
If the target communities of this proposal are different from your current communities served, please explain.	As a reminder, the demographic questions above refer to your overall organization. If the demographics of your proposed work differ from the demographics of your overall organization, please share that information here. For example, a large social services provider may be proposing work that serves young people experiencing homelessness. The demographics data above should reflect the overall organization. This section can be used to share specific demographics for the proposed work, such as, *"100% of young people have experienced homelessness or housing instability, approximately 1/3 identify as 2SLGBTQIA+, and 70% have experienced interpersonal violence."* ***This question is optional**
If you selected "do not collect" for any of the above information, please tell us more about why you do not collect this information (capacity, organization priorities, documentation status, etc.)?	Please provide any context needed for why your organization does not collect specific demographic data. ***A response to this question is only needed if you choose "do not collect" for a demographic question.**

SECTION 9: Financial Information (if applicable)	
Question	**Guidance**
The following section is for application requests exceeding $25,000. Please provide the most current fiscal year-end financial statement of your organization for the requested items below. **IMPORTANT NOTE: The financial section of this application will ask for different information and attachments based on how you answer the following questions.**	
Do you have audited financial statements?	Choose "yes" or "no" If the response is "yes" you will be asked to attach audited financial statements under the document section. If the response is "no" then you will be asked **"Do you have a 990/990EZ?"** If the response is "yes" you will be asked to attach your most recent 990/990EZ under the document section.

	If the response is "no" you will be asked to please attach the most recently completed fiscal year internal financial statement.
Select the end date of the financial period for the financial document referenced above:	Input the end date of the financial document referenced above (e.g., 12/31/2024).
If GuideStar is used, profile seal:	If your organization has a GuideStar profile, please choose the seal color: • Bronze • Silver • Gold • Platinum Select N/A if your organization does not have a GuideStar profile.
Financial Summary: Most Recently Completed Fiscal Year (xxxx) Fiscal Year End (mm/dd) **Financial Information for fiscal year:** (most recent) Total Assets: Total Liabilities: Revenue: Expenses: **Financial Information for fiscal year:** (previous) Total Assets: Total Liabilities: Revenue: Expenses:	Your Total Assets, Total Liabilities, Revenue, and Expenses for the past two fiscal years can be found on your audited financial statements or your 990/990EZ for the most recently completed fiscal year and the prior year. If you do not have audited financial statements or a 990/990EZ, you can use internal statements. **Please note that you must hit "save" after you enter the data to update the financial fields.**

SECTION 10: Documentation	
Question	**Guidance**
Year-to-Date Financial Statements	Attach most current year-to-date internal financial statement (Balance Sheet and Statement of Activities)
Supplemental Financials	You will be asked to upload one of the following based on your responses in Section 3: Financial Information. • Audited Financials from the most recent completed year. • 990/990EZ for the most recently completed fiscal year end. • Most recently completed fiscal year internal statement.
Operating Budget	Attach the current-year annual operating budget.
Optional Attachment	Please consolidate any additional materials into a PDF and attach them as one file.

Caring for Colorado FOUNDATION

IMPORTANT NOTE: Applicants are unable to modify uploaded files. If you make a mistake or need to replace an uploaded file, please email our Grants Management Team at grants@caringforcolorado.org.

APPENDIX A: Template Links	
Template	**Link**
CFC Demographics Template	**Click here** or copy and paste below: https://caringforcolorado.org/wp-content/uploads/2025/10/CFC-Demographics-Template.xlsx **IMPORTANT NOTE: Choose When applicants are not asked about demographics for the organization's board members, staff, and leadership.**

AGENDA ITEM or FINAL CONTRACT REVIEW SUBMITTAL FORM

Agenda Item: Community Resource Network Participation Agreement

Action Requested: Board of County Commissioners' Signature

Parties to the Agreement: Contexture

Term Begins: March 15, 2026 **Term Ends:** **Grant Contract #:**

Summary:

HHS would like to contract with Contexture for the Community Resource Network (CRN).

Fiscal Impact: $3,000

Submitted by: Margaret Wacker **Submitter's Email Address:** mwacker@gunnisoncounty.org

Finance Review: (●) Required ( ) Not Required

Comments:

Reviewed by: GUNCOUNTY1\mrozman Discharge Date: 2/25/2026

County Attorney Review: (●) Required ( ) Not Required

Comments:
Legally sufficient. SO 2/24/26

Reveiwed by: GUNCOUNTY1\sobaid Discharge Date: 2/24/2026 Certificate of Insurance Required

Yes ( ) No (●)

County Manager Review:

Comments:

Reveiwed by: GUNCOUNTY1\mbirnie Discharge Date: 2/25/2026

(●) Consent Agenda ( ) Regular Agenda ( ) Worksession Time Allotted: 0

Agenda Date: 3/3/2026

Revised April 2015

COMMUNITY RESOURCE NETWORK PARTICIPATION AGREEMENT
("Agreement")

CONTEXTURE, a Colorado nonprofit corporation (herein "Contexture")

Address of Contexture:

2000 S. Colorado Blvd.
Tower 1, Ste. 12000
Denver, CO 80222

_____, (herein "PARTICIPANT")

Address of Participant:

_____

_____

Tax I.D. No.: _____

RECITALS

A. Contexture provides the Community Resource Network System ("CRN System") to facilitate the exchange of electronic data, coordinate care and services and improve the quality of health in the community. Contexture may also provide other products or services from time to time. Participant desires to use the CRN System.

B. The placement and use of information in the CRN System and the sharing of such information using the CRN System are subject to various Information Privacy and Protection Laws. By placing information in the CRN System, Participant agrees such information can be disclosed and used as allowed by the CRN System. Participant shall comply with all applicable laws when using or disclosing information through use of the CRN System. Such compliance is required of all persons who are authorized to use the CRN System.

NOW, THEREFORE, in consideration of the recitals set forth above and the mutual promises set forth below, the parties agree as follows:

A. Products and Services Provided and Fees. So long as this Agreement is in effect and Participant and Participant Users comply with all terms of this Agreement, Contexture will provide Participant and Participant Users access to use the CRN System as well as other products and services. Access and use of the CRN System and products and services will be described in an order ("Order"). Orders are further described in attached Exhibit B, and all Orders are considered as part of this Agreement.

B. Agreement to Terms and Conditions. Contexture and Participant agree to all Terms and Conditions, attached.

This Agreement is dated and shall be effective on the date set forth below by Contexture as the effective date.

Contexture, **a Colorado nonprofit corporation**	_____ (print/type name of Participant)
By: _____ (signature)	By: _____ (signature)
Name/Title: _____ (print/type name and title of signatory)	Name/Title: _____ (print/type name and title of signatory)
Effective Date: _____	

TERMS AND CONDITIONS:

1. Definitions. Capitalized terms in this Agreement are defined as follows:

1.1. "Board of Directors" shall mean the Board of Directors of Contexture.

1.2. "Breach" as it relates to HIPAA and PHI shall have the meaning given to such term in Section 13400 of HITECH and 45 C.F.R. 164.402 and as related to other Information Privacy and Protection Laws shall mean the unlawful disclosure of PHI or CSI which results in a requirement to provide notices to Individuals or a governmental entity or requires the taking of other actions related to the unlawful disclosure.

1.3. "Business Associate" shall mean with respect to a Covered Entity, a person who is defined in 45 C.F.R. 160.103.

1.4. "Community Resource Network System" or "CRN System" shall mean the functionality provided as software as a service through access to that portion of the Contexture System used for the exchange of CSI and limited PHI for services and care coordination purposes. The CRN System expressly does not include health information exchange functionality of the Contexture System.

1.5. "Community Services Information" or "CSI" means information created, maintained, or received by a public, governmental or private entity, including information that relates to the past, present or future need for or provision of services related to an Individual. CSI is information which is not subject to the requirements of HIPAA.

1.6. "Covered Entity" shall have the meaning of the term "Covered Entity" as defined in 45 C.F.R. 160.103.

1.7. "De-identification" shall mean to remove, encode, encrypt, or otherwise eliminate or conceal data which identifies an Individual, or modifies information so that there is no reasonable basis to believe that the information can be used to identify an Individual. De-identification includes, without limitation, any process meeting the requirements for De-identification set forth in 45 C.F.R. § 164.514, as such provision is currently drafted and as it may be subsequently updated, amended, or revised.

1.8. "Designated Record Set" means Protected Health Information maintained by or for Participant that is: (a) the medical records and billing records about Individuals maintained by or for a covered health care provider; (b) the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or (c) used, in whole or in part, by or for Participant to make decisions about Individuals.

1.9. "Disclose," "Disclosing," or "Disclosure" means the release, transfer, provision of access to, or divulging in any manner of information outside the entity holding the information.

1.10. "HITECH" means the Health Information Technology for Economic and Clinical Health Act in the American Recovery and Reinvestment Act of 2009, including any implementing regulations.

1.11. "Individual" means a natural person who is the subject of PHI or CSI.

1.12. "Information Privacy and Protection Laws" mean: (a) the Health Insurance Portability and Accountability Act of 1996, as amended and including any implementing regulations ("HIPAA"); (b) HITECH; (c) the Gramm-Leach-Bliley Act, as amended and including any implementing regulations; (d) any statute, regulation, administrative or judicial ruling requiring a party to protect the privacy or security of information pertaining to an Individual, and/or the payment for care for an Individual; (e) any statute, regulation, administrative or judicial ruling requiring a party to protect the privacy of information pertaining to the financial or credit status or condition of an individual; (f) any statute, regulation, administrative or judicial ruling requiring a party to protect information pertaining to individuals based upon the individuals' status as consumers; and (g) any other statute, regulation, administrative or judicial ruling requiring a party to protect the confidentiality, privacy and/or security of information pertaining to individuals; all to the extent that such Information Privacy and Protection Laws have been enacted, promulgated, issued or published by any federal or state governmental

authority with jurisdiction over a Covered Entity, a Business Associate, an individual, Participant or Contexture.

1.13. "Network Account" shall mean the right given to Participant to access and use of the Contexture System by Participant and Participant Users.

1.14. "Participant User" shall mean any person accepted by Contexture and who is authorized to use the Contexture System through Participant's right of use set forth in this Agreement. Participant shall designate Participant Users.

1.15. "Protected Health Information," or "PHI," shall have the same meaning as the term "protected health information" in 45 C.F.R. 160.103 and 164.501.

1.16. "Contexture participant" shall mean a person or entity which has entered into an agreement with Contexture to allow such person or entity to use the Contexture System.

1.17. "Contexture System" shall mean the technology tools, application, software, services and systems Contexture provides and/or maintains for use by Third Parties to facilitate the electronic exchange of information or other lawful purposes as may be determined by Contexture. The Contexture System includes the Community Resource Network System.

1.18. "Contexture's Standards" shall mean those standards, policies and procedures adopted by Contexture or Quality Health Network, a Contexture affiliate, which address requirements and standards with regard to Use of the Contexture System. Contexture's Standards may address and include but are not limited to: activity on the CRN System, operating rules, definitions and specifications of format, content, and transmission of electronic data, support descriptions and details of connecting to the CRN System.

1.19. "Receive," "Receiving," and "Receipt" means: (a) to take physical delivery of media containing information; or (b) in the case of electronic delivery, for information to come into existence in a party's information processing system in a form capable of being processed by or perceived from a system of that type by the Receiving party if the Receiving party has designated that system or address as a place for Receipt of information to a Disclosing party and the Disclosing party does not know that the information cannot be accessed from the particular system.

1.20. "Security Incident" shall mean the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in Participant's or Contexture's information system, as applicable.

1.21. "Security Rule" means the Security Standards for Protection of Electronic Protected Health Information at 45 C.F.R. Part 164, Subpart C.

1.22. "Third Party" means any individual, person, or organization not a party to this Agreement.

1.23. "Transaction" means the Transmission of information between parties to this Agreement.

1.24. "Transmit," "Transmitted," or "Transmission" means the transfer of information by one party to another, regardless of the method or technology used to transfer the information.

1.25. "Use" shall mean the sharing, employment, application, utilization, examination, analysis, De-identification, or commingling with other information, of information by a party that holds that information.

Terms used but not otherwise defined in this Agreement but used in relation to HIPAA shall have the same meaning as those terms are given under HIPAA.

2. Duties and Obligations of Contexture.

2.1. Use of CRN System. Subject to all terms of this Agreement, Contexture grants Participant a nonexclusive, nontransferable, and non-sublicensable right for Participant and Participant Users to access and use the CRN System for the uses described in an Order.

2.2. Data Storage and Distribution. PHI and CSI within the CRN System will be available to Participant and Participant Users in accordance with this Agreement, Contexture's Standards and applicable laws.

2.3. Data Backup. Contexture shall maintain requisite disk space for the storage of software and data as determined in Contexture's Standards. Backups will be regularly performed and stored in a secured off-site location.

2.4. Data and Information Uses and Disclosures. Contexture may use and disclose PHI and CSI provided by Participant (a) to operate the CRN System and for purposes of Treatment, Payment and Health Care Operations (as those terms are defined in HIPAA) (b) for quality improvement programs, practice management, research, and (c) for such other uses as may be allowed by applicable law provided that such use is consistent with Contexture's Standards and requirements of applicable law. Participant authorizes Contexture to facilitate establishment of care coordination teams, and Use and Disclose PHI and CSI to facilitate care coordination by and among such care coordination teams as allowed by applicable law. Care coordination teams may be composed of Covered Entities and social welfare/human service organizations that provide services to Individuals. Social welfare/human service organizations that provide services to Individuals may be added to such Individual's care coordination team in compliance with this agreement.

2.5. Inquiries from Individuals. Should Contexture receive from an Individual, or a person with a proper authorization, a request for data specific to such Individual, Contexture shall either redirect the Individual or person, to the Participant or provide such data as allowed by applicable law.

2.6. Right to Audit. Contexture shall have the right to audit Participant's and Participant Users' use of the CRN System to ascertain compliance with Contexture's Standards and applicable law with regard to use of the CRN System. The results of such audits may be shared with Participant and the Contexture Board of Directors.

2.7. Right to Impose Sanctions. Contexture shall have the right to impose sanctions on Participant and a Participant User should Participant or Participant User's use of the CRN System be in violation of this Agreement, Contexture's Standards or applicable law.

2.8. Liability Insurance. Contexture shall purchase and/or maintain general liability insurance or a self-insurance plan which provides coverage to Contexture of not less than one million dollars ($1,000,000) per incident per year.

2.9. Indemnity. Contexture agrees to indemnify Participant from any and all claims, demands, actions, and causes of action asserted by a Third Party against Participant which may result or arise out of any actions or omissions of Contexture or any of Contexture's agents, employees, or representatives due to Contexture's failure to comply with privacy or security obligations under this Agreement or imposed by law or Contexture's failure to comply with the terms of this Agreement. This indemnity shall include the payment to Participant for attorney's fees, court costs and expert witness fees Participant incurs in defending itself from any such claims, demands, actions or cause of action. For this indemnity obligation to apply, Participant shall: (a) provide Contexture notice in writing upon the discovery of the claim; (b) fully cooperate with Contexture in the defense of the claim; and (c) not settle the claim without the prior written consent of Contexture, which consent shall not be unreasonably withheld. If there is a Breach by Contexture and/or Contexture's agents or subcontractors in the course of Contexture providing services to Participant and Participant is required by law to notify the involved Individual(s) of whom such Breach pertains and/or any governmental entity as may be required by law, Contexture shall pay all Participant's reasonable notification costs and, as mutually agreed by the parties, reasonable costs associated with mitigating any harmful effects of such Breach. For purposes of this paragraph, a Contexture agent or subcontractor shall mean those persons or entities that have a contract with Contexture to provide Contexture with products or services. Contexture's liability under this paragraph shall not exceed one million dollars ($1,000,000) or the limits of Contexture's available insurance coverage, whichever is greater.

2.10. **DISCLAIMER. CONTEXTURE MAKES NO WARRANTIES, EXPRESS OR IMPLIED, WITH REGARD TO THE CRN SYSTEM, INCLUDING BUT NOT LIMITED TO, ANY WARRANTY OF NONINFRINGEMENT, OR THE IMPLIED WARRANTY OF MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE REGARDLESS OF THE SERVICES OR**

RESOURCES PROVIDED BY IT. CONTEXTURE DISCLAIMS ANY LIABILITY FOR THE FAILURE OF PERSON WHO USES THE CRN SYSTEM TO COMPLY WITH CONTEXTURE'S STANDARDS OR APPLICABLE LAW OR THE CONTENT OR USE OF THE CRN SYSTEM BY ANY SUCH PERSON. CONTEXTURE DOES NOT WARRANT UNINTERRUPTED OR ERROR FREE OPERATION OF THE CRN SYSTEM OR THE COMPATIBILITY OF THE CRN SYSTEM WITH ANY PARTICULAR HARDWARE, SOFTWARE OR INTER-CONNECTIVITY WITH OTHER NETWORKS OR SERVICES.

2.11. LIMITATION OF LIABILITY. EXCEPT FOR CONTEXTURE'S LIABILITY OBLIGATIONS AS EXPRESSLY SET FORTH IN THE INDEMNITY PARAGRAPH OF THIS AGREEMENT, REGARDLESS OF WHETHER ANY REMEDY FAILS OF ITS ESSENTIAL PURPOSE, THE MAXIMUM LIABILITY OF CONTEXTURE UNDER THIS AGREEMENT SHALL NOT EXCEED THE TOTAL AMOUNT PAID BY PARTICIPANT TO CONTEXTURE TO OBTAIN SERVICES UNDER THIS AGREEMENT FOR THE TWELVE (12) MONTH PERIOD PRECEDING THE DATE THE LIABILITY AROSE. IN NO EVENT, AND WHETHER OR NOT CONTEXTURE WAS OR SHOULD HAVE BEEN AWARE OR ADVISED OF THE POSSIBILITY OF SUCH DAMAGE, SHALL CONTEXTURE BE LIABLE FOR SPECIAL, INDIRECT, INCIDENTAL, CONSEQUENTIAL, OR EXEMPLARY DAMAGES INCLUDING WITHOUT LIMITATION, LOST DATA OR INFORMATION, LOST PROFITS, COSTS OF PROCUREMENT OF SUBSTITUTE SERVICES, OR INJURY TO REPUTATION.

3. Duties and Obligations of Participant.

3.1. Assistance and Cooperation with Contexture in Providing Products and Services. Participant, at its sole cost and expense, shall assist, cooperate and work in good faith with Contexture to provide the products and services described in an Order.

3.2. Complying with Contexture's Standards In Use of CRN System. When using the CRN System, Participant and Participant Users shall comply with this Agreement, Contexture's Standards and applicable law. Participant specifically agrees to be subject to Contexture's Standards. Contexture's Standards are subject to amendment, revision and modification by Contexture solely in its discretion. Changes to Contexture's Standards may reflect changes in applicable law or the need to adopt new technologies, systems, or desired functionality or changes in Contexture's operational policies. Participant is encouraged to provide input to Contexture regarding Contexture's Standards and to propose changes. Contexture's Standards may be reviewed upon request.

3.3. Participant Restrictions. Participant will not, and will not permit any Participant User or Third Party to: (a) alter, modify, reverse engineer, decompile, disassemble, or otherwise attempt to derive the method of operation of the CRN System; (b) interfere in any manner with the hosting of the CRN System; (c) use the CRN System for other than Participant's or the Participant User's own business purposes; (d) use the CRN System for purposes of providing outsourcing, service bureau, hosting, application service provider or online services to Third-Parties, or otherwise make access to the CRN System available to any Third-Party not related to or affiliated with Participant; or (e) use the CRN System for any purpose that is illegal in any way, or that advocates illegal activity. Participant will keep intact and will not alter, obscure or remove any notices or legends provided on or in connection with the CRN System.

3.4. Participant Responsibility for Data. Contexture provides tools for Participant Users to use the CRN System but otherwise does not act in any other way for Participant. Participant's decision to place certain data in and use the CRN System is based on Participant's sole discretion. By placing PHI or CSI in the CRN System, Participant is certifying to Contexture that such PHI or CSI can be Disclosed to and Used: (a) by Covered Entities for purposes of treatment, payment and healthcare operations; (b) by organizations for care coordination purposes; (c) for purposes of improving the health or well-being of an Individual; and (d) for uses allowed under this Agreement.

Except as may otherwise be agreed to by Contexture in writing, Participant shall not at any time place any record in the CRN System if that record is subject to disclosure restrictions under 42 U.S.C. 290dd which concerns substance abuse records. As between Participant and Contexture, Participant is solely responsible for establishing the connection to the CRN System, the proper transmission and receipt of data, for implementing sufficient safeguards and procedures to satisfy particular requirements for access, security, privacy and accuracy of data placed in or transmitted by Participant in Using the CRN System. If a Participant User works at multiple practice locations, the Participant User is responsible for ensuring that any PHI or CSI routed between locations for the Participant User will be maintained and Used in compliance with Information Privacy and Protection Laws at each location. Backup of data located on Participant's own computer components is Participant's responsibility. In some instances, Contexture may interpret data, provide data analytics or provide other data that may be Used by Participant or Participant Users. Contexture disclaims any warranty or representation as to the accuracy or completeness of this data and any other data in the CRN System. Participant and Participant Users are responsible for verifying the accuracy and completeness of data Used. Contexture is not responsible for the contents of data that Participant or any other person or entity places in or obtains from the CRN System. Participant and Participant Users hereby release Contexture from any claims whatsoever as to the completeness or accuracy of data in the CRN System.

3.5. Contact Information. Participant agrees to notify Contexture in writing as soon as possible as to any change in status of a Participant User. Participant is responsible for and shall provide Contexture with the most current name and contact information for Participant and all Participant Users.

3.6. Training of Staff. Compliance with applicable federal and state laws, rules and regulations concerning adequate training of staff is the sole responsibility of the Participant.

3.7. Resources. Participant, at Participant's own expense: (a) shall cooperate and work in good faith with Contexture to establish connectivity to the CRN System and to allow Contexture to provide the products and services described in Orders; and (b) shall provide, install and maintain necessary hardware, software, equipment and services necessary to connect to, access or use the CRN System.

3.8. Responsibility for Network Account. Participant shall be solely responsible for all Use of its Network Account, for payment of charges incurred for such Use, and for violations of the terms of this Agreement by anyone using the Network Account.

3.9. Warranties with Use. By its Use of the CRN System, Participant warrants: (a) that Participant's and Participant Users' use of the CRN System is in compliance with the terms of this Agreement; (b) that Participant's and Participant Users' Use of the CRN System and placement of information in the CRN System is in compliance with applicable laws; (c) that Participant has obtained any and all consents or authorizations from Individuals as may be necessary, whether required by law, Contexture Standards, or other applicable requirements, before Participant engages in any Use or Disclosure of or access to PHI or CSI; and (d) that Participant and Participant Users shall only Use and Disclose PHI and CSI as allowed by law.

3.10. Liability Insurance. Participant shall purchase and/or maintain general liability insurance or a self-insurance plan which provides coverage to Participant of not less than one million dollars ($1,000,000) per incident per year.

3.11. Indemnity. Participant agrees to indemnify Contexture and hold Contexture harmless from any and all claims, demands, actions, and causes of action asserted by a Third Party against Contexture which may result or arise out of any actions of Participant or any Participant User who becomes an authorized user through this Agreement or any use through Participant's Network Account. This indemnity shall include the payment to Contexture for attorney's fees, court costs and expert witness fees Contexture incurs in defending itself from any such claims, demands, actions or cause of action. For this indemnity obligation to apply, Contexture shall: (a) provide Participant notice in writing upon the discovery of the claim; (b) fully cooperate with Participant in the defense of the claim; and (c) not settle the claim without the prior written consent of Participant, which consent shall

not be unreasonably withheld. If there is a Breach by Participant and/or Participant's agents or subcontractors in the course of Contexture providing services to Participant and Contexture is required by law to notify the involved Individual(s) of whom such Breach pertains and/or any governmental entity as may be required by law, Participant shall pay all Contexture's reasonable notification costs and, as mutually agreed by the parties, reasonable costs associated with mitigating any harmful effects of such Breach. For purposes of this paragraph, a Participant agent or subcontractor shall mean those persons or entities that have a contract with Participant to provide Participant with products or services. Participant's liability under this paragraph shall not exceed one million dollars ($1,000,000) or the limits of Participant's available insurance coverage, whichever is greater.

3.12. Rights in Products and Confidential Information. Participant shall not assert and shall not have any ownership rights or other property rights in any of Contexture's Standards, the CRN System or any information or materials furnished by Contexture to Participant. Participant agrees that the parties from whom Contexture licenses the software products and related documentation ("Products") which may be used in the CRN System, own all right, title and interest in such Products. Participant will not delete or in any manner alter the copyright, trademark or other proprietary rights or notices of the parties from whom Contexture licenses the Products or from Contexture appearing on the Products as delivered to Participant. Participant will reproduce such notices on all copies it makes of the Products. Participant will treat this Agreement, source codes and other business and technical information relating to the Products and relating to Contexture's Standards or the CRN System as confidential information and will not disclose the same except as may be required under applicable law or as may be necessary to perform its duties and obligations under this Agreement.

3.13. Compliance with Contexture's Agreements with Other Participants. Participant shall not take any action that would result in Contexture's violation of requirements of the Community Resource Network Agreements or other similar agreements that facilitate the lawful exchange of PHI and CSI that Contexture has entered into with other participants.

4. Confidentiality and Privacy-Covered Entity and Business Associates. If Participant is a Covered Entity for which Contexture is performing functions as a Business Associate of Participant, then Contexture and Participant agree to be bound to the terms of the Business Associate Agreement attached as Exhibit A to this Agreement.

5. Confidentiality and Privacy-CSI.

5.1. Terms Applicable if Participant is Not Acting in the Capacity of a Covered Entity or Business Associate. This Section 5 shall apply (a) if Participant is not a Covered Entity or a Business Associate of a Covered Entity, and (b) to the extent Participant is not acting in the capacity of a Covered Entity or Business Associate of a Covered Entity in its use of the CRN System to access CSI (even if Participant is a Covered Entity or Business Associate for other purposes and activities).

5.2. Permitted Uses and Disclosures of an Individual's Community Services Information by Contexture. The scope of CSI that may be Used, Disclosed, or accessed and/or the functions performed by Contexture includes CSI necessary to perform functions and uses permitted or required by this Agreement. Contexture may Use, Disclose, and access CSI for the proper management and administration of Contexture, to carry out legal responsibilities of Contexture, or to analyze CSI and create de-identified information for purposes of data analysis, research and in furtherance of generalizable knowledge as may be allowed by applicable law. Contexture may Use, Disclose and access CSI in providing care coordination and data aggregation services for the Participant, Covered Entities, and other Contexture participants that have entered agreements that are identical to, or substantially similar to, this Agreement. Contexture will not Use, Disclose, or access CSI in violation of any applicable law.

5.3. Authority to Access and Use CSI. Participant warrants and represents that it is authorized or permitted by applicable law to have access to and use CSI. Participant shall immediately notify Contexture if Participant is no longer permitted by applicable law to access CSI. In such case, Participant will cease all access to the CRN System.

5.4. Amendment to Records. Contexture agrees to allow Participant to make any amendment(s) to CSI in Contexture's possession that Participant initially provided for inclusion in the CRN System in the time and manner designated by Participant. Participant shall only make such amendments as may be allowed or required by applicable law.

5.5. Privacy Practices. Before placing an Individual's CSI in the CRN System, Participant shall, to the extent required by law, obtain any permission or consent from the Individual necessary to allow such placement. Before accessing, Using or Disclosing an Individual's CSI that was not placed in the CRN System by the Participant, the Participant shall, to the extent required by law or applicable Contexture Standards, confirm that an authorization from the Individual allowing such access, Use and Disclosure has been obtained. Such authorization shall allow the Individual's CSI to be Used by or Disclosed to other Contexture participants as allowed by this Agreement. If Participant obtained such authorization, Participant shall provide documentation of such authorization to Contexture upon request, maintain a copy of the authorization on behalf of Contexture and upload a copy of the authorization to the CRN System as required by Contexture Standards. Participant shall notify Contexture of any changes in, or revocation of, the authorization by an Individual to Use or Disclose his or her CSI. Participant's access to and use of CSI in the CRN System shall be limited to use of CSI for the purposes authorized by law and for no other purposes.

5.6. Notice of Security Incidents or Breach. Participant shall notify Contexture of: (a) any Security Incident involving CSI of which it becomes aware; (b) any Use or Disclosure of CSI not permitted by or contrary to the terms of this Agreement of which Participant becomes aware; and (c) any Breach of unsecured CSI following the discovery of such Breach. In any event, such notice of the above events will be provided without unreasonable delay and in no case later than five (5) days after discovery. Contexture and Participant will cooperate with each other with regard to reporting of any such events or a Breach as required by law.

5.7. Incorporation of Additional Requirements; Construction. The requirements of applicable law pertaining to CSI are, to the extent not adequately provided for in this Agreement, hereby incorporated by this reference and shall become a part of this Agreement. This Agreement shall be construed as broadly as necessary to implement and comply with Information Privacy and Protection Laws and other laws that may be applicable to certain types or categories of CSI. Notwithstanding the foregoing, Contexture shall not be responsible for ensuring compliance with any legal requirements that apply to Participant, including but not limited to requirements to obtain consent or authorization from Individual's prior to CSI being placed in the CRN System and being Disclosed to other Contexture participants as allowed by this Agreement.

6. Arbitration.

6.1. Agreement to Arbitrate. Except to recover unpaid fees for use of the CRN System in amounts up to twenty thousand dollars ($20,000.00) or to obtain injunctive relief, any claim arising out of or in any way related to the rights, duties and obligations described in this Agreement shall be submitted to final and binding arbitration in accordance with this paragraph, and such claim shall be submitted to arbitration within one (1) year of the event on which the claim is based. Notwithstanding any other provision of this Agreement, Contexture may sue in any court of competent jurisdiction to recover unpaid fees in amounts up to twenty thousand dollars ($20,000.00) or to obtain injunctive relief.

6.2. Arbitration Procedures. The arbitration shall be governed by the Colorado Uniform Arbitration Act, section 13-22-201, et seq., C.R.S., except as otherwise expressly provided herein. The panel of arbitrators shall consist of three arbitrators. One arbitrator shall be selected by one party, one arbitrator shall be selected by the other party, and the third arbitrator shall be selected by the two arbitrators that have been chosen. If the two arbitrators are unable to agree to the selection of a third arbitrator, the third arbitrator shall be selected in accordance with the Colorado Uniform Arbitration Act. Each party shall be required to make "Disclosures" as set forth in Colorado Rule of Civil Procedure (C.R.C.P.) 26(a)(1), which disclosures shall be made within ten (10) days after a date is selected for the arbitration hearing. In

addition to such disclosures, each party shall disclose to the other party the "Disclosure of Expert Testimony" as set forth in C.R.C.P. 26(a)(2)(A) and 26(a)(2)(B), which disclosures shall be made at least twenty (20) days prior to the date of the arbitration hearing. The arbitration shall be conducted in either Denver County or Mesa County, Colorado as agreed upon by the Parties, or if the Parties cannot agree, as determined by the arbitrators. The arbitrators shall follow Colorado law in making an award. Written findings of fact and conclusions of law shall be issued by the arbitrators.

6.3. Powers of Arbitrators -- Enforcement of Award. The arbitrators shall have all powers as set forth in section 13-22-201, et seq., C.R.S. The decision or award of the arbitrators shall be binding upon the parties to the same extent and to the same degree as if the matter had been adjudicated by a court of competent jurisdiction. The party in whose favor any award shall be made may file the same with the Clerk of the Denver County or Mesa County, Colorado District Court, which may enter a judgment thereon, and if such award requires the payment of money, the Clerk may issue execution therefore. Each party, however, shall pay its own attorneys' fees and costs of arbitration, including filing fees, arbitration fees, and other costs. Fees and expenses incurred by the arbitrator that each party chooses shall be paid by that party. Each party shall pay one-half of the fees and expenses incurred by the arbitrator chosen by the other two arbitrators.

6.4. Jurisdiction and Venue. No court shall have subject matter jurisdiction over any claim set forth in paragraph 6. The dispute procedure in this paragraph 6 is the exclusive and mandatory dispute resolution procedure under this Agreement.

6.5. Time Requirements. All time periods to take or request action provided or required under this paragraph 6 shall be strictly construed and shall be of the essence of this Agreement.

7. Termination.

7.1. Unilateral Termination. This Agreement may be terminated by Contexture or Participant with or without cause on at least sixty (60) days' prior written notice to the other party.

7.2. Participant's Right to Termination.

7.2.1. Participant may terminate this Agreement upon thirty (30) days' prior written notice to Contexture should Contexture's Standards change regarding Use of the CRN System in a manner that Participant reasonably believes lessens the safeguards on accessing the data that is available through Use of the CRN System.

7.2.2. Participant may terminate this Agreement upon thirty (30) days' prior written notice to Contexture should Contexture change the fees referenced on the applicable Order . Notice of termination under this subparagraph must be given by Participant within thirty (30) days of Contexture changing the fees.

7.3. Termination for Material Breach. Notwithstanding anything to the contrary in this Agreement, upon gaining knowledge of a material breach of the terms of this Agreement by a party to this Agreement, the non-breaching party may: (a) if the breach cannot be cured, terminate this Agreement upon thirty (30) days written notice to the breaching party; or (b) if the breach can be cured, provide at least ten (10) business days written notice of the breach to the breaching party and the opportunity to cure the same within the ten (10) day period or be subject to termination of this Agreement within thirty (30) days.

7.4. Contexture's Right to Termination / Suspension.

7.4.1. Contexture may terminate this Agreement upon written notice to Participant should Contexture determine or become aware that: (a) Participant or Participant Users have not complied with Contexture's Standards, Information Privacy and Protection Laws or requirements of applicable law with regard to Use of the CRN System and fail to cure such noncompliance within ten (10) business days after receiving notice of such noncompliance from Contexture; (b) Participant's license, if any, to provide health care services is terminated or suspended; or (c) Participant has engaged in any pattern or practice that would constitute a violation of this Agreement and Participant fails to discontinue such conduct within ten (10) business days after receiving notice of such noncompliance from Contexture.

7.4.2. Contexture may terminate this Agreement upon written notice to Participant if Participant fails to pay amounts owed to Contexture when due, and such failure to pay continues for thirty (30) days after written notice from Contexture.

7.4.3. Contexture may also immediately suspend a Participant or Participant User's access to the CRN System, without terminating this Agreement, pursuant to terms of Contexture's Standards.

7.5. Participant Rights Upon Termination. Upon termination of this Agreement, Contexture may retain data received from Participant. If such data is PHI, Contexture will continue to use appropriate safeguards and comply with Subpart C of 45 C.F.R. Part 164 with respect to electronic PHI to protect Use or Disclosure of the PHI for as long as Contexture retains the PHI, and for data that is not PHI, Contexture shall comply with all applicable laws to safeguard the confidentiality of such data. Such PHI retained by Contexture shall be subject to the same conditions of this Agreement which applied prior to termination. The provisions of paragraphs 4 and 5 of this Agreement shall survive termination of this Agreement and continue to apply to Participant's data not removed from the CRN System. Upon notice of termination for reasons other than termination by Contexture under paragraph 7.3 or paragraph 7.4.1 of this Agreement, Contexture and Participant shall agree upon a reasonable time (not to exceed one hundred eighty (180) days from the effective date of termination) and terms and conditions within which Participant may continue use of the CRN System. During this time period, Participant may continue use of the CRN System in accordance with this Agreement, and the parties shall be subject to all terms of this Agreement and any agreement between the parties regarding the termination, including payment of all amounts that may be owed to Contexture.

8. General Provisions.

8.1. Compliance with Law. Contexture, Participant and each Participant User shall comply with applicable laws regarding use of the CRN System. This Agreement shall be interpreted to the maximum extent possible as being consistent with such laws.

8.2. Independent Contractor. This Agreement is intended to create the relationship of independent contractor between Participant and Contexture. Nothing contained herein shall be interpreted to create any relationship of agency, employment, partnership or joint venture between Contexture and Participant. Neither party shall represent or hold themselves out to any person or entity other than is consistent with the relationship of independent contractor.

8.3. Entire Agreement. This Agreement, and the Exhibits attached to this Agreement, constitute the entire understanding and agreement of the parties, and shall supersede all prior understandings and agreements of the parties on the subject matter of this Agreement.

8.4. Amendment. Except as otherwise set forth in this Agreement, this Agreement shall not be changed, modified or altered except by amendment, which, to be valid and enforceable, shall be in writing and signed by the parties. Notwithstanding the foregoing, Contexture may unilaterally amend this Agreement to comply with any applicable federal or state laws or regulations, including but not limited to Information Privacy and Protection Laws, effective immediately upon written notice to the Participant, and may otherwise amend the terms of this Agreement effective upon ninety (90) days prior written notice to the Participant. Participant's use of the CRN System after the effective date specified in such notice shall constitute acceptance of the amendment. Notwithstanding the foregoing, Contexture's Standards may be modified as provided in this Agreement.

8.5. Notices. Either party may send any notices required pursuant to this Agreement, except notices of termination and notices regarding indemnity obligations, by first class mail, electronic transmission, certified mail or a recognized overnight delivery service, to the last known physical or electronic address for Participant in Contexture's records. All termination notices under this Agreement by either party, and all notices regarding indemnity obligations, shall be made in writing and sent via certified mail, return receipt requested, or a recognized overnight delivery service, to the addresses of the parties set forth above.

8.6. Assignment. Except as set forth in this paragraph, neither party's rights, duties and responsibilities pursuant to this Agreement may be assigned or delegated without the prior written consent of the other party. This Agreement may be transferred or assigned by a party to a parent, subsidiary or affiliate of a party or an entity with which a party is merged or consolidated, or the purchaser of all or substantially all of a party's assets provided that the transferee assumes all of such party's obligations under this Agreement. Unless Contexture provides notice to the contrary, this Agreement shall be assigned to the sole member of Contexture, Contexture, a Colorado nonprofit corporation, effective as of January 1, 2026.

8.7. Severability. If any provision of this Agreement is held to be invalid or unenforceable, the remaining provisions shall continue in full force and effect, unless the invalid or unenforceable provision is material to this Agreement and its invalidity or unenforceability results in substantial economic detriment to either party to this Agreement.

8.8. Governing Law. This Agreement shall be governed by the laws of the State of Colorado. Except as expressly stated otherwise in this Agreement, jurisdiction for any dispute under this Agreement that is not subject to the mandatory arbitration requirements hereof shall be in the appropriate state or federal court located in either Denver County or Mesa County, Colorado.

8.9. Benefit. The terms and provisions of this Agreement shall bind and benefit Participant and permitted assigns and shall bind and benefit Contexture and its permitted assigns. There shall be no third-party beneficiaries of this Agreement.

8.10. Interpretation. Any ambiguity or inconsistency in this Agreement shall be resolved in favor of a meaning that permits both parties to comply with applicable laws.

8.11. Non-Exclusion. Each party represents and warrants that it and its employees are not and have not been sanctioned, debarred, excluded or otherwise declared ineligible to participate in any state or federal health care program. If a party is ever sanctioned, debarred, excluded or otherwise declared ineligible for participation in any state or federal health care program, the other party to this Agreement may immediately terminate this Agreement by providing written notice of such termination.

ATTACHMENTS:

Exhibit A: Business Associate Agreement—Covered Entity
Exhibit B: Orders

EXHIBIT A
TO
COMMUNITY RESOURCE NETWORK PARTICIPATION AGREEMENT

Applicability: If Participant is a Covered Entity for which Contexture is performing functions as a Business Associate of Participant, then Contexture and Participant agree to be bound to the terms of this Business Associate Agreement. This Business Associate Agreement is only applicable if Participant is such a Covered Entity.

BUSINESS ASSOCIATE AGREEMENT—Covered Entity

This Business Associate Agreement ("Agreement") is agreed to by Contexture ("Contexture") and "Participant" named in the Community Resource Network Participation Agreement ("Services Agreement") to which this Agreement is attached.

RECITALS:

WHEREAS, Participant is a health care provider or health plan. Participant desires to Use the CRN System provided by Contexture for purposes of promoting the improvement of health care treatment, payment and operations.

WHEREAS Contexture and Participant have entered into the Services Agreement, pursuant to which Contexture will have access to Protected Health Information.

WHEREAS, the relationship between Contexture and Participant created under the terms of this Services Agreement results in Contexture's classification as a "Business Associate" under HIPAA. The HIPAA regulations require Participant to enter agreements that include certain mandated provisions, which are included in this Agreement, with all vendors and contractors that are classified as "Business Associates.

WHEREAS, the purpose of this Agreement is to comply with a federal law, "HIPAA," as defined below, that applies to Contexture and Participant.

THEREFORE, In consideration of the mutual promises below and any fees paid pursuant to the Services Agreement, and the exchange of information pursuant to this Agreement, the parties agree as follows:

I. Definitions. The definitions in the Services Agreement are incorporated herein by this reference. Terms used but not otherwise defined in this Agreement shall have the same meaning as those terms in 45 C.F.R. parts 160 and 164.

II. Contexture and Participant Obligations.

A. Permitted Uses and Disclosures of PHI by Contexture. The scope of PHI that may be Used, Disclosed, or accessed and/or the functions performed by Contexture includes PHI necessary to perform functions permitted or required by the Services Agreement, or to take other measures to satisfy the Participant's obligations under 45 C.F.R. 164.524, as such measures are described in this Agreement. Contexture may, if necessary, Use PHI for the proper management and administration of Contexture, or to

carry out legal responsibilities of Contexture, as may be allowed by the Information Privacy and Protection Laws. Contexture may Disclose PHI for the proper management and administration of Contexture or to carry out the legal responsibilities of Contexture, provided the Disclosures are required by law, or Contexture obtains reasonable assurances from the person to whom the information is Disclosed that the information will remain confidential and Used or further Disclosed only as required by law, or for purposes for which it was Disclosed to the person, and the person notifies Contexture of any instances of which it is aware in which the confidentiality of the information has been Breached. Contexture may Use and Disclose PHI in providing data aggregation services relating to the health care operations of the Participant. Contexture may Use and Disclose PHI as required by law and for public health activities, as provided in 45 C.F.R. 164.512. Contexture will not Use, Disclose, or access PHI in violation of any applicable Information Privacy and Protection Laws. Contexture further agrees to not Use or further Disclose PHI other than as permitted or required by this Agreement or by law. Contexture shall comply with the requirements of HITECH applicable to Contexture as a Business Associate. Except as set forth above, Contexture may not Use or Disclose PHI in a manner that would violate Subpart E of 45 C.F.R. Part 164 if done by Participant.

B. Access to Records. To the extent Contexture has possession of PHI in a Designated Record Set, upon a request made by an Individual Contexture agrees to provide access: (i) at the request of Participant to PHI in a Designated Record Set to Participant (but not to an Individual) as may be necessary to meet the requirements under 45 CFR 164.524; or (ii) directly to the Individual in a manner consistent with Contexture Policies and in compliance with the requirements of 45 C.F.R. 164.524.

C. Amendment to Records. Contexture agrees to allow Participant (but not an Individual) to make any amendment(s) to PHI in a Designated Record Set in Contexture's possession that Participant may be required to make pursuant to 45 CFR 164.526 in the time and manner designated by Participant. Participant shall make such amendments as may be required by applicable law. Contexture will assist Participant as required by law with regard to such amendments. Contexture is not responsible for making any amendments to medical records, or for the accuracy of any amendments made to medical records.

D. Accounting for Disclosure of Records. Contexture shall maintain an accounting or record of all Disclosures of PHI it makes only as required by and in accordance with 45 C.F.R 164.528. Records of Disclosures shall be retained by Contexture for a period of time that complies with HIPAA and other applicable federal or state law requirements pertaining to record retention. The record of the Disclosure shall include the following information: (a) the date of the Disclosure; (b) the name and address of the organization and/or individual receiving the information; (c) a brief description of the information Disclosed; and (d) a copy of all requests for Disclosures. Contexture agrees to provide to Participant (but not an Individual), in the time and manner designated by Participant, information collected in accordance with this section, to permit Participant to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR 164.528.

E. Mitigation. Contexture agrees to mitigate, to the extent practicable, any harmful effect that is known to Contexture of a Use or Disclosure of PHI by Contexture in violation of the requirements of this Agreement.

F. Safeguards and Security Incidents. At all times following the Receipt of PHI, until such time as the PHI is no longer in Contexture's possession or subject to its control:

1. Contexture shall implement administrative, physical, and technical safeguards, as required by the Security Rule, that reasonably and appropriately protect the confidentiality, integrity and availability of PHI that it Receives, maintains, or Transmits on behalf of Participant. Such administrative, physical, and technical safeguards shall be implemented in order to prevent any Use or Disclosure of PHI other than those permitted under this Agreement;

2. Contexture shall notify Participant of any Use or Disclosure of PHI not permitted by or contrary to the terms of this Agreement of which Contexture becomes aware;

3. Contexture shall notify Participant of any Security Incident of which it becomes aware;

4. Contexture shall comply with the requirements of the Information Privacy and Protection Laws in order to notify Participant of any Breach of unsecured PHI following the discovery of such Breach. In any event, such notice will be provided without unreasonable delay and in no case later than thirty (30) days after discovery of a Breach of unsecured PHI. Such notice shall include the identification of each Individual whose unsecured protected health information has been, or is reasonably believed by Contexture to have been, accessed, acquired or disclosed during such Breach. Contexture and Participant will cooperate with each other with regard to reporting of such a Breach if such reporting is required by law.

G. Disclosure of PHI to Third Parties. Contexture may not Disclose PHI to Third Parties except under the following conditions:

1. The Disclosure is of the "minimum necessary" (as that term is defined in HIPAA) information for the purposes of the Disclosure, if such standard is required by applicable law; and

2. The Disclosure is necessary to accomplish a purpose for which the PHI was Disclosed to the Receiving party and is permitted under applicable Information Privacy and Protection Laws and this Agreement.

For purposes of this Agreement, a Participant or Participant User's access and Use of the CRN System shall not be considered a Disclosure of PHI by Contexture under this Agreement.

H. Subcontractors. In accordance with 45 C.F.R. 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, Contexture agrees to ensure that any agent or subcontractor of Contexture agrees to the same restrictions, conditions and requirements as regards PHI that apply

to Contexture throughout this Agreement when such agents or subcontractors are performing any of the tasks, duties, or obligations required of Contexture by this Agreement.

I. De-identified PHI. Contexture is authorized to Use PHI to de-identify the information in accordance with 45 C.F.R. 164.514(a)-(c). Once de-identified, such information may be used or disclosed as allowed by applicable law.

J. Privacy Practices and Restrictions. Participant shall notify Contexture of any limitation(s) in the notice of privacy practices of Participant under 45 C.F.R. 164.520, to the extent that such limitation may affect Contexture's Use or Disclosure of PHI. Participant shall notify Contexture of any changes in, or revocation of, the permission by an Individual to Use or Disclose his or her PHI, to the extent that such changes may affect Contexture's Use or Disclosure of PHI. Participant shall notify Contexture of any restriction on the Use or Disclosure of PHI that Participant has agreed to or is required to abide by under 45 C.F.R. 164.522, to the extent that such restriction may affect Contexture's Use or Disclosure of PHI.

K. Auditing of Records. Contexture agrees to make its internal practices, books, and records relating to its access to, Use, and Disclosure of PHI received from or on behalf of Participant or created by Contexture on behalf of Participant available to Participant or, at the request of Participant, to the U.S. Secretary of the Department of Health and Human Services ("Secretary") in a time and manner designated by Participant or the Secretary for purposes of determining compliance with Information Privacy and Protection Laws.

L. Compliance with Law and Agreement. To the extent Contexture is to carry out one or more of the Participant's obligations under Subpart E of 45 C.F.R. Part 164, Contexture shall comply with the requirements of Subpart E that apply to Participant's performance of such obligations. Each party to this Agreement shall comply with, and as applicable shall require its directors, officers and employees to comply with, all applicable Information Privacy and Protection Laws and with each party's duties and obligations pursuant to this Agreement.

M. Incorporation of Additional Requirements; Construction. The requirements of applicable law pertaining to PHI are, to the extent not adequately provided for in this Agreement, hereby incorporated by this reference and shall become a part of this Agreement. This Agreement shall be construed as broadly as necessary to implement and comply with Information Privacy and Protection Laws.

III. Obligations of Participant.

A. If necessary for Contexture to perform its obligations under the terms of the Services Agreement, Participant shall provide Contexture with the notice of privacy practices that Participant produces in accordance with 45 CFR 164.520, as well as any changes to such notice.

B. Participant shall provide Contexture with any changes in, or revocation of, permission by an Individual to Use or Disclose PHI, if such changes affect Contexture's permitted or required Uses and Disclosures.

C. Participant shall notify Contexture of any restriction to the Use or Disclosure of PHI that Participant has agreed to or any alternate means of communication requirements with an Individual that Participant must comply with in accordance with 45 CFR 164.522.

IV. Term and Termination.

A. Effective Date. The Effective Date of this Agreement shall be the Effective Date of the Services Agreement.

B. Term. Except as otherwise agreed, this Agreement shall be in effect for the term of the Services Agreement and shall remain in effect until all of the PHI provided by Participant to Contexture, or created or Received by Contexture on behalf of Participant, is destroyed or returned to Participant, or if it is not feasible to return or destroy PHI, protections are extended to such information in accordance with the termination provisions of this Agreement.

C. Termination for Cause. Notwithstanding anything to the contrary in this Agreement or the Services Agreement, upon gaining knowledge of a material breach by Contexture of the terms of this Agreement, including but not limited to a pattern or practice that would constitute a breach of this Agreement, Participant may at its sole discretion:

1. Immediately terminate this Agreement and the Services Agreement, and suspend all services (without penalty) immediately upon written notice to Contexture without any term of notice and/or judicial intervention being required, and without liability on behalf of Participant for such suspension; or,

2. Allow Contexture an opportunity to cure the breach.

D. Participant Rights Upon Termination. Upon termination of this Agreement, Contexture may retain data received from Participant. With regard to such data that is PHI, Contexture will continue to use appropriate safeguards and comply with Subpart C of 45 C.F.R. Part 164 with respect to electronic PHI to protect Use or Disclosure of the PHI for as long as Contexture retains the PHI and for data that is not PHI, Contexture shall comply with all applicable laws to safeguard the confidentiality of such data. Contexture will not Use or Disclose such PHI retained by Contexture, other than for the purposes for which such PHI or CSI was retained and subject to the same conditions of this Agreement which applied prior to termination.

V. Miscellaneous.

A. Amendment of Agreement. Except as otherwise set forth in this Agreement, this Agreement shall not be changed, modified or altered except by amendment, which, to be valid and enforceable, shall be in writing and signed by the parties. Notwithstanding the foregoing, Contexture may unilaterally amend this Agreement in order to comply

with any applicable federal or state laws or regulations, including but not limited to Information Privacy and Protection Laws, effective immediately upon written notice to Participant. Upon the addition of, change, or amendment to any applicable federal or state laws or regulations, including but not limited to Information Privacy and Protection Laws, which would require an amendment to this Agreement, this Agreement shall be deemed to be amended to comply with such addition, change or amendment.

B. Interpretation. The requirements of applicable law pertaining to PHI are, to the extent not adequately provided for in this Agreement, hereby incorporated by this reference and shall become a part of this Agreement. This Agreement shall be construed as broadly as necessary to implement and comply with Information Privacy and Protection Laws.

EXHIBIT B
TO
COMMUNITY RESOURCE NETWORK PARTICIPATION AGREEMENT

Orders

I. **Fees**. One time and/or recurring fees for use of the CRN System and other products and services shall be those set forth on an Order which Contexture will provide to Participant. Participant shall pay Contexture the fees set forth on the Order pursuant to the payment terms of the Order and this Agreement. Any amounts owed to Contexture which are not paid when due shall bear interest at the rate of eighteen percent (18%) per annum. The payment amount and interest rate are subject to change upon sixty (60) days written notice to Participant from Contexture, subject to Participant's right to terminate the Agreement as provided herein. Contexture may refuse Participant and Participant Users access to uses of the CRN System if payment is not timely made by Participant.

II. **Uses, Products and Services**. The Order shall describe Participant's access and use of the CRN System or other products and services provided by Contexture.

III. **Order Issuance and Acceptance**. Orders are issued by Contexture. Orders shall be binding upon Contexture and Participant upon execution by Participant and acceptance by Contexture.

IV. **Termination**. Either Contexture or Participant may terminate an Order upon sixty (60) days prior written notice. Participant shall pay Contexture for any work completed up to the date of the termination. Termination of an Order shall not terminate this Agreement.

AMENDMENT TO CRN ELECTRONIC COMMERCE AGREEMENT FOR GOVERNMENTAL ENTITIES

CONTEXTURE,
a Colorado nonprofit corporation (herein "Contexture")

_____
print/type name of contracting entity
(herein "Participant")

Address of Contexture:

Address of Participant:

_____
_____
_____

Contexture and Participant are parties to a Community Resource Network Electronic Commerce Agreement ("Electronic Commerce Agreement") and amendments thereto, if any ("Prior Amendments"). The Electronic Commerce Agreement and Prior Amendments shall collectively be referred to as the "Agreement." All definitions and terms of the Agreement are incorporated herein by this reference.

Contexture and Participant desire to enter into this Amendment for the purpose of addressing legal matters that involve Participant's status as a public entity.

Participant and Contexture agree to all attached Terms and Conditions.

This Amendment is dated and shall be effective on the date set forth below by Contexture as the effective date.

Contexture,
a Colorado nonprofit corporation

_____
(print/type name of Participant)

By:_____
(signature)

By:_____
(signature)

Name/Title: _____
(print/type name of signatory and title)

Name/Title: _____
(print/type name of signatory and title)

Effective Date: _____
(To be completed by Contexture)

TERMS AND CONDITIONS

1. **Indemnity**. Any provisions of the Agreement wherein Participant indemnifies Contexture or Contexture indemnifies Participant are hereby deleted.

2. **Arbitration**. All provisions of the Agreement regarding submitting claims to arbitration are hereby deleted. Venue for any legal actions concerning the Agreement shall only be in Mesa County, Colorado or Denver, Colorado.

3. **Additions to Agreement**. The following provisions are added to the Agreement.

   A. Colorado Open Records Act. Contexture understands that certain information, including this Agreement and all Exhibits thereto, may be public records available for public inspection and copying under the Colorado Open Records Act ("CORA") and other applicable laws. Nothing in the Agreement shall in any way limit the ability of the Participant to comply with any laws or legal process concerning disclosures by public entities. Any information subject to CORA as a public record may be released to third parties in compliance with CORA. The parties further agree that any such release by the Participant will not constitute a breach or threatened breach of this Agreement.

   B. Colorado Taxpayers Bill of Rights. Financial obligations of the Participant payable after the current fiscal year are contingent upon funds for that purpose being appropriated, budgeted, and otherwise made available. The parties acknowledge that appropriation of moneys by the Participant is a governmental function which the Participant cannot contractually commit to in advance and that this Agreement does not constitute: (i) a multiple fiscal year direct or indirect debt or financial obligation; or (ii) an obligation payable in any fiscal year beyond the fiscal year for which funds are lawfully appropriated; or (iii) an obligation creating a pledge of or a lien on Participant tax or general revenues. If the Participant's board or other authorized governing body or authority of Participant does not approve an appropriation of funds at any time during the term of this Agreement for any payment due or to become due for a fiscal year during the term of this Agreement, the Participant shall have the right to terminate the Agreement on the last day of the fiscal period for which sufficient appropriations were received, without penalty or expense. The Participant may terminate this Agreement by giving notice in writing that (a) funds have not been appropriated for the fiscal period, and (b) the Participant has exhausted all funds legally available for the payment.

   C. Colorado Governmental Immunity Act. Nothing contained in this Agreement will be construed as an express or implied waiver by Participant of its governmental immunity or an express or implied acceptance by Participant of liabilities in excess of the liabilities allowable under the Colorado Governmental Immunity Act ("CGIA"), to the extent the provisions of the CGIA apply to this Agreement. Any liability of Participant (including indemnification) is strictly limited by the provisions of the CGIA, to the extent those provisions apply to this Agreement.

4. **Effect**. Except as set forth in this Amendment, all terms, covenants and conditions of the Agreement shall remain in full force and effect.

AGENDA ITEM or FINAL CONTRACT REVIEW SUBMITTAL FORM

Agenda Item: Behavioral Health 260 Program License Agreement; C

Action Requested: Board of County Commissioners' Signature

Parties to the Agreement: CredibleMind

Term Begins: March 15th 2026 **Term Ends:** **Grant Contract #:**

Summary:

HHS wishes to purchase the CredibleMind platform for the West Central Public Health Partnership region.

Fiscal Impact: $17,000

Submitted by: Margaret Wacker **Submitter's Email Address:** mwacker@gunnisoncounty.org

Finance Review: (●) Required ( ) Not Required

Comments:

Reviewed by: GUNCOUNTY1\mrozman Discharge Date: 2/25/2026

County Attorney Review: (●) Required ( ) Not Required

Comments:
Contract has indemnity provision (paragraph 8). To address our concerns, Contractor added, "To the extemt permitted by law." Otherwise, legally sufficient. SO 2/24/26

Reveiwed by: GUNCOUNTY1\sobaid Discharge Date: 2/24/2026 Certificate of Insurance Required

Yes ( ) No (●)

County Manager Review:

Comments:

Reveiwed by: GUNCOUNTY1\mbirnie Discharge Date: 2/25/2026

(●) Consent Agenda ( ) Regular Agenda ( ) Worksession Time Allotted: 0

Agenda Date: 3/3/2026

Revised April 2015

Behavioral Health 360 Program
License Agreement

This License Agreement ("Agreement") is made and entered into as of the date last signed below (the "Effective Date") by and between CredibleMind, Inc. ("CM"), a Delaware Corporation with its principal place of business located at 30 Liberty Ship Way, Suite 3200, Sausalito, CA 94965, and Gunnison County Health and Human Services ("Client"), with its principal place of business located at 220 N. Spruce Street, Gunnison, CO 81230.

1. Customization of Behavioral Health 360 Program. The Behavioral Health 360 Program is a combination of the CredibleMind Platform and Support Services provided by CredibleMind. In consideration for Client's payment of the fees set forth in the Statement of Work attached as Exhibit A hereto ("Statement of Work"), CM will use all reasonable business efforts to customize its CredibleMind Platform ("CM Platform"), and provide implementation, training, and maintenance support services for the CM Platform as described in the Statement of Work within the time frames estimated in the Statement of Work. CM will host, operate and maintain its CM Platform implementation on servers operated by or for CM.

2. Limited Warranty; Disclaimer. Client acknowledges that (i) CM's products and services, including the CM Platform and supporting services provided hereunder, are not a substitute for medical or legal advice. CM does not make any express or implied warranties in connection with this Agreement, the CM Platform or any supporting services or deliverables provided to Client hereunder except those specifically set forth herein.

3. Payment. Client agrees to pay to CM the fees as set forth in the Statement of Work. In the event that any amount due to CM hereunder is not paid within 45 days of Client's receipt of the corresponding invoice, without waiving any claim or right against Client and without liability whatsoever to Client, CM reserves the right to suspend or terminate Client's access to the CM Platform and the performance of any services provided hereunder. The amounts payable to CM set forth in Exhibit A are exclusive of any sales or use or other taxes or governmental charges. Client shall be responsible for payment of all such taxes or charges except for any taxes based solely on CM's net income. If Client is required to pay any taxes based on this Section 3, Client shall pay such taxes with no reduction or offset in the amounts payable to CM hereunder. This Agreement is subject to Client making an annual budget appropriation in an amount sufficient to fund this Agreement. If Client fails or refuses to make such an appropriation, Client reserves the right to terminate this Agreement pursuant to the Termination paragraph of this Agreement.

4. Term; Termination. This Agreement is effective upon signing and will continue for one (1) year with automatic annual renewals thereafter unless CM or Client gives sixty (60) days' prior written notice to the other party of non-renewal. CM or Client may terminate this Agreement upon thirty (30) days' prior written notice of the other's material breach and failure to substantially cure the breach within thirty (30) days of receipt of the notice of breach. CM or Client may terminate this Agreement for convenience upon sixty (60) days' prior written notice to the other party. Upon expiration or termination of this Agreement, all Licenses granted by CM to Client hereunder shall terminate. Client shall promptly cease use of and delete or return any electronic information associated with the CM Platform and associated intellectual property. If CM terminates this Agreement for convenience or the Agreement is terminated due to CM's breach as provided above, it shall refund to Client the unearned prorated portion of the Annual License Fee (as defined in Exhibit A) paid for the then-current annual licensing period. If Client terminates this Agreement for convenience or the Agreement is terminated due to Client's breach as provided above, Client will pay to CM any unpaid portion of the Implementation Fee (as defined in Exhibit A) and any unpaid portion of the Annual License Fee due for the then-current annual licensing period.

5. Limitation of Liability. In no event shall CM be liable for any loss of profit or revenue or cost of procurement of substitutes by Client, or for any other consequential, incidental, indirect or special damages incurred or suffered by Client arising as a result of or related to this Agreement, whether in contract, tort, or otherwise, even if CM was advised of the possibility of such loss or damages. Client further agrees that the total liability of CM for all claims of any kind arising as a result of or related to this Agreement, or to any act or omission of CM, whether in contract, tort or otherwise, shall not exceed an amount equal to the amount actually paid by Client to CM hereunder during the twelve (12) month period preceding the date the claim arises. Client's sole and exclusive remedy for any claim against CM with respect to the quality of the deliverables and supporting services provided under this Agreement shall be the correction by CM of any material defects or deficiencies therein, of which Client notifies CM in writing within ten (10) days after the delivery of such deliverables or completion of that portion of the supporting services. In the absence of any such notice, the deliverables and supporting services provided hereunder shall be deemed satisfactory to and accepted by Client.

6. Intellectual Property. **Licenses**: While this Agreement is in effect and in consideration for Client's payment of the fees set forth in the Statement of Work, CM grants to Client a non-exclusive, non-transferable, non-sublicenseable, License to (a) access and remotely interact with the CM Platform and allow users of its CM Platform website ("Users") such access and interaction; (b) use CM's trademarks to the limited extent as stated below; (c) access CM Platform utilization data; and (d) access error corrections to the CM Platform, including fixes to problems in software but excluding additional options, enhancements, and/or new features. Client grants to CM a worldwide, non-exclusive, royalty-free License to use, reproduce, distribute, perform and display any and all content it provides to CM in connection with the CM Platform. **Trademarks**: CM and Client each grant to the other a limited, non-exclusive, non-sublicenseable, worldwide License to use the other's trademarks, trade names, copyrights and logos and trade dress (collectively, "Trademarks") only as necessary to fulfill each party's obligations under this Agreement during its term. CM and Client each agree that the quality of its manner of use of the other's Trademarks shall be high. CM and Client may each terminate the other's License to use its Trademarks if it determines that the other's use of such Trademarks tarnishes, blurs or dilutes the quality or good will associated with such Trademarks and such problem is not cured within ten (10) days of notice thereof. Each party agrees not to contest the other party's ownership of its Trademarks, not to disparage or call into question the validity, value or ownership thereof, and not to use any of the other party's Trademarks in any manner so as to create a combined trademark. Except as expressly granted in this Agreement, no other rights or Licenses or uses whatsoever in or to the CM Platform or CM's Trademarks are granted to Client. CM is, and at all times shall remain, the sole and exclusive owner of all right, title and interest, throughout the world (including all intellectual property and other proprietary rights), in and to the original and copies of the CM Platform and any associated and derivative intellectual property, all website usage statistics (system utilization data), all new features and enhancements to the CM Platform, and any deliverables and supporting services provided by CM under this Agreement. **Protections**: CM and Client shall cooperate to police and protect the CM Platform and its associated intellectual property. Client shall promptly notify CM in writing of any unauthorized use, infringement, misappropriation, dilution or other violation of the CM Platform and its associated intellectual property ("Violations") of which it becomes aware and CM shall have the primary right, but not the obligation, to bring and control any suits against any such Violations and retain the entirety of any award arising from such suit. Client shall have no claim of any kind against CM based on or arising out of CM's handling of or decisions regarding Violations or any such suit or suits. **Notices and Attributions**: Client shall accurately produce and reproduce all CM intellectual property notices on all copies Client produces or reproduces of the CM Platform and associated data, screens, and software, and shall not remove any CM intellectual property notices from any materials. Any website through which a user interacts with the CM Platform shall have, at a minimum, attribution to CM for creating and operating the website and service, including a "Powered by CredibleMind clickable link in the navigation header of all pages, CM copyright notices on all pages, and appropriate credit for the platform and links back to CM in any "about us" section. **Confidential Information**: During the term of this Agreement and for a period of two (2) years thereafter, each of CM and Client will keep in confidence and not disclose or disseminate, or permit anyone working under its direction to disclose or disseminate, the existence, source, content or substance of any of the other's Confidential Information

to any other person. "Confidential Information" is all nonpublic information concerning the business, technology, internal structure and strategies of either CM or Client disclosed to the other orally, or in tangible form, and is either marked as "confidential" or identified as "confidential" prior to disclosure. Employees and independent contractors of one party will be given access to the Confidential Information of the other party only on a need-to-know basis. Client agrees that the trade secrets and know-how included in the CM Platform and associated intellectual property shall be treated as Confidential Information regardless of whether such trade secrets and know-how are marked, stamped or otherwise identified as confidential. Information shall not be deemed Confidential Information if it is (i) now generally known or available or which, hereafter through no act or failure to act on the part of CM or Client as the receiving party ("Recipient"), becomes generally known or available; (ii) rightfully known to Recipient at the time of receiving such information; (iii) furnished to Recipient by a third party without restriction on disclosure and without Recipient having actual notice or reason to know that the third party lacks authority to so furnish the information; (iv) independently developed by Recipient; or (v) required to be disclosed by law or by a government entity, provided however that Recipient, before making a use or compelled disclosure of Confidential Information, shall give ten (10) business days' prior written notice to the owner of the Confidential Information stating the intended use or disclosure to be made and citing the applicable sub-section of (i) - (v) above allegedly giving it the right or obligation to do so.

7. User Relations**.** Client will either incorporate CM's terms of use into its terms of use, as will be displayed on Client's website, or allow CM to maintain a terms of use link and document on the CM Platform implementation's website for Client. Client's Users must agree to the terms of use or will not be allowed to use the CM Platform implementation's website. Client's staff shall have first line responsibility for dealing with User support inquiries in a commercially reasonable manner agreed to by CM. CM will provide second tier support directly to Client through Web, email and telephone support during normal business hours (9AM to 5PM Pacific Time) with an initial response within one business day that includes an estimated time for final resolution. Client will designate and CM will train one support person who will be Client's interface with CM on support matters.

8. Indemnity**.** To the extent permitted by law, each of CM and Client (the "Indemnifying Party") shall indemnify the other (the "Indemnified Party") against any and all claims, losses, costs and expenses, including reasonable attorneys' fees, which the Indemnified Party may incur as a result of claims in any form by third parties arising from: (a) the Indemnifying Party's gross negligence or willful misconduct in the performance of its obligations under this Agreement, or (b) the Indemnifying Party's content or trademarks or associated intellectual property. The foregoing obligations are conditioned on the Indemnified Party: (i) giving the Indemnifying Party notice of the relevant claim, (ii) cooperating with the Indemnifying Party, at the Indemnifying Party's expense, in the defense of such claim, and (iii) giving the Indemnifying Party the right to control the defense and settlement of any such claim, except that the Indemnifying Party shall not enter into any settlement that affects the Indemnified Party's rights or interest without the Indemnified Party's prior written approval. The Indemnified Party shall have the right to participate in the defense at its expense. Notwithstanding the foregoing, CM assumes no liability for any claims arising from the following: (i) the combination of the CM Platform and associated intellectual property or use with other hardware, software or other items not provided by CM; (ii) the modification of the CM Platform or any part thereof by Client; (iii) use of the CM Platform for a purpose or in a manner for which it was not designed, or (iv) Client's specifications or designs. To the extent permitted by law, Client shall indemnify and hold harmless CM from and against any claims arising out of such exclusions (i)-(iv). This Section 8 states Client's sole and exclusive remedy and CM's entire liability for any alleged infringement of a third party's intellectual property right.

9. Resolution of Disputes. Except as expressly otherwise provided herein, the parties agree that any dispute arising out of or relating to this Agreement shall be resolved in accordance with the procedures specified in this Section 9, which shall be the sole and exclusive procedures for the resolution of disputes.

(a) In the event a dispute arises between the parties, each party's goal is a neutral and cost-effective means of resolving the dispute quickly. Accordingly, each party agrees that any claim or controversy

arising out of or relating to this Agreement shall be resolved, in the first instance, by contacting the other party to the controversy directly to seek a resolution.

(b) If a dispute between the parties cannot be resolved by informal meeting and discussions within thirty (30) days after commencement thereof, the parties agree to submit the dispute to mediation. The parties further agree that their participation in mediation is a condition precedent to (i) either party pursuing any other available remedy in relation to the dispute and (ii) either party recovering attorneys' fees under Section 10. During mediation, the parties agree to negotiate in good faith as to the matter submitted to mediation. Mediation shall take place under the then current Center for Public Resources ("CPR") Model Procedure for Mediation of Business Disputes. The parties shall jointly appoint a mutually acceptable neutral third-party mediator. If the parties are unable to agree upon the appointment of a mediator, either party may request CPR assistance in the selection of a mediator under its guidelines. The costs of the mediation will be shared equally between the parties, unless otherwise agreed to in writing by the parties. Mediation shall take place remotely. If the parties are unable to come to a resolution of the dispute within the lesser of forty-five (45) days after appointment of a mediator or fifteen (15) days after commencement of the first mediation session, unless extended by agreement of the parties, either party may institute arbitration proceedings pursuant to Section 9(c) below.

(c) All disputes that have not been resolved by the parties through informal discussions or mediation shall be finally settled by arbitration by a mutually acceptable arbitrator in accordance with the then applicable Commercial Arbitration Rules of the American Arbitration Association. The arbitration hearing will be remote. The decision of the arbitrator will be final and may not be appealed. Judgment on any award rendered by the arbitrator may be entered in any court of competent jurisdiction. The arbitrator shall have the authority to grant injunctive relief and specific performance to enforce the terms of this Agreement, and may, in its discretion, award fees and costs as part of its award.

10. Attorneys' Fees. Subject to Section 9, if any action is necessary to enforce the terms of this Agreement, the substantially prevailing party will be entitled to reasonable attorneys' fees, costs and expenses in addition to any other relief to which such prevailing party may be entitled.

11. General Provisions. **Governing Law**: This Agreement shall be governed by and construed in accordance with the laws of the State of Colorado. **Severability, Headings**: If any provision herein is held to be invalid or unenforceable for any reason, the remaining provisions will continue in full force and effect without being impaired or invalidated in any way. Headings are for reference purposes only and in no way define, limit, construe or describe the scope or extent of such section. **No Hire.** Without the prior written consent of CM until twelve (12) months after the date the CM personnel were last involved in any activity related to the Agreement, Client agrees to refrain from employing, as a result of direct solicitation, or directly or indirectly soliciting the employment/engagement of CM's employees, agents, and subcontractors who have worked on the Agreement ("Personnel"). If Client is interested in hiring one or more of CM's Personnel, such interest will be discussed first with CM prior to discussing such an offer with the Personnel. In no event shall this provision apply with respect to Personnel of CM who are recruited in response to a solicitation made to the public. **Force Majeure**: If performance of a party's obligations is interfered with by any condition beyond such party's reasonable control, the affected party shall be excused from performance to the extent of such condition. The operation of CM's servers and the provision of the CM Platform and supporting services hereunder may be interfered with by numerous factors outside of CM's control. CM does not guarantee continuous, uninterrupted or secure provision of the CM Platform and supporting services, and Client acknowledges that the CM Platform and supporting services may be unavailable for sustained periods of time. Should the CM Platform and supporting services be unavailable to Client and Users due to force majeure for more than 10 days, and if CM does not restore service within 30 days thereafter, Client may terminate this Agreement and be entitled to a refund of the unearned prorated portion of the Annual License Fee paid for the then-current annual licensing period. **Independent Contractors:** CM and Client are independent contractors, and no agency, partnership, joint venture, employee-employer or franchiser-franchisee relationship is intended or created hereunder. **Notice:** Any notices hereunder shall be given to the appropriate party at the address specified herein or at such other address, as the party shall specify in

writing. Notice shall be deemed given: upon personal delivery; if sent by fax, upon confirmation of receipt; or if sent by certified mail, postage prepaid, three (3) days after the date of mailing. **Assignment:** This Agreement may not be assigned by either party without the express written consent of the other party. Notwithstanding the foregoing, CM may assign this Agreement and the provision of services hereunder, together with the rights and ownership of the CM Platform and associated intellectual property, to another party so long as such assignment is to an authorized partner of CM that agrees to be bound by the terms and conditions of this Agreement. This Agreement shall inure to the benefit of and be binding on the parties hereto and their respective successors and assigns (if assignment is properly made pursuant to this Agreement). **Announcement and Non-compete:** Upon signing of this Agreement the Parties shall jointly announce the business relationship in a manner mutually agreeable to both Parties, such as a press release or other similar form. During the term of this Agreement (including any renewal period(s) hereof), Client agrees that it will not develop, nor embed, link, co-brand or promote on its CM Platform implementation's website, any tools, products or services provided internally or by a third party, that are substantially competitive with or similar to CM's tools, products or services without giving to CM 90 days' prior written notice, which notice shall provide to CM the option of terminating this Agreement for Client's material breach. **Entire Agreement; Waiver:** This Agreement (including Exhibit A attached hereto) sets forth the entire agreement of the parties, and supersedes any and all oral or written agreements or understandings between them, as to the subject matter of this Agreement. It may be changed only in a writing signed by both parties. The waiver of a breach of any provision of this Agreement will not operate or be interpreted as a waiver of any other or subsequent breach. **Survival:** Sections 4 ("Termination"), 5 ("Limitation of Liability"), 6 ("Intellectual Property"), 8 ("Indemnity"), 9 ("Resolution of Disputes"), 10 ("Attorneys' Fees") and 11 ("General Provisions") shall survive any expiration or termination of this Agreement. **Counterparts:** This Agreement may be executed in one or more counterparts, by facsimile, by electronic signature, or otherwise, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument. **Authority to Bind:** Each signatory represents that he/she is fully authorized to enter into the terms and conditions of this Agreement and to legally bind the party on whose behalf the signature is proffered. The parties agree that faxed and scanned copies of fully executed contracts are accepted as original and binding on the parties. **No Waiver of Governmental Immunity:** The parties hereto understand and agree that Client is relying upon, and has not waived, the monetary limitations and all other rights, immunities and protection provided by the Colorado Governmental Act, § 24-10-101, et seq., C.R.S. Nothing in this Agreement is, or shall be construed to be, a waiver, in whole or part, by Client of governmental immunity provided by the Colorado Governmental Immunity Act or

IN WITNESS WHEREOF, the parties hereto, having been duly authorized, execute this Agreement on the dates indicated:

For CredibleMind, Inc.	**For Gunnison County Health and Human Services**
Signature: _____	Signature: _____
Print Name: Deryk Van Brunt	Print Name:_____
Title: CEO	Title: _____
Date: _____	Date: _____
30 Liberty Ship Way, Suite 3200 Sausalito, CA 94965	220 N. Spruce Street Gunnison, CO 81230

Exhibit A

Statement of Work: Behavioral Health 360 Program

The Behavioral Health 360 Program consists of a combination of the CredibleMind Platform and Services provided by CredibleMind, Inc.. CredibleMind ("CM") will make the CredibleMind Platform and Services ("CM Platform") available to Gunnison County Health and Human Services ("Client") for the West Central Public Health Partnership (Counties of Delta, Hinsdale, Montrose, Ouray, San Miguel, Mineral and Gunnison) as follows:

Implementation

Project Summary

The CM Platform is a Software as a Service (SaaS) tool delivered through a unique URL branded to Client. During implementation of the platform, Client and CM will work together to build a customized version for Client. Client will have access to the most recent version of the platform, including access to expert-reviewed resources for user mental health and well-being improvement, interactive assessments, and mental health and well-being topic write-ups. During the implementation, the Client project team will be trained in how to use the platform and how to engage their end-users.

Client Responsibilities

In the implementation phase, Client will be responsible for the following:

- Provide a logo to be placed on CM Platform
- Attend Kickoff Meeting
- Approve Site Branding and Design
- Access the CredibleMind online client portal to add in customer resources to their CM Platform, as desired, including but not limited to organization benefit programs, wellness programs, and partner organizations. Unlimited accounts to add and edit content are available.

Milestones

- Kickoff Meeting - Within 2 Weeks of contract signing
- Build, modify and design custom CM Platform - Within 2 weeks of Kickoff Meeting, upon receiving unique client resources
- Launch - Within 6 weeks of contract signing

Project Deliverable

At the end of the implementation, Client will have access to a co-branded version of the CM Platform.

Account Management and Support

CM will assign one Customer Success Manager (CSM) to work directly with Client. The CSM will be available during normal business hours.

Maintenance

The maintenance phase begins after launch of the CM Platform. During this phase, Client will continue to receive ongoing training and support to ensure successful adoption and usage of the CM Platform by the target audience.

Reporting

After launch, Client will receive a report on site usage following each calendar quarter. The report will include information such as number of users and most frequently visited topics, trends, resource views and recommendations. In addition, Client will have access to an online reporting dashboard. The dashboard includes real time data on number of users, frequently visited topics, trends, and resource views. CM will have access to the deidentified aggregated user data for purposes of research and product insight. Up to five reporting user accounts tied to specific email addresses are included in the Annual License Fee.

End-User Engagement

Client will be responsible for marketing and promoting the CM Platform to their intended users. CM will support these efforts with the following:

- Client newsletters with expert curated resources and content that can be shared by Client in their own communication channels
- CM-produced end-user engagement emails for all signed-up users
- Embeddable widgets to drive site traffic
- Up to two (2) posters or other pieces of collateral to be used for CM Platform marketing with a limit of two (2) revisions per item
- Access to the CredibleMind engagement playbook with best practices on marketing and launching the platform.
- Access to the CredibleMind social media toolkit - a database of over 100 CredibleMind branded social media posts on over 50 topics
- Provide a $1,200 one year Google Ad credit to be used to promote the anxiety and/or depression assessments

Account Management and Support

CM will assign one Customer Success Manager (CSM) to work directly with Client. The CSM will be available during normal business hours.

Service Level Agreement

CM guarantees the CM Platform will be up and running 24/7/365 with 99.5% uptime outside of planned monthly service windows.

Payment Terms

Pricing

CredibleMind Platform for Gunnison County Health and Human Services

Community: The West Central Public Health Partnership (7 counties: Delta, Hinsdale, Montrose, Ouray, San Miguel, Mineral and Gunnison; Total population est. 108,000)

Description	Fee
Implementation	$2,000
Platform Annual License: $14,000 Platform Spanish Translation Annual License: $2,500	$16,500

Optional Add-On Services

Additional services can be purchased by Client through a written request to the Customer Success Manager (CSM) for the following additional fees:

1. Additional reporting user accounts: $150/user/term year
2. Google Ads for anxiety and/or depression resources: the cost of the Google Ad + 10% fee.
3. Additional Google Ads for other topics: a one-time setup fee of $1000 per topic and the cost of the Google Ad + 10% fee.
4. Additional languages are available for an additional fee. Contact your CSM for the most up to date pricing.

Billing Schedule

1. The Implementation Fee of $2,000 and Year 1 Annual License Fee (ALF) of $16,500 shall be due upon contract signing for a total of $18,500.
2. Subsequent ALFs shall be due upon the anniversaries of contract signing. ALFs shall automatically increase by five percent (5%) each year.
3. Additional fees incurred by Client hereunder will be invoiced periodically by CM and payments are due within thirty (30) days of receipt of the invoice.
4. CM will provide an invoice to Client for all payments that become due. In the event of non-payment 60 days after the due date, the amount due will increase 1% per each month that the invoice is not paid starting on the due date.
5. Client has assigned the following as the billing contact for CM:

   Margaret Wacker, MPH
   West Central Public Health Partnership Co-Coordinator
   Community Health Manager, Gunnison County Health and Human Services
   220 N. Spruce St., Gunnison, CO 81230
   970-641-7913; mwacker@gunnisoncounty.org

Travel and Related Business Expenses

In-person meetings are available at request. Travel and related business expenses associated with in-person meetings must be pre-authorized by Client, and will then be reimbursed to CM.

AGENDA ITEM or FINAL CONTRACT REVIEW SUBMITTAL FORM

Agenda Item: Grant Application; Colorado Health Foundation; Juv

Action Requested: Motion

Parties to the Agreement: Colorado Health Foundation and Gunnison County

Term Begins: **Term Ends:** **Grant Contract #:**

Summary:

grant application for bi-lingual diversion and FAST position. no signature needed unless we get funded

Fiscal Impact:

Submitted by: Kari Commerford **Submitter's Email Address:** kcommerford@gunnisoncounty.org

Finance Review: (●) Required ( ) Not Required

Comments:

Reviewed by: GUNCOUNTY1\mlamonica Discharge Date: 2/20/2026

County Attorney Review: (●) Required ( ) Not Required

Comments:
Legally sufficient. SO 2/20/26

Reveiwed by: GUNCOUNTY1\sobaid Discharge Date: 2/20/2026 Certificate of Insurance Required

Yes ( ) No (●)

County Manager Review:

Comments:

Reveiwed by: GUNCOUNTY1\mbirnie Discharge Date: 2/25/2026

(●) Consent Agenda ( ) Regular Agenda ( ) Worksession Time Allotted: 0

Agenda Date: 3/3/2026

Revised April 2015

Gunnison County

RG-37963 - Grant
Amount Requested: $246,950

Table of Contents

Organization & Contact Information

Organization

Gunnison County

Location

Gunnison ,CO
Proposal Contact

Kari Commerford
CEO/President/ED

Matthew Birnie
Secondary Contact

Kari Commerford
Finance/Payment Contact

Kari Commerford
Does this grant include a Fiscal Sponsor?

No

I Am Applying For

To begin, please select the type of application you will be using:

- **Standard Application**. Select if you are applying for an **open funding opportunity**
- **Advocacy Rapid Response Application.** Select if you are applying for **Rolling Funding - Advocacy Rapid Response**

I am Applying For:

Standard Application

Funding Type:

Funding Opportunity - Developing Agency, Identity, and Belonging in Young People

Application

The purpose of The Colorado Health Foundation's grant application is to better understand your organization and proposed program or project. We consider the information included in this application as a "first look" into your program or project, and do not expect it to be an extensive description of your organization and program or project. As needed, Foundation staff will reach out to you with further questions after reviewing this initial information. Please note that your proposal will not be evaluated based on grammar, sentence structure, writing style or how "well-written" it is. This application can be used for all types of funding requests, including general operating support.

We encourage you to refer to this **glossary** when completing your responses to some of the narrative questions below, in an effort to ensure a clear understanding of how the Foundation defines key terms used below.

How We Are Working to Achieve Health Equity

We believe keeping equity at the heart of our work will lead Coloradans to better health. While there are countless drivers of health, we know that racial injustice - fueled by systemic racism - is the leading driver of health inequity for communities of color living on low income. That's why we prioritize Coloradans of color and address the deepest, most historically entrenched inequities that affect health based on a person's socioeconomic status, disability, gender identity, sexual orientation, country of origin and religion.

Racial justice - dismantling and/or shifting conditions that are intentionally and unintentionally racist - is the key pathway in our work to achieve health equity. It is essential that every step we take creates fair opportunities for people whose health is furthest from reach. This is why our work, and that which we expect in the work of our partners, is rooted in three cornerstones:

- Serve Coloradans who have less power, privilege and income, and prioritize Coloradans of color;
- Do everything with the intention of creating health equity; and
- Be informed by the community and those we exist to serve.

Our grant application reflects these three cornerstones, and includes key prompts that help us better understand how your organization is strategically advancing health equity and racial justice.

Organization Information

Current Mission Statement

*(To edit, please save the application and access this field by going to the ORGANIZATIONS tab of the portal and selecting UPDATE ORGANIZATION CONTACT INFORMATION. If you do not have access to edit this section, email **grants@coloradohealth.org** with either your updated mission statement or with a request for moderator editing rights to your organization.)*

Provide a brief summary of the programs and services your organization offers in order to bring this mission to life.

1,000-character limit:

The Department of Juvenile Services (DJS) provides collaboration and culturally competent continuum of prevention services to youth and families so they can be empowered to lead, be connected to trusted adults and thrive in our community. The Family Advocacy Support Team (FAST) provides connection and coordinated services for children and youth ages 0 - 21 and their families who have or need assistance from multiple agencies. FAST helps create better access, coordination to services and assistance for overcoming educational, legal, mental, and/or health challenges. Youth Intervention Services Activity provides screenings, assessments, case management, mentoring, life skills training, and restorative justice processes to school or court-referred youth so they can become better functioning individuals and have no further negative involvement within the justice system. Both programs are essential to have trained staff who linguistically and culturally represent the youth that they serve.

For *general operating* requests, enter your total organizational budget for **Total Project Budget**. If using a fiscal sponsor, enter the **Total Organization Budget** for the sponsored organization/project (not the fiscal sponsor).

Total Organization Budget:

$250,000

What is your organization's awareness of and commitment to Racial Justice, Equity, Diversity and Inclusion (JEDI)? How do these values show up in your overall work? Please include what, if any, JEDI work your organization is doing internally with your staff, leadership, Board of Directors and in your operations.

2,500-character limit:

Gunnison County is committed to serving all our community members as equitably as we can. Our Department of Health and Human Services has created a Multicultural Resource office to help our non-English speaking community members navigate and access services. The Department of Juvenile Services (DJS) is dedicated to JEDI work as well. In 2020, DJS in partnership with the RE1-J school District, provided opportunities for staff to be part of a multi-month equity lab. The intention of the equity lab was to help staff understand implicit bias and to create cultural understanding. This experience also helped create unity in the DJS team and with our school partners. This has become a common practice for our

department and coalitions that fall under our department. We hold equity book clubs quarterly for staff and community partners. In 2021, the DJS started to see an increase of Latino youth in the Diversion and FAST services. In 2020, approximately one in ten youth were Latino/Spanish speaking and in 2025 60% of youth/families in FAST and 30% of Diversion/Colorado Youth Detention Continuum youth are Latino/Spanish Speaking. In 2020 we hired a part-time interpreter to help serve our Diversion and FAST program. We quickly realized that simply having an interpreter was not adequate and that the service that the community was receiving was not equitable. By 2023 we hired a part-time Diversion/FAST bi-lingual position and the outcomes were more positive for our Spanish speaking youth. Being able to serve individuals in their mother language and having staff that understand and represent the culture that they are serving is essential to providing effective and equitable services. In 2025 it became apparent that we need to increase the DJS ability and staffing to meet the JEDI needs of the community and our office. The DJS is dedicated to provide all our services – direct services, presentations for parents, schools, community members and all written material in both English and Spanish. This requires growing individuals who already work in our office into the FAST/Diversion positions and re-hiring for entry level positions

As part of the Foundation's commitment to learning and evolving, we strive to understand how we and our partners are working to advance equity within our own institutions and the communities we exist to serve. One way of doing this is by requesting key demographic data from grant applicant organizations and the communities you serve. The information collected serves as one data point, among many, in our efforts to understand how our partners are approaching the work of advancing equity. If you have questions about this data collection, please reach out to the grantmaking operations team at **grants@coloradohealth.org**.

We understand that you may not have the requested demographic data for some or all of the sections; please provide what you can. You may select "do not track" and provide an explanation as needed. If applicable, when completing the Multiracial field(s) for your staff or program participants, please count an individual one time for the Multiracial field. If you have and would like to provide additional information on the identities of people referenced in the demographic data table, please include in the narrative space provided.

Organization Demographic Information

Number of Board Members: 3
Number of Executive Leadership: 2
Number of All Other Staff: 12

Race and Ethnicity

Arab / Middle Eastern:			
Asian / Asian American / Pacific Islander:			
Black, non-Hispanic:			
Hispanic / Latinx:			2
Indigenous / Native American:			
Multiracial:			
Another Race or Ethnicity:			
Please Describe:			
White, non-Hispanic:	3	2	
Prefer Not to Say:			
Do Not Track:			10

Gender

Man:	1	1	5
Woman:	2	1	7
Nonbinary / Nonconforming:			
Another Gender Identity:			
Please Describe:			
Prefer Not to Say:			
Do Not Track:			

People Who Identify as Lesbian, Gay, Bisexual, Transgender and/or Queer

Yes:			2
No:	3	2	
Prefer Not to Say:			
Do Not Track:			

People Who Identify as Living with a Disability

Yes:			
No:			
Prefer Not to Say:			
Do Not Track:			

Is there any other demographic information on board, leadership and staff your organization tracks that you'd like to share? If so, please note here.

DJS is a County government department. Our board is the Board of County Commissioners, the executive leadership is the County Manager and Assistant County Manager. The DJS works with youth and their families. We follow a moto "nothing for youth without youth". DJS has youth representation on staff. We hire Western Colorado University interns and are dedicated to hiring a youth-support partner to ensure that our staff represents those we serve in age, language and cultural background

If you selected "do not track" for any of the above information, please explain why you do not collect this information.

Project Information

Project Title:

Increasing belonging and connection for Latino youth and families.

Proposal Summary (A one- to two-sentence description of your proposal) 500-character limit:

This proposal is aimed at increasing the sense of belonging and connection for our Latino youth who receive services from the DJS and for families in the community. This proposal will provide direct services for youth and families and will provide prevention education materials in English and Spanish. Efforts will be at the individual, family and community level.

Type of Support:

General Operating

Total Project Budget:

$350,000

Total Amount Requested:

$246,950

Funding Term (Months):

18

Counties Served - Please click on the '+" button to add all counties the proposed work will specifically serve, or select 'Colorado Statewide' from the list, as applicable.

- Gunnison (100%)

Age Group - Please select the primary age group(s) targeted by your proposal. Please select at least one. If you do not know what percentage of the age groups are targeted, press the "X" to close the window that appears.

- Children (6-11) (40%)
- Infants and Young Children (0-5) (20%)
- Youth/Teens (12-18) (40%)

Community Served Demographic Information

Race and Ethnicity

	Anticipated Program Participants Served through this Grant	Participants Actually Served by All Organizational Programs (if different)
Arab / Middle Eastern:		
Asian / Asian American / Pacific Islander:		
Black, non-Hispanic:	1%	
Hispanic / Latinx:	18%	
Indigenous / Native American:	1%	
Multiracial:	9%	
Another Race or Ethnicity:	3%	
Please Describe:		
White, non-Hispanic	68%	
Prefer Not to Say:		
Do Not Track:		

Gender

	Anticipated Program Participants Served through this Grant	Participants Actually Served by All Organizational Programs (if different)
Man:	54%	
Woman:	46%	
Nonbinary / Nonconforming:		
Another Gender Identity:		
Please Describe:		
Prefer Not to Say:		
Do Not Track:		

People Who Identify as Lesbian, Gay, Bisexual, Transgender and/or Queer

	Anticipated Program Participants Served through this Grant	Participants Actually Served by All Organizational Programs (if different)
Yes:	12%	
No:	86%	
Prefer Not to Say:	2%	
Do Not Track:		

People Who Identify as Living with a Disability

	Anticipated Program Participants Served through this Grant	Participants Actually Served by All Organizational Programs (if different)
Yes:		
No:		
Prefer Not to Say:		
Do Not Track:	100%	

Is there any other demographic information on people served by your organization and program or project that you'd like to share? If so, please note here.

In 2022-23 the school district saw 59 Newcomer students and in 23-24 there were 90 additional students. Newcomers refer to K-12 students born outside the U.S. who have arrived in the country in the last three years and are still learning English, they can be any age/grade level. "Impacted Newcomers" are students who may have experienced trauma or are here without parents. Currently, there are about 23 students in this category. The DJS serves many of these youth.

If you selected "do not track" for any of the above information, please explain why you do not collect this data.
We do not currently track disabilities.

Cornerstones

Our **cornerstones** are the foundation upon which The Colorado Health Foundation's work is based, and that we expect to see reflected in the work of our partners.

- ***Who We Serve:*** *We serve Coloradans who have less power, privilege and income, and prioritize Coloradans of color.*
- ***Health Equity:*** *We do everything with the intent of creating health equity.*
- ***Community-Informed:*** *We are informed by the community and those we exist to serve.*

Please describe the people or community that your project will serve. How will your program or project address the health inequities experienced by the individuals you are serving?

2,500-character limit:

The DJS FAST and Early intervention program will serve Gunnison County youth and their families between the ages of 0-18. As stated above, we have seen over 150 Newcomers in the past 3 years, and 23 of those youth are identified as "Impacted Newcomer". This can be any student who may have experienced trauma, are here without parents, or are SLIFE (Students with Limited or Interrupted Formal Education). Newcomers refers to K-12 students born outside the United States who have arrived in the country in the last three years and are still learning English. Newcomers can be any age and grade level, and older students may have some additional needs. The term newcomer families refers to the families or guardians of these students. Some newcomers may arrive in the United States voluntarily (e.g., to reunite with families or to work), while others are forced to leave their home countries due to violence or war (e.g., refugees).

Our Latino youth are increasingly receiving suspensions, referrals for truancy and other services and tickets from law enforcement. The rate is disproportionately high compared to total number youth served. In 2024-25 there were 28 referrals from the RE1-J School District; 12 were male, 16 were female and of these 19 were Hispanic and 9 were Caucasian. Additionally in 24-25 the suspension rates across schools were:

Gunnison High School: 15 total suspensions/7 nicotine or marijuana related
Gunnison Middle School: 34 total suspensions/18 nicotine or marijuana related

Crested Butte Community School: 27 Total Suspensions/7 nicotine, marijuana, or alcohol related.

When we receive referrals for youth in our office we screen for mental health, assess social determinates of health and provide individualized plans that wrap around youth and families. We often see a lack of understanding of laws, lack of guardian/parent support and essential basic need support as contributing factors for youth "criminal" behaviors. We use a clinical rather than criminal lenes when working with youth and create learning experiences to help redirect youth. This project aims to ensuring a safe, inclusive, and welcoming environment for all youth in our community. The two bi-lingual positions will help ensure services are in the primary language for Latino youth and families. The youth support will help build connections with youth and families, create a safe environment that fosters trust for system support and help elevate youth voice.

Please describe how your program or project was shaped by the people and community you will serve. What type of information was used to help you understand the context, needs or perspectives of these individuals (e.g., feedback from the people and community you will serve, needs assessments, census data, community conversations, etc.)?

2,500-character limit:

The DJS has a long standing relationship with the RE1-J School District. Over the past 19 years we have been collecting Healthy Kids Colorado Survey data and implementing prevention education to youth and families. As part of this relationship we regularly engage youth and parents in focus groups to substantiate and provide story telling around the quantitative data. The DJS houses the Gunnison County Substance Abuse Prevention Project, which leads two youth coalitions; one middle school and one high school. The youth coalitions provide direct feedback from youth about the needs and concerns that they have about the community and their peers. Additionally, the DJS has a data coordinator on staff. This position is charged with keeping up to date on national, state, regional and local data. In 2025, the DJS data coordinator completed a "state of the community report" that snapshot the behavioral health landscape of Gunnison County. In looking at the needs for our program we include all of these qualitative and quantitative data resources. The following is what our resources tell us. Mental health is a concern. Adult suicide rates are significantly higher then the state and national average (CDC, 2023). In 2019, 21.2% of middle school youth indicated feeling sad or hopeless two weeks or more in the past 12 months, while in 2023 it was 24.5%. Fourteen percent of MS ever considered suicide in 2019, that number increased to 21.2% in 2023. Hispanic youth attempted suicide at twice the rate (15.3%) of the district

average (7.5%) (HKCS, 2023). The GCSAPP Youth Coalition focus groups have identified nicotine, alcohol use, and mental health as some of their most significant concerns for their peers. These are often paired with other high-risk behaviors like poly-substance use, impaired driving, and non-consensual sex. Additionally, declining real incomes and rising costs increase the financial pressure on many households. As a result,

over one-third of students in the School District qualify to receive free or reduced meals and activity fees. The food pantry's request for food assistance quadrupled from 2016 to 2024. Roughly 15 percent of the county population received food assistance in 2024—60 percent more than 2019. Our Latino community makes up less than 20% of our overall population and is disproportionately experiencing involvement in our systems. Our community members are the experts and we will continue to allow them to influence and shape our programs.

Proposed Activities

- **Please describe your proposed project or program - what you will do and how you will do it. How did you decide this was the right approach to address the needs of the people and community you will serve?**

5,000-character limit:

The DJS uses a framework that focuses on Positive Youth Development, being trauma-informed and understanding the impacts of risk and protective factors. This project addresses the Colorado Health Foundations priorities by advancing equity and support for underserved communities and increasing belonging and connections for youth. This project will provide more equitably services to youth/families by providing bilingual diversion programming for youth, bi-lingual FAST support and hiring a youth support partner. We will also be tracking outcomes and receiving youth feedback with support from our data coordinator.

The cornerstone of diversion is the ability to build relationships with youth and parents. We have seen the increased need in bi-lingual services also increase through our Collaborative Management Program as well, more than doubling in the past year. The proposed project will help to meet the early intervention needs by building capacity and providing more equitable services and providing a youth support position to come alongside youth.

We aim to provide direct services to youth who are diverted from the criminal justice system and will provide screening, assessment, connection to community support and mental health services and partnership with the school to increase attendance and decrease school-behavioral incidents. This project will build capacity by expanding our bi-lingual staff throughout the DJS while supporting the RE1-J school district . There is cross-sector support for the expansion of the DJS services to help youth understand the impact of their choices and how to repair harm.

Throughout the district, chronic absenteeism is one of the greatest challenges facing all schools, with about 20% of all students identified as chronically absent. At Gunnison High School (GHS), that number rises to 35% of students. Additionally, GWSD employs PowerSchool risk analytics to determine student need for intervention. Two weeks into the Fall 2022 semester, over 15% percent of the combined population of K-12 students are identified with at least some risk for academic failure and/or discipline referral. Nine percent of GES students, 26% of GMS students, and 15% for GHS students are currently identified as "at risk," and this number will likely increase as the semester progresses. Risk analysis can be a reliable indicator of suspension and dropout and, while graduation rates at GHS are higher than the state average, they have declined over the past two years. Hispanic or Latino students are at a higher risk of dropping out before graduation. The youth support partner and FAST position will work directly with this population to create youth/family specific goals for stabilizing the family, ensuring basic needs are met and helping kids socially and academically succeed. A cornerstone to this is feeling connected to their community. The youth support partner will be an new and essential resource to help youth feel a sense of belonging and connection to their school and community by providing one on one support and navigation through systems.

Gunnison County is starting to see an increased need for culturally sensitive and equitable services as the number of Non-English-speaking community members are aware of and utilizing services. Gunnison County is also seeing the impact of toxic stress in our community youth. We utilized the 2025 Behavioral Health Environmental Scan and Gaps Analysis to understand the needs of the whole community and create a community wide strategic plan for implementation. The DJS leads the planning and implementation of prevention programming that comes from this process. One identified risk is the increase of youth and families accessing the FAST program with more complex needs. Each youth and family are assessed through an equity lens. Every youth participates in a personal interview to share their own story, to know each youth as the unique, layered individual they are. Our intent is

to identify barriers youth, and their families are facing and give them access to the resources they need to thrive. Families living at poverty levels are doubly disadvantaged. Poverty isolates and separates, inhibiting the ability to make positive connections. In the promotion of equity, the newest research points to the effectiveness of targeted life skills in addition to group life skills sessions. All staff will utilize life skills as part of their support for youth/families.

The data tells a story and we ensure that all participants served by the project are able to share their experiences and their voice is integrated into success and changes to programs. Using a positive youth development lens we understand the importance of “nothing for youth without youth”. When our young people express a need (i.e. access to mental health), our community partners take youth voice seriously and work to identify and remove obstacles.

Intermediate Milestones

- **Please provide no more than five important milestones (e.g., significant achievements) you hope to achieve for each year of your program or project.**

2,500-character limit:

Goal 1: By December 2027, the DJS will increase program engagement for Latino youth in the DJS programs, as evidenced by number of youth served and pre-post outcome surveys.

Objective 1.1: Provide equitable services for Spanish speaking youth/families; serving at least 10 youth in the diversion/ court referred program during award period.

Activities:

1. Hire/promote current staff into Bi-lingual Diversion position. Y1-Q1

2. Train staff in Diversion, Positive Youth Development and Restorative Practices. -Y1Q1/ Q2

3. All youth in Diversion will be served in their primary language. Y1/Y2

Objective 1.2: Provide equitable services for Spanish speaking youth/families; serving at least 10 youth in the FAST/ truancy program during award period.

1. Hire staff into Bi-lingual FAST position. Y1-Q1

2. Train staff inFAST, Positive Youth Development and Restorative Practices. -Y1Q1/ Q2

3. All youth in FAST will be served in their primary language. Y1/Y2

Goal 2: By December, 2027 the DJS will increase protective factor of youth sense of belonging and connection for Latino youth as evidenced by the number of youth with lived experience who are participating in youth and community coalitions and youth served by Youth Support Partner.

Objective 2.1: Increase protective factors for youth through Youth Support Partner, serving 12 youth during program.

Activities:

1. Hire 1 FTE Youth Support Partner. - Y1 Q2,

2. Match youth with Youth Support Partner. - Y1/Y2

3. Data Coordinator will create pre-post survey - Y1 Q2

4. Number of youths served, and pre-post Youth Support survey shared. - Y1/Y2

Objective 2.2: Increase the number of youth with lived experience who are participating in youth and community coalitions, 8 additional youth:

Activities:

1. DJS and the school district will engage youth in coalition work. Y1 Q2

2. DJS Diversion and FAST program will engage youth and families with lived experience - Youth support partner is the lead. Y1/Y2

3. Provide opportunities for youth to guide the prevention and intervention work in the community with monthly meetings – meeting youth where they are at. Y1/Y2

Understanding Your Impact

- **How many unique individuals do you expect to serve or reach with your program or project? (# answer, not narrative)**
- **Please describe how you will know that your program or project has led to the overall results you want to see? How will you know that your program or project has led to greater health equity for the people or community you will serve?**

5,000-character limit:

24 youth

As part of this program we will work with our data coordinator. Our data coordinator will continue to lead the evaluation and program impact efforts. The data coordinator will continue to evaluate current data points including Health Kids Colorado Surveys, local behavioral health data, diversion and Colorado Youth Detention and probation data, FAST data and RE1-J school district data. Additionally, the data coordinator will continue to work with staff to ensure youth focus groups continue to be facilitated and that youth voice is at the center of programmatic changes. The data coordinator will also create new measurement tools to ensure the program(s) has led to greater health equity for our youth and families. He will work to create pre-post surveys for the FAST and Diversion program and work with the school and DJS to create at least one shared measure of success.

Financial Information

- **Please describe how you will use the requested funding by providing a brief budget narrative. If applying for more than one year of funding, please include the total amount requested for each year.**
- **What are the other major sources of funding, financial and non-financial, for this project?**

2,500-character limit:

Total Amount Requested

$246,950 (18months) - Year 1 $74,085 (30%) Year 2 $172,865 (70%)

Bi-lingual Diversion Staff $35/hr. $10/hr x 1300 hrs. = $58,500

FAST Bi-lingual Staff $32/hr. $10/hr. x 1300hrs = $54,600

Data Coordinator $35/hr. $10/hr x 1300 hrs= $54,600

Youth Support Partner $30/hr. $10/hr. x 1300hrs - $52,000

Incentives for meeting program goals 24 youth x $100 = $2,400

Phone for 4 staff $50 x 4 x 12 = $2400

TOTAL = $224,500

Indirect = $22,450

TOTAL = $246,950

Other funding support - The DJS is 88% funded by grants and foundation funds.
The Collaborative Management state allocation funding will help to support for the additional hours 5 needed for the FAST position and supports the FAST facilitator position and the program Director. The School district EARRS grant will help to support 5 hours a week for the Youth Support position. Juvenile Services department funding will help support 5-10 hours for bi-lingual diversion position and covers part of the Diversion/CYDC case manager position and Department Director position. The data coordinator is funded by prevention dollars from the state (EPIC/CTC) for 15 hours a week and this funding would be used to ensure that is a full time position.

Requested Attachments

The following documentation is requested:

- Most recent full 12 months financial statements, audited if available within that timeframe. This is to include an income statement and balance sheet.

For proposals using a fiscal sponsor:

- Fiscal sponsor agreement - template available **here**, other formats accepted
- Fiscal sponsor financials (most recent full 12 months financial statements, audited if available within that timeframe. This is to include an income statement and balance sheet.)

Click here for guidance on how to upload documents.

If you are unable to include documents electronically, please contact **Grantmaking Operations** to make arrangements for an alternative submission.

- Most Recent 12 Months Financial Statements
- Fiscal Sponsor Agreement (If Applicable)
- Fiscal Sponsor's Financial Statements (If Applicable)

Uploaded Application Documents

-

Please tell us approximately how many hours it took for you to complete this application.

Number of Hours:

At The Colorado Health Foundation, we are committed to listening and learning from Colorado communities, which is why we invite you to provide anonymous feedback through GrantAdvisor on how you've experienced us as a funder and partner. Your feedback is critical to helping inform decisions on how we can improve our practices.

- In order to submit the application you must first save it.
- To access a saved but not submitted application, you'll find it under the "In Progress" section in your Grantee Portal.

AGENDA ITEM or FINAL CONTRACT REVIEW SUBMITTAL FORM

Agenda Item: Grant Award Letter; Intergovernmental Agreement; P

Action Requested: Board of County Commissioners' Signature

Parties to the Agreement: Gunnison County and CDOT, Division of Aeronautics

Term Begins: Grant execution date **Term Ends:** **Grant Contract #:** 26-GUC-01

Summary:

CDOT grant award letter to receive $525,000 of funding for the purchase of a 20' plow w/ 4.4 carrier vehicle.

Fiscal Impact: CDOT share: $525,000; Local share: $58,334

Submitted by: Stephanie Petsch **Submitter's Email Address:** spetsch@gunnisoncounty.org

Finance Review: (•) Required ( ) Not Required

Comments:

Reviewed by: GUNCOUNTY1\mlamonica Discharge Date: 2/20/2026

County Attorney Review: (•) Required ( ) Not Required

Comments:
Legally sufficient. SO 2/19/26

Reveiwed by: GUNCOUNTY1\sobaid Discharge Date: 2/19/2026 Certificate of Insurance Required

Yes ( ) No (•)

County Manager Review:

Comments:

Reveiwed by: GUNCOUNTY1\mbirnie Discharge Date: 2/25/2026

(•) Consent Agenda ( ) Regular Agenda ( ) Worksession Time Allotted: 0

Agenda Date: 3/3/2026

Revised April 2015

Grant Award Letter
Intergovernmental Grant Agreement

Cover Page

State Agency

Colorado Department of Transportation,
Colorado Aeronautical Board,
Division of Aeronautics

Grant Issuance Date

The Effective Date

Grant Expiration Date

June 30, 2029

Grantee

Board of County Commissioners of Gunnison County

Grant Amount

State Funds:	$525,000.00
Local Match Amount:	$58,334.00

Agreement Authority

Authority to enter into this Agreement exists in CRS §43-10-108.5 and funds have been budgeted, appropriated and otherwise made available pursuant to CRS §§39-27-112(2)(b), 43-10-109, 43-10-102 and a sufficient unencumbered balance thereof remains available for payment. Required approvals, clearance, and coordination have been accomplished from and with appropriate agencies.

Grant Purpose

1. Snow Removal Equipment

Exhibits and Order of Precedence

The following Exhibits and attachments are included with this Agreement:

1. Exhibit A, Discretionary Aviation Grant Application/Statement of Work
2. Exhibit B, Resolution
3. Exhibit C, Grant Assurances
4. Exhibit D, Sample Option Letter

In the event of a conflict of inconsistency between this Agreement and any Exhibit or attachment, such conflict or inconsistency shall be resolved by reference to the documents in the following order of priority:

1. Colorado Special Provisions in §19 of the main body of the Grant Award Letter
2. The provisions of the other sections of the main body of the Grant Award Letter
3. Exhibit A, Discretionary Aviation Grant Application/Statement of Work
4. Exhibit B, Resolution
5. Exhibit C, Grant Assurances
6. Executed Option Letters, if any

Principal Representatives

For the State:

Scott Storie, Aviation Planner
CDOT - Division of Aeronautics
5126 Front Range Parkway
Watkins, CO 80137
scott.storie@state.co.us
(303) 512-5251

For Grantee:

Rick Lamport
Gunnison-Crested Butte Regional Airport
519 Rio Grande Avenue
Gunnison, CO 81230
rlamport@gunnisoncounty.org
(970) 642-7388

Signature Page

The Signatories Listed Below Authorize this Grant

GRANTEE

Gunnison County

_____

By: Laura Pucket Daniels, BOCC Chair

Date: _____

STATE OF COLORADO

Jared S. Polis, Governor

Department of Transportation

Division of Aeronautics

_____

By: David R. Ulane, Director

Date: _____

In accordance with §24-30-202, C.R.S., this Agreement is not valid until signed and dated below by the State Controller or an authorized delegate.

STATE CONTROLLER

Robert Jaros, CPA, MBA, JD

_____

By: Department of Transportation

Date_____

1. GRANT

As of the Grant Issuance Date, the State Agency shown on the first page of this Grant Award Letter (the "State") hereby obligates and awards to Grantee shown on the first page of this Grant Award Letter (the "Grantee") an award of Grant Funds in the amounts shown on the first page of this Grant Award Letter. By accepting the Grant Funds provided under this Grant Award Letter, Grantee agrees to comply with the terms and conditions of this Grant Award Letter and requirements and provisions of all Exhibits to this Grant Award Letter.

2. TERM

A. Initial Grant Term and Extension

The Parties' respective performances under this Grant Award Letter shall commence on the Grant Issuance Date and shall terminate on the Grant Expiration Date unless sooner terminated or further extended in accordance with the terms of this Grant Award Letter. Upon request of Grantee, the State may, in its sole discretion, extend the term of this Grant Award Letter by providing written notice to the Grantee in a form substantially equivalent to Exhibit D.

B. Early Termination in the Public Interest

The State is entering into this Grant Award Letter to serve the public interest of the State of Colorado as determined by its Governor, General Assembly, the Colorado Aeronautical Board, or Courts. If this Grant Award Letter ceases to further the public interest of the State or if State, Federal or other funds used for this Grant Award Letter are not appropriated, or otherwise become unavailable to fund this Grant Award Letter, the State, in its discretion, may terminate this Grant Award Letter in whole or in part by providing written notice to Grantee that includes, to the extent practicable, the public interest justification for the termination. If the State terminates this Grant Award Letter in the public interest, the State shall pay Grantee an amount equal to the percentage of the total reimbursement payable under this Grant Award Letter that corresponds to the percentage of Work satisfactorily completed, as determined by the State, less payments previously made. Additionally, the State, in its discretion, may reimburse Grantee for a portion of actual, out-of-pocket expenses not otherwise reimbursed under this Grant Award Letter that are incurred by Grantee and are directly attributable to the uncompleted portion of Grantee's obligations, provided that the sum of any and all reimbursements shall not exceed the maximum amount payable to Grantee hereunder. This subsection shall not apply to a termination of this Grant Award Letter by the State for breach by Grantee.

C. Extension Terms - State's Option

The State, at its discretion, shall have the option to extend the performance under this Grant Award Letter beyond the Initial Term for a period, or for successive periods, of one year or less at the same rates and under the same terms specified in the Grant Award Letter (each such period an "Extension Term"). In order to exercise this option, the State shall provide written notice to Grantee in a form

substantially equivalent to Exhibit D, Sample Option Letter, attached to this Grant Award Letter.

3. PURPOSE

The General Assembly of the State of Colorado declared in Title 43 of the Colorado Revised Statutes, Article 10, 1991 in CRS §43-10-101 (the Act) "… that there exists a need to promote the safe operations and accessibility of general aviation in this state; that improvements to general aviation transportation facilities will promote diversified economic development across the state; and that accessibility to airport facilities for residents of this state is crucial in the event of a medical or other type of emergency…"

The Act created the Colorado Aeronautical Board ("the Board") to establish policy and procedures for distribution of monies in the Aviation Fund and created the Division of Aeronautics ("the Division") to carry out the directives of the Board, including technical and planning assistance to airports and the administration of the state aviation system grant program. SEE CRS §43-10-103 and C.R.S. §43-10-105 and CRS §43-10-108.5 of the Act.

Any entity operating a public-accessible airport in the state may file an application for and be recipient of a grant to be used solely for aviation purposes. The Division is authorized to assist such airports as request assistance by means of a Resolution passed by the applicant's duly-authorized governing body, which understands that all funds shall be used exclusively for aviation purposes and that it will comply with all grant procedures, grant assurances and requirements as defined in the Division's Programs and Procedures Manual, ("the Manual") and the Airport Sponsor Assurances for Colorado Discretionary Aviation Grant Funding attached hereto as Exhibit C.

4. DEFINITIONS

The following terms shall be construed and interpreted as follows:

A. "**Breach of Agreement**" means the failure of a Party to perform any of its obligations in accordance with this Grant Award Letter, in whole or in part or in a timely or satisfactory manner. The institution of proceedings under any bankruptcy, insolvency, reorganization or similar law, by or against Grantee, or the appointment of a receiver or similar officer for Grantee or any of its property, which is not vacated or fully stayed within 30 days after the institution of such proceeding, shall also constitute a breach. If Grantee is debarred or suspended under §24-109-105, C.R.S. at any time during the term of this Grant Award Letter, then such debarment or suspension shall constitute a breach.

B. "**Budget**" means the budget for the Work described in Exhibit A.

C. "**Business Day**" means any day in which the State is open and conducting business, but shall not include Saturday, Sunday or any day on which the State observes one of the holidays listed in §24-11-101(1) C.R.S.

D. "**CJI**" means criminal justice information collected by criminal justice agencies needed for the performance of their authorized functions, including, without limitation, all information defined as criminal justice information by the U.S. Department of Justice, Federal Bureau of Investigation, Criminal Justice

Information Services Security Policy, as amended and all Criminal Justice Records as defined under §24-72-302 C.R.S.

E. "**CORA**" means the Colorado Open Records Act, §§24-72-200.1 *et. seq.*, C.R.S.

F. "**Exhibits**" means the exhibits and attachments included with this Grant Award Letter as shown on the first page of this Grant Award Letter

G. "**Extension Term**" means the period of time by which the Grant Expiration Date is extended by the State through delivery of notice as described in §2.A of this Grant Award Letter.

H. "**Federal Award**" means an award of Federal financial assistance or a cost-reimbursement agreement under the Federal Acquisition Regulations by a Federal Awarding Agency to the Recipient. "Federal Award" also means an agreement setting forth the terms and conditions of the Federal Award. The term does not include payments to a contractor or payments to an individual that is a beneficiary of a Federal program .

I. "**Federal Awarding Agency**" means a federal agency providing a Federal Award to a Recipient. The Federal Aviation Administration is the Federal Awarding Agency for the Federal Award which is the subject of this Grant.

J. "**Goods**" means any movable material acquired, produced, or delivered by Grantee as set forth in this Grant Award Letter and shall include any movable material acquired, produced, or delivered by Grantee in connection with the Services.

K. "**Grant Award Letter**" means this letter which offers Grant Funds to Grantee, including all attached Exhibits, all documents incorporated by reference, all referenced statutes, rules and cited authorities, and any future updates thereto.

L. "**Grant Funds**" means the funds that have been appropriated, designated, encumbered, or otherwise made available for payment by the State under this Grant Award Letter.

M. "**Grant Expiration Date**" means the Grant Expiration Date shown on the first page of this Grant Award Letter.

N. "**Grant Issuance Date**" means the Grant Issuance Date shown on the first page of this Grant Award Letter.

O. "**Incident**" means any accidental or deliberate event that results in or constitutes an imminent threat of the unauthorized access or disclosure of State Confidential Information or of the unauthorized modification, disruption, or destruction of any State Records.

P. "**Initial Term**" means the time period between the Grant Issuance Date and the Grant Expiration Date.

Q. **"Manual**" means the Programs and Procedures Manual as approved by the Colorado Aeronautical board that is available on the Colorado Division of Aeronautics' website.

R. "**Matching Funds**" means the funds provided by Grantee as a match required to receive the Grant Funds.

S. "**Party**" means the State or Grantee, and "Parties" means both the State and Grantee.

T. "**PII**" means personally identifiable information including, without limitation, any information maintained by the State about an individual that can be used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, or biometric records; and any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information. PII includes, but is not limited to, all information defined as personally identifiable information in §§24-72-501 and 24-73-101 C.R.S.

U. "**Services**" means the services to be performed by Grantee as set forth in this Grant Award Letter, and shall include any services to be rendered by Grantee in connection with the Goods.

V. "**State Confidential Information**" means any and all State Records not subject to disclosure under CORA. State Confidential Information shall include, but is not limited to, PII, CJI, and State personnel records not subject to disclosure under CORA. State Confidential Information shall not include information or data concerning individuals that is not deemed confidential but nevertheless belongs to the State, which has been communicated, furnished, or disclosed by the State to Grantee which (i) is subject to disclosure pursuant to CORA; (ii) is already known to Grantee without restrictions at the time of its disclosure to Grantee; (iii) is or subsequently becomes publicly available without breach of any obligation owed by Grantee to the State; (iv) is disclosed to Grantee, without confidentiality obligations, by a third party who has the right to disclose such information; or (v) was independently developed without reliance on any State Confidential Information.

W. "**State Fiscal Rules**" means the fiscal rules promulgated by the Colorado State Controller pursuant to §24-30-202(13)(a) C.R.S.

X. "**State Fiscal Year**" means a 12 month period beginning on July 1 of each calendar year and ending on June 30 of the following calendar year. If a single calendar year follows the term, then it means the State Fiscal Year ending in that calendar year.

Y. "**State Records**" means any and all State data, information, and records, regardless of physical form, including, but not limited to, information subject to disclosure under CORA.

Z. "**Subcontractor**" means third-parties, if any, engaged by Grantee to aid in performance of the Work. "Subcontractor" also includes sub-grantees.

AA. "**Work**" means the delivery of the Goods and performance of the Services described in this Grant Award Letter.

BB. "**Work Product**" means the tangible and intangible results of the Work, whether finished or unfinished, including drafts. Work Product includes, but is not limited to, documents, text, software (including source code), research, reports, proposals, specifications, plans, notes, studies, data, images, photographs, negatives, pictures, drawings, designs, models, surveys, maps, materials, ideas,

concepts, know-how, and any other results of the Work. "Work Product" does not include any material that was developed prior to the Grant Issuance Date that is used, without modification, in the performance of the Work.

Any other term used in this Grant Award Letter that is defined in an Exhibit shall be construed and interpreted as defined in that Exhibit.

5. STATEMENT OF WORK

Grantee shall complete the Work as described in this Grant Award Letter and in accordance with the provisions of Exhibit A. The State shall have no liability to compensate or reimburse Grantee for the delivery of any goods or the performance of any services that are not specifically set forth in this Grant Award Letter.

6. PAYMENTS TO GRANTEE

A. Maximum Amount

Payments to Grantee are limited to the unpaid, obligated balance of the Grant Funds. Financial obligations of the State payable after the current State Fiscal Year are contingent upon funds for that purpose being appropriated, budgeted, and otherwise made available. The State shall not be liable to pay or reimburse Grantee for any Work performed or expense incurred before the Grant Issuance Date or after the Grant Expiration Date; provided, however, that Work performed and expenses incurred by Grantee before the Grant Issuance Date that are chargeable to an active Federal Award may be submitted for reimbursement as permitted by the terms of the Federal Award.

B. Increase or Decrease Quantities and Total Price - State's Option

The State, at its discretion, shall have the option to increase or decrease the quantity of goods/services described in Exhibit A at the same rates and under the same terms specified in this Grant Award Letter. In order to exercise this option, the State shall provide written notice to Contractor in in form substantially equivalent to Exhibit D prior to the end of the current Grant Award Letter term. Delivery of Goods and performance of Services shall continue at the same rates and terms as described in this Grant Award Letter.

C. Matching Funds.

Grantee shall provide the Local Match Amount shown on the first page of this Grant Award Letter and described in Exhibit A (the "Local Match Amount"). Grantee shall appropriate and allocate all Local Match Amounts to the purpose of this Grant Award Letter each fiscal year prior to accepting any Grant Funds for that fiscal year. Grantee does not by accepting this Grant Award Letter irrevocably pledge present cash reserves for payments in future fiscal years, and this Grant Award Letter is not intended to create a multiple-fiscal year debt of Grantee. Grantee shall not pay or be liable for any claimed interest, late charges, fees, taxes or penalties of any nature, except as required by Grantee's laws or policies.

D. Reimbursement of Grantee Costs

The State shall reimburse Grantee's allowable costs, not exceeding the maximum total amount described in this Grant Award Letter for all allowable costs described

in this Grant Award Letter and shown in the Budget, except that Grantee may adjust the amounts between each line item of the Budget without formal modification to this Agreement as long as the Grantee provides notice to the State of the change, the change does not modify the total maximum amount of this Grant Award Letter or the maximum amount for any state fiscal year, and the change does not modify any requirements of the Work.

E. Close-Out.

Grantee shall close out this Grant within 45 days after the Grant Expiration Date. To complete close out, Grantee shall submit to the State all deliverables (including documentation) as defined in this Grant Award Letter and Grantee's final reimbursement request or invoice.

7. REPORTING - NOTIFICATION

A. Performance and Final Status

Grantee shall submit all financial, performance and other reports to the State no later than the end of the close out described in §6.E, containing an evaluation and review of Grantee's performance and the final status of Grantee's obligations hereunder.

B. Violations Reporting

Grantee shall disclose, in a timely manner, in writing to the State and the Federal Awarding Agency, all violations of federal or State criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal Award. The State or the Federal Awarding Agency may impose any penalties for noncompliance allowed under 2 CFR Part 180 and 31 U.S.C. 3321, which may include, without limitation, suspension or debarment.

8. GRANTEE RECORDS

A. Maintenance and Inspection

Grantee shall make, keep, and maintain, all records, documents, communications, notes and other written materials, electronic media files, and communications, pertaining in any manner to this Grant Award Letter for a period of three years following the completion of the close out of this Grant Award Letter. Grantee shall permit the State to audit, inspect, examine, excerpt, copy and transcribe all such records during normal business hours at Grantee's office or place of business, unless the State determines that an audit or inspection is required without notice at a different time to protect the interests of the State.

B. Monitoring

The State will monitor Grantee's performance of its obligations under this Grant Award Letter using procedures as determined by the State. The State shall have the right, in its sole discretion, to change its monitoring procedures and requirements at any time during the term of this Agreement. The State shall monitor Grantee's performance in a manner that does not unduly interfere with Grantee's performance of the Work.

C. Final Audit Report

Grantee shall promptly submit upon request to the State a copy of any final audit report of an audit performed on Grantee's records that relates to or affects this Grant Award Letter or the Work, whether the audit is conducted by Grantee or a third party.

9. CONFIDENTIAL INFORMATION-STATE RECORDS

A. Confidentiality

Grantee shall hold and maintain, and cause all Subcontractors to hold and maintain, any and all State Records that the State provides or makes available to Grantee for the sole and exclusive benefit of the State, unless those State Records are otherwise publicly available at the time of disclosure or are subject to disclosure by Grantee under CORA. Grantee shall not, without prior written approval of the State, use for Grantee's own benefit, publish, copy, or otherwise disclose to any third party, or permit the use by any third party for its benefit or to the detriment of the State, any State Records, except as otherwise stated in this Grant Award Letter. Grantee shall provide for the security of all State Confidential Information in accordance with all policies promulgated by the Colorado Office of Information Security and all applicable laws, rules, policies, publications, and guidelines. Grantee shall immediately forward any request or demand for State Records to the State's principal representative.

B. Other Entity Access and Nondisclosure Agreements

Grantee may provide State Records to its agents, employees, assigns and Subcontractors as necessary to perform the Work, but shall restrict access to State Confidential Information to those agents, employees, assigns and Subcontractors who require access to perform their obligations under this Grant Award Letter. Grantee shall ensure all such agents, employees, assigns, and Subcontractors sign nondisclosure agreements with provisions at least as protective as those in this Grant Award Letter, and that the nondisclosure agreements are in force at all times the agent, employee, assign or Subcontractor has access to any State Confidential Information. Grantee shall provide copies of those signed nondisclosure restrictions to the State upon request.

C. Use, Security, and Retention

Grantee shall use, hold and maintain State Confidential Information in compliance with any and all applicable laws and regulations in facilities located within the United States, and shall maintain a secure environment that ensures confidentiality of all State Confidential Information wherever located. Grantee shall provide the State with access, subject to Grantee's reasonable security requirements, for purposes of inspecting and monitoring access and use of State Confidential Information and evaluating security control effectiveness. Upon the expiration or termination of this Grant Award Letter, Grantee shall return State Records provided to Grantee or destroy such State Records and certify to the State that it has done so, as directed by the State. If Grantee is prevented by law or regulation from returning or destroying State Confidential Information, Grantee warrants it will guarantee the confidentiality of, and cease to use, such State Confidential Information.

D. Incident Notice and Remediation

If Grantee becomes aware of any Incident, it shall notify the State immediately and cooperate with the State regarding recovery, remediation, and the necessity to involve law enforcement, as determined by the State. After an Incident, Grantee shall take steps to reduce the risk of incurring a similar type of Incident in the future as directed by the State, which may include, but is not limited to, developing and implementing a remediation plan that is approved by the State at no additional cost to the State.

E. Safeguarding PII

If Grantee or any of its Subcontractors will or may receive PII under this Grant Award Letter, Grantee shall provide for the security of such PII, in a manner and form acceptable to the State, including, without limitation, State non-disclosure requirements, use of appropriate technology, security practices, computer access security, data access security, data storage encryption, data transmission encryption, security inspections, and audits. Grantee shall be a "Third-Party Service Provider" as defined in §24-73-103(1)(i), C.R.S. and shall maintain security procedures and practices consistent with §§24-73-101 *et seq.*, C.R.S.

10. CONFLICTS OF INTEREST

Grantee shall not engage in any business or activities, or maintain any relationships that conflict in any way with the full performance of the obligations of Grantee under this Grant. Grantee acknowledges that, with respect to this Grant Award Letter, even the appearance of a conflict of interest shall be harmful to the State's interests and absent the State's prior written approval, Grantee shall refrain from any practices, activities or relationships that reasonably appear to be in conflict with the full performance of Grantee's obligations under this Grant Award Letter. If a conflict or the appearance of a conflict arises, or if Grantee is uncertain whether a conflict or the appearance of a conflict has arisen, Grantee shall submit to the State a disclosure statement setting forth the relevant details for the State's consideration.

11. INSURANCE

Grantee shall maintain at all times during the term of this Grant Award Letter such liability insurance, by commercial policy or self-insurance, as is necessary to meet its liabilities under the Colorado Governmental Immunity Act, §24-10-101, *et seq.*, C.R.S. (the "GIA"). Grantee shall ensure that any Subcontractors maintain all insurance customary for the completion of the Work done by that Subcontractor and as required by the State or the GIA.

12. BREACH OF AGREEMENT

In the event of a Breach of Agreement, the aggrieved Party shall give written notice of Breach of Agreement to the other Party. If the notified Party does not cure the breach, at its sole expense, within 30 days after the delivery of written notice, the Party may exercise any of the remedies as described in §13 for that Party. Notwithstanding any provision of this Grant Award Letter to the contrary, the State, in its discretion, need not provide notice or a cure period and may immediately terminate this Grant Award Letter in whole or in part or institute any other remedy in

this Grant Award Letter in order to protect the public interest of the state; or if Grantee is debarred or suspended under §24-109-105, C.R.S., the State, in its discretion, need not provide notice or cure period and may terminate this Grant Award Letter in whole or in part or institute any other remedy in this Grant Award Letter as of the date that the debarment or suspension takes effect.

13. REMEDIES

In addition to any remedies available under any exhibit to this Grant Award Letter, if Grantee fails to comply with any term or condition of this Grant Award Letter, the State may terminate some or all of this Grant and require Grantee to repay any or all Grant Funds to the State in the State's sole discretion. The State may also terminate this Grant Award Letter at any time if the State has determined, in its sole discretion, that Grantee has ceased performing the Work without intent to resume performance, prior to the completion of the Work.

14. DISPUTE RESOLUTION

Except as herein specifically provided otherwise or as, disputes concerning the performance of this Grant Award Letter that cannot be resolved by the designated Party representatives shall be referred in writing to a senior departmental management staff member designated by the State and a senior manager or official designated by Grantee for resolution.

15. NOTICES AND REPRESENTATIVES

Each Party shall identify an individual to be the principal representative of the designating Party and shall provide this information to the other Party. All notices required or permitted to be given under this Grant Award Letter shall be in writing, and shall be delivered either in hard copy or by email to the representative of the other Party. Either Party may change its principal representative or principal representative contact information by notice submitted in accordance with this **§15**.

16. RIGHTS IN WORK PRODUCT AND OTHER INFORMATION

Grantee hereby grants to the State a perpetual, irrevocable, non-exclusive, royalty free license, with the right to sublicense, to make, use, reproduce, distribute, perform, display, create derivatives of and otherwise exploit all intellectual property created by Grantee or any Subcontractors or Subgrantees and paid for with Grant Funds provided by the State pursuant to this Grant Award Letter.

17. GOVERNMENTAL IMMUNITY

Liability for claims for injuries to persons or property arising from the negligence of the Parties, their departments, boards, commissions committees, bureaus, offices, employees and officials shall be controlled and limited by the provisions of the Colorado Governmental Immunity Act, §24-10-101, et seq., C.R.S.; the Federal Tort Claims Act, 28 U.S.C. Pt. VI, Ch. 171 and 28 U.S.C. 1346(b), and the State's risk management statutes, §§24-30-1501, et seq. C.R.S. No term or condition of this Grant Award Letter shall be construed or interpreted as a waiver, express or implied, of any of the immunities, rights, benefits, protections, or other provisions, contained in these statutes.

18. GENERAL PROVISIONS

A. Assignment

Grantee's rights and obligations under this Grant Award Letter are personal and may not be transferred or assigned without the prior, written consent of the State. Any attempt at assignment or transfer without such consent shall be void. Any assignment or transfer of Grantee's rights and obligations approved by the State shall be subject to the provisions of this Grant Award Letter.

B. Captions and References

The captions and headings in this Grant Award Letter are for convenience of reference only, and shall not be used to interpret, define, or limit its provisions. All references in this Grant Award Letter to sections (whether spelled out or using the § symbol), subsections, exhibits or other attachments, are references to sections, subsections, exhibits or other attachments contained herein or incorporated as a part hereof, unless otherwise noted.

C. Entire Understanding

This Grant Award Letter represents the complete integration of all understandings between the Parties related to the Work, and all prior representations and understandings related to the Work, oral or written, are merged into this Grant Award Letter.

D. Modification

The State may modify the terms and conditions of this Grant Award Letter by issuance of an updated Grant Award Letter, which shall be effective if Grantee accepts Grant Funds following receipt of the updated letter. The Parties may also agree to modification of the terms and conditions of the Grant Award Letter in a formal amendment to this Grant Award Letter, properly executed and approved in accordance with applicable Colorado State law and State Fiscal Rules.

E. Statutes, Regulations, Fiscal Rules, and Other Authority.

Any reference in this Grant Award Letter to a statute, regulation, State Fiscal Rule, fiscal policy or other authority shall be interpreted to refer to such authority then current, as may have been changed or amended since the Grant Issuance Date. Grantee shall strictly comply with all applicable Federal and State laws, rules, and regulations in effect or hereafter established, including, without limitation, laws applicable to discrimination and unfair employment practices.

F. Digital Signatures

If any signatory signs this Grant Award Letter using a digital signature in accordance with the Colorado State Controller Contract, Grant and Purchase Order Policies regarding the use of digital signatures issued under the State Fiscal Rules, then any agreement or consent to use digital signatures within the electronic system through which that signatory signed shall be incorporated into this Grant Award Letter by reference.

G. Severability

The invalidity or unenforceability of any provision of this Grant Award Letter shall not affect the validity or enforceability of any other provision of this Grant Award

Letter, which shall remain in full force and effect, provided that the Parties can continue to perform their obligations under the Grant in accordance with the intent of the Grant.

H. Survival of Certain Grant Award Letter Terms

Any provision of this Grant Award Letter that imposes an obligation on a Party after termination or expiration of the Grant shall survive the termination or expiration of the Grant and shall be enforceable by the other Party.

I. Third Party Beneficiaries

Except for the Parties' respective successors and assigns described above, this Grant Award Letter does not and is not intended to confer any rights or remedies upon any person or entity other than the Parties. Any services or benefits which third parties receive as a result of this Grant are incidental to the Grant, and do not create any rights for such third parties.

J. Waiver

A Party's failure or delay in exercising any right, power, or privilege under this Grant Award Letter, whether explicit or by lack of enforcement, shall not operate as a waiver, nor shall any single or partial exercise of any right, power, or privilege preclude any other or further exercise of such right, power, or privilege.

K. Accessibility

i. Grantee shall indemnify, save, hold harmless, and assume liability on behalf of the State, its officers, employees, agents and assignees (collectively the "Indemnified Parties") for any and all costs, expenses, claims, damages, liabilities, court awards, attorney fees and related costs, and other amounts incurred by any of the Indemnified Parties in relation to Grantee's noncompliance with §§24-85-101, et seq., C.R.S., or the *Accessibility Standards for Individuals with a Disability* as established by the Office of Information Technology pursuant to Section §24-85-103, C.R.S. State employees are considered third parties for the purposes of this section.

ii. Grantee shall comply with the *Accessibility Standards for Individuals with a Disability*, as adopted by the Office of Information Technology pursuant to ¤24-85-103 C.R.S.

iii. The State may require Grantee's compliance with the *Accessibility Standards for Individuals with a Disability* adopted by the Office of Information Technology pursuant to §24-85-103 C.R.S. is determined and tested by a qualified third party selected by the State. The State may ask the Grantee to review the selection of the third party. Grantee shall be responsible for all costs associated with the third-party vendor's assessment. If Grantee is not in compliance as determined by the third-party vendor, at the State's request and at the State's direction, Grantee shall promptly take all necessary actions to come into compliance using a State-approved vendor, at no additional cost to the State.

19. COLORADO SPECIAL PROVISIONS (COLORADO FISCAL RULE 3-3)

A. Statutory Approval. §24-30-202(1) C.R.S.

This Grant Award Letter shall not be valid until it has been approved by the Colorado State Controller or designee. If this Grant Award Letter is for a Major Information Technology Project, as defined in §24-37.5-102(2.6), then this Grant Award Letter shall not be valid until it has been approved by the State's Chief Information Officer or designee.

B. Fund Availability. §24-30-202(5.5) C.R.S.

Financial obligations of the State payable after the current fiscal year are contingent upon funds for that purpose being appropriated, budgeted, and otherwise made available.

C. Governmental Immunity.

Liability for claims for injuries to persons or property arising from the negligence of the Parties, its departments, boards, commissions committees, bureaus, offices, employees and officials shall be controlled and limited by the provisions of the Colorado Governmental Immunity Act, §24-10-101, et seq., C.R.S.; the Federal Tort Claims Act, 28 U.S.C. Pt. VI, Ch. 171 and 28 U.S.C. 1346(b), and the State's risk management statutes, §§24-30-1501, et seq. C.R.S. No term or condition of this agreement shall be construed or interpreted as a waiver, express or implied, of any of the immunities, rights, benefits, protections, or other provisions, contained in these statutes.

D. Independent Contractor.

Grantee shall perform its duties hereunder as an independent contractor and not as an employee. Neither Grantee nor any agent or employee of Grantee shall be deemed to be an agent or employee of the State. Grantee shall not have authorization, express or implied, to bind the State to any agreement, liability, or understanding, except as expressly set forth herein. Grantee and its employees and agents are not entitled to unemployment insurance or workers compensation benefits through the State and the State shall not pay for or otherwise provide such coverage for Grantee or any of its agents or employees. Grantee shall pay when due all applicable employment taxes and income taxes and local head taxes incurred pursuant to this Grant Award Letter. Grantee shall (a) provide and keep in force workers' compensation and unemployment compensation insurance in the amounts required by law, (b) provide proof thereof when requested by the State, and (c) be solely responsible for its acts and those of its employees and agents.

E. Compliance with Law.

Grantee shall comply with all applicable federal and State laws, rules, and regulations in effect or hereafter established, including, without limitation, laws applicable to discrimination and unfair employment practices.

F. Choice of Law, Jurisdiction, and Venue.

Colorado law, and rules and regulations issued pursuant thereto, shall be applied in the interpretation, execution, and enforcement of this Grant Award Letter. Any

provision included or incorporated herein by reference which conflicts with said laws, rules, and regulations shall be null and void. All suits or actions related to this Grant Award Letter shall be filed and proceedings held in the State of Colorado and exclusive venue shall be in the City and County of Denver.

G. Prohibited Terms.

Any term included in this Grant Award Letter that requires the State to indemnify or hold Grantee harmless; requires the State to agree to binding arbitration; limits Grantee's liability for damages resulting from death, bodily injury, or damage to tangible property; or that conflicts with this provision in any way shall be void ab initio. Nothing in this Grant Award Letter shall be construed as a waiver of any provision of §24-106-109 C.R.S.

H. Software Piracy Prohibition.

State or other public funds payable under this Grant Award Letter shall not be used for the acquisition, operation, or maintenance of computer software in violation of federal copyright laws or applicable licensing restrictions. Grantee hereby certifies and warrants that, during the term of this Grant Award Letter and any extensions, Grantee has and shall maintain in place appropriate systems and controls to prevent such improper use of public funds. If the State determines that Grantee is in violation of this provision, the State may exercise any remedy available at law or in equity or under this Grant Award Letter, including, without limitation, immediate termination of this Grant Award Letter and any remedy consistent with federal copyright laws or applicable licensing restrictions.

I. Employee financial Interest/Conflict of Interest. §§24-18-201 and 24-50-507 C.R.S.

The signatories aver that to their knowledge, no employee of the State has any personal or beneficial interest whatsoever in the service or property described in this Grant Award Letter. Grantee has no interest and shall not acquire any interest, direct or indirect, that would conflict in any manner or degree with the performance of Grantee's services and Grantee shall not employ any person having such known interests.

Exhibit A, Discretionary Aviation Grant Application/Statement of Work

Colorado Division of Aeronautics

APPLICANT INFORMATION

Applicant Sponsor:
Gunnison County

Airport:
Gunnison-Crested Butte Regional Airport

Identifier:
GUC

Mailing Address:
519 Rio Grande Avenue
Gunnison, CO 81230

Email Address:
rlamport@gunnisoncounty.org

Phone Number:
(970) 642-7388

GRANT DETAILS

Grant Name: 26-GUC-01

Project Director: Rick Lamport

Terms

Execution Date:
The Effective Date

Expiration Date:
June 30, 2029

FUNDING SUMMARY

Funding Source	Funding Amount
State Aviation Grant:	$525,000.00
Local Cash:	$58,334.00
Local In-Kind:	$0.00
Federal Aviation Grant:	$0.00
Total Project Funding:	**$583,334.00**

PROJECT SUMMARY & BUDGET

Acquire SRE Plow Truck Specs: 20' Plow w/ 4x4 Carrier Vehicle. Cost Estimate: $800,000.00. Time Frame: As soon as possible

ELEMENT DESCRIPTION	STATE FUNDING	STATE %	LOCAL FUNDING	LOCAL %	FEDERAL FUNDING	FED %	TOTAL
A. Snow Removal Equipment	$525,000	Up to 90.00	$58,334	10.00	$0	0.00	$583,334
TOTALS	**$525,000**		**$58,334**		**$0**		**$583,334**

EXHIBIT B, RESOLUTION

RESOLUTION

WHEREAS:
The General Assembly of the State of Colorado declared in Title 43 of the Colorado Revised Statutes, Article 10, 1991 in CRS §43-10-101 (the Act) "… that there exists a need to promote the safe operations and accessibility of general aviation in this state; that improvements to general aviation transportation facilities will promote diversified economic development across the state; and that accessibility to airport facilities for residents of this state is crucial in the event of a medical or other type of emergency…"
The Act created the Colorado Aeronautical Board ("the Board") to establish policy and procedures for distribution of monies in the Aviation Fund and created the Division of Aeronautics ("the Division") to carry out the directives of the Board, including technical and planning assistance to airports and the administration of the state aviation system grant program. SEE CRS §43-10-103 and C.R.S. §43-10-105 and CRS §43-10-108.5 of the Act.
Any eligible entity operating a public-accessible airport in the state may file an application for and be recipient of a grant to be used solely for aviation purposes. The Division is authorized to assist such airports as request assistance by means of a Resolution passed by the applicant's duly-authorized governing body, which understands that all funds shall be used exclusively for aviation purposes and that it will comply with all grant procedures, grant assurances and requirements as defined in the Division's Programs and Procedures Manual, ("the Manual") and the Airport Sponsor Assurances for Colorado Discretionary Aviation Grant Funding ("Grant Assurances") attached hereto as Exhibit C.
NOW, THEREFORE, BE IT RESOLVED THAT:
Gunnison County, as a duly authorized governing body of the grant applicant, hereby formally requests assistance from the Colorado Aeronautical Board and the Division of Aeronautics in the form of a state aviation system grant. The **Gunnison County** states that such grant shall be used solely for aviation purposes, as determined by the State, and as generally described in the Application.
By signing this Grant Agreement, the applicant commits to keep open and accessible for public use all grant funded facilities, improvements and services for their useful life, as determined by the Division and stated in the Grant Agreement and Grant Assurances as shown in Exhibit C, Table 1.

FURTHER BE IT RESOLVED:
That **Gunnison County** hereby designates Richard Lamport as the Project Director, as described in the Manual and authorizes the Project Director to act in all matters relating to the work project proposed in the Application in its behalf, including executions of the Grant Agreement and any amendments.

FURTHER:
Gunnison County has appropriated or will otherwise make available in a timely manner all funds, if any, that are required to be provided by the Applicant under the terms and conditions of the Grant Agreement.

FINALLY:
Gunnison County hereby accepts all guidelines, procedures, standards, and requirements described in the Manual as applicable to the performance of the grant work and hereby approves the Grant Agreement submitted by the State, including all terms and conditions contained therein.

_____
By: Laura Pucket Daniels, BOCC Chair Date: _____

ATTEST (if needed)

_____
By: Holly Perry, County Clerk Date: _____

Exhibit "C"
Airport Sponsor Assurances for
Colorado Discretionary Aviation Grant Funding

Revised October 15, 2025

I. APPLICABILITY

a. These assurances shall be complied with by Airport Sponsors in the performance of all projects at airports that receive Colorado Department of Transportation – Division of Aeronautics (Division) Colorado Discretionary Aviation Grant (CDAG) funding for projects including but not limited to: master planning, land acquisition, equipment acquisition or capital improvement projects (Project). It is not the intent of these Assurances to expand existing Federal Aviation Administration (FAA) Grant Assurances for airports included in the National Plan of Integrated Airport Systems (NPIAS); as similar assurances already exist for acceptance of FAA funding.

b. Upon acceptance of this grant agreement these assurances are incorporated in and become a part thereof.

II. DURATION

a. The terms, conditions and assurances of the grant agreement shall remain in full force and effect throughout the useful life of the Project as defined in Table 1 (Useful Life), or if the airport for which the Project is funded ceases to function as a public airport, for twenty (20) years from the date of Project completion, whichever period is greater. However, there shall be no limit on the duration of the assurances with respect to real property acquired with CDAG Project funds.

III. COMPLIANCE

a. Should an Airport Sponsor be notified to be in non-compliance with any terms of this agreement, they may become ineligible for future Division funding until such non-compliance is cured.

b. If any Project is not used for aviation purposes during its Useful Life, or if the airport for which the Project is funded ceases to function as a public airport, for twenty (20) years from the date of Project completion or at any time during the estimated useful life of the Project as defined in Table 1, whichever period is greater, the Airport Sponsor may be liable for repayment to the Division of any or all funds contributed by the Division under this agreement. If the airport at which the Project is constructed is abandoned for any reason, the Division may in its discretion discharge the Airport Sponsor from any repayment obligation upon written request by the Airport Sponsor.

IV. AIRPORT SPONSOR STATE GRANT ASSURANCES

1. **Compatible Land Use.** Compatible land use and planning in and around airports benefits the state aviation system by providing opportunities for safe airport development, preservation of airport and aircraft operations, protection of airport approaches, reduced potential for litigation and compliance with appropriate airport design standards. The airport will take appropriate action, to the extent reasonable, to restrict the use of land adjacent to, in the immediate

vicinity of, or on the airport to activities and purposes compatible with normal airport operations, including landing and takeoff of aircraft.

2. **On-Airport Hazard Removal and Mitigation**. The airport will take appropriate action to protect aircraft operations to/from the airport and ensure paths are adequately cleared and protected by removing, lowering, relocating, marking, or lighting or otherwise mitigating existing airport hazards and by preventing the establishment or creation of future airport hazards.

3. **Safe, Efficient Use, and Preservation of Navigable Airspace.** The airport shall comply with 14 CFR Part 77 for all future airport development and anytime an existing airport development is altered.

4. **Operation and Maintenance.** In regards to Projects that receive Division funding, the airport sponsor certifies that it has the financial or other resources that may be necessary for the preventive maintenance, maintenance, repair and operation of such projects during their Useful Life.

   The airport and all facilities which are necessary to serve the aeronautical users of the airport shall be operated at all times in a safe and serviceable condition. The airport will also have in effect arrangements for:

   a. Operating the airport's aeronautical facilities whenever required;
   b. Promptly marking and lighting hazards resulting from airport conditions, including temporary conditions; and
   c. Promptly notifying airmen of any condition affecting aeronautical use of the airport.

5. **Airport Revenues.** All revenues generated by the airport will be expended by it for the capital or operating costs of the airport, the local airport system, or other local facilities owned or operated by the owner or operator of the airport for aviation purposes.

6. **Airport Layout Plan (ALP).** Once accomplished and as otherwise may be required to develop, it will keep up-to-date a minimum of an ALP of the airport showing (1) boundaries of the airport and all proposed additions thereto, together with the boundaries of all offsite areas owned or controlled by the sponsor for airport purposes and proposed additions thereto; (2) the location and nature of all existing and proposed airport facilities and structures (such as runways, taxiways, aprons, terminal buildings, hangars and roads), including all proposed extensions and reductions of existing airport facilities; and (3) the location of all existing improvements thereon.

7. **Use for Aviation Purposes.** The Airport Sponsor shall not use runways, taxiways, aprons, seeded areas or any other appurtenance or facility constructed, repaired, renovated or maintained under the terms of this Agreement for activities other than aviation purposes unless otherwise exempted by the Division.

TABLE 1

Project Type	Useful Life
a. All construction projects (unless listed separately below)	20 years
b. All equipment and vehicles	10 years
c. Pavement rehabilitation (not reconstruction, which is 20 years)	10 years
d. Asphalt seal coat, slurry seal, and joint sealing	3 years
e. Concrete joint replacement	7 years
f. Permanent aviation fuel farms, including storage tanks, dispensing vehicles and related equipment*	15 years
g. Airfield lighting and signage	10 years
h. Navigational Aids	15 years
i. Buildings	40 years
j. Land	Unlimited

*Temporary, non-permanent aviation fuel storage equipment (such as tank trailers and skid mounted self-contained storage tanks) that is used exclusively to facilitate the transition from 100LL avgas to unleaded avgas is not subject to a specific useful life.

Exhibit D, Sample Option Letter

State Agency

Colorado Department of Transportation, Colorado Aeronautical Board, Division of Aeronautics

Grantee

[Insert Grantee's Full Legal Name, including "Inc.", "LLC", etc.]

Current Agreement Maximum Amount

Initial Funding

State Funding:	$0.00

Modifications

Option Letter 1	$0.00
Option Letter 2	$0.00
Option Letter 3	$0.00
Option Letter 4	$0.00
Modified Agreement Maximum Amount	**$0.00**

Option Letter Number

[Insert the Option Number (e.g. "1" for the first option)]

Original Agreement Number

[Insert CMS number or Other Agreement Number of the Original Agreement]

Option Agreement Number

[Insert CMS number or Other Agreement Number of this Option]

Agreement Performance Beginning Date

[Month Day, Year]

Current Agreement Expiration Date

[Month Day, Year]

Options:

A. Option to extend for an Extension Term

B. Option to change the quantity of Goods/Service under the Agreement

Required Provisions:

A. **For use with Option 1(A):** In accordance with Section(s) Number of the Original Agreement referenced above, the State hereby exercises its option for an additional term, beginning Insert start date and ending on the current Agreement expiration date shown above, at the rates stated in the Original Agreement, as amended.

B. **For use with Options 1(B):** In accordance with Section(s) Number of the Original Agreement referenced above, the State hereby exercises its option to Increase/Decrease the Agreement Maximum Amount for an Increase/Decrease in the quantity of Goods/Services or both at the rates stated in the Original Agreement, as amended.

C. **For use with all Option Letters:** The Agreement Maximum Amount table on the Agreement's Signature and Cover Page is hereby deleted and replaced with the Current Agreement Maximum Amount table shown above and Exhibit A is hereby deleted and replaced with Exhibit A-# incorporated and attached hereto.

Option Effective Date:

The effective date of this Option Letter is upon approval of the State Controller.

GRANTEE	**STATE OF COLORADO**
Gunnison County	Jared S. Polis, Governor Department of Transportation Division of Aeronautics
By: Name of Authorized Signer, Title	By: David R. Ulane, Director
Date: _____	Date: _____

In accordance with §24-30-202, C.R.S., this Agreement is not valid until signed and dated below by the State Controller or an authorized delegate.

STATE CONTROLLER

Robert Jaros, CPA, MBA, JD

By: Department of Transportation

Date_____

AGENDA ITEM or FINAL CONTRACT REVIEW SUBMITTAL FORM

Agenda Item: Amendment #1; Gunnison County, Colorado Employee M

Action Requested: Board of County Commissioners' Signature

Parties to the Agreement:

Term Begins: 01/01/2025 **Term Ends:** **Grant Contract #:**

Summary:

Consideration and approval of Amendment #1 to the Gunnison County Employee Medical Benefit Plan (Cost Plus Plan), effective retroactive to January 1, 2025. The amendment updates the Urgent Care benefit payment levels under the HSA Plan. This change aligns plan language with the

Fiscal Impact: N/A

Submitted by: Lauren Trautz **Submitter's Email Address:** ltrautz@gunnisoncounty.org

Finance Review: ○ Required ◉ Not Required

Comments:

Reviewed by: Discharge Date:

County Attorney Review: ◉ Required ○ Not Required

Comments:
Legally sufficient. SO 2/24/26

Reveiwed by: GUNCOUNTY1\sobaid Discharge Date: 2/24/2026 Certificate of Insurance Required

Yes ○ No ◉

County Manager Review:

Comments:

Reveiwed by: GUNCOUNTY1\mbirnie Discharge Date: 2/25/2026

◉ Consent Agenda ○ Regular Agenda ○ Worksession Time Allotted: 0

Agenda Date: 3/3/2026

Revised April 2015

AMENDMENT #1

To Plan Document Dated September 1, 2017 and Restated January 1, 2025

GUNNISON COUNTY, COLORADO EMPLOYEE MEDICAL BENEFIT PLAN

COST PLUS PLAN

Effective January 1, 2025:

1. **DELETE and REPLACE the Level I Benefits – Payment Levels and Limits, Urgent Care Facility (Minor Emergency Medical Clinic) benefit in the SCHEDULE OF BENEFITS – HSA Plan as follows:**

Urgent Care Facility (Minor Emergency Medical Clinic)		
All Covered Expenses	100% of Allowable Claim Limits Deductible applies	

2. **DELETE and REPLACE the Level II Benefits – Payment Levels and Limits, Urgent Care Facility (Minor Emergency Medical Clinic) benefit in the SCHEDULE OF BENEFITS – HSA Plan as follows:**

***Urgent Care Facility** (Minor Emergency Medical Clinic)	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	

I, _____, certify that I am the _____
Name Title

of the **Plan Administrator** for the above named Plan, and further certify that I am authorized to sign this Amendment. I have read and agree with the above change to the Plan and am hereby authorizing its implementation as of the effective date stated above.

Signature: _____

Print Name: _____

Date: _____

PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

FOR

GUNNISON COUNTY, COLORADO

EFFECTIVE: SEPTEMBER 1, 2017
RESTATED: JANUARY 1, 2025

COST PLUS PLAN

GUNNISON COUNTY, COLORADO EMPLOYEE MEDICAL BENEFIT PLAN

ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

It is the intention of the Plan Sponsor, **Gunnison County, Colorado**, to hereby amend and restate the Gunnison County, Colorado Employee Medical Benefit Plan, a program of benefits constituting a self-funded "Employee Welfare Benefit Plan"

Effective Date
The Plan Document is effective as of the date first set forth below, and each amendment is effective as of the date set forth therein (the “Effective Date”).

Adoption of the Plan Document
The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description, This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has executed, and the Claims Administrator has acknowledged, this Plan Document as of the Plan effective date shown herein.

Effective Date of the Plan: **September 1, 2017**; Amended and restated effective: **January 1, 2025**

Gunnison County, Colorado:

By: _____

Printed Name: Laura Puckett Daniels

Title: Chairperson

Date: 4/15/25

TABLE OF CONTENTS

PAGE

GENERAL INFORMATION AND PURPOSE

This Plan Document describes the benefits for the Employees of **Gunnison County, Colorado**.

Introduction and Purpose
The Plan Sponsor has established the Plan for the benefit of Eligible Employees, in accordance with the terms and conditions described herein. Plan benefits may be self-funded through a benefit fund or a trust established by the Plan Sponsor and self-funded with contributions from Participants and/or the Plan Sponsor, or may be funded solely from the general assets of the Plan Sponsor. Participants in the Plan may be required to contribute toward their benefits.

The Plan Sponsor's purpose in establishing the Plan is to help offset, for Eligible Employees, the economic effects arising from a Non-occupational Injury or Illness. To accomplish this purpose, the Plan Sponsor must be cognizant of the necessity of containing health care costs through effective plan design, and of abiding by the terms of the Plan Document, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to the maximum feasible extent.

The purpose of this Plan Document is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain covered expenses for medical charges. The Plan Document is maintained by **Gunnison County, Colorado** and may be inspected at any time during normal working hours by any Covered Person.

Name of Plan
Gunnison County, Colorado Employee Medical Benefit Plan

Participating Employers
Gunnison County, Colorado

Plan Sponsor
Gunnison County, Colorado
200 E. Virginia
Gunnison, CO 81230
1-970-641-7623

Plan Administrator
Gunnison County, Colorado
200 E. Virginia
Gunnison, CO 81230
1-970-641-7623

Type of Plan
Self-Funded Employee Welfare Benefit Plan

Agent for Service of Legal Process
Legal Process may also be served on the Plan Administrator
Gunnison County, Colorado
200 E. Virginia
Gunnison, CO 81230
1-970-641-7623

Claims Administrator
Imagine360 Administrators, LLC
Park Central 8
12770 Merit Drive, Suite 200
Dallas, Texas 75251
972-238-7900 ♦ 800-827-7223
The Plan Administrator has retained the services of the Claims Administrator to administer Claims under the Plan.

Utilization Review Department
Imagine360 Administrators, LLC
Park Central 8
12770 Merit Drive, Suite 200
Dallas, Texas 75251
972-744-2486 ◆ 866-206-3224

Plan Year
The twelve (12) month period beginning January 1 and ending December 31 of each Calendar Year

Employer Tax ID Number
84-6000770

Group Number
H880141

Legal Entity; Service of Process
The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

INTRODUCTION

Gunnison County, Colorado, hereafter referred to as "Employer" hereby amends and restates the Gunnison County, Colorado Employee Medical Benefit Plan, a self-funded Employee Welfare Benefit Plan, hereafter referred to as the "Plan." The Plan's benefits and administration expenses are paid directly from the Employer's general assets, and the rights and privileges of which shall pertain to Employees and their Dependents with respect to such Plan. The Plan is not insured. Contributions received from Covered Persons are used to cover Plan costs and are expended immediately. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

PLAN ADMINISTRATOR AND IMAGINE360

The Plan is administered by the Plan Administrator. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

Notwithstanding any provisions of this Plan Document and Summary Plan Description to the contrary, the Plan Sponsor has the authority to, and hereby does, allocate certain Fiduciary responsibility to Imagine360. The Fiduciary responsibility allocated to Imagine360 is limited to discretionary authority and decision-making authority with respect to any appeals of denied Claims, which shall be referred to Imagine360 by the Plan Administrator (the "Referred Appeals"). The Plan Sponsor has allocated additional Fiduciary responsibility to Imagine360, limited to discretionary authority and decision-making authority with respect to the review and audit of certain Claims in accordance with the applicable Plan provisions under the section, "Claim Review and Audit Program". Such Claims selected as eligible for review and audit shall be identified by Imagine360 under guidelines to which the Plan Sponsor has agreed, and shall be referred to Imagine360 by the Plan Administrator. Imagine360 shall have no authority, responsibility or liability other than with respect to the Referred Appeals and its duties under the Claim Review and Audit Program.

The Plan Administrator shall establish the policies, practices and procedures of this Plan. The Plan Administrator and Imagine360 shall administer this Plan in accordance with its terms. It is the express intent of this Plan that the Plan Administrator and Imagine360 shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of which services, supplies, care and treatment are Experimental/Investigational), to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator and/or Imagine360 as to the facts related to any Claim for benefits and the meaning and intent of any provision of the Plan, or its application to any Claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator or Imagine360 decides, in its discretion, that the Covered Person is entitled to them.

DUTIES OF THE PLAN ADMINISTRATOR

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a Plan Participant's rights;
6. To prescribe procedures for filing a Claim for benefits, to review Claim denials and appeals relating to them and to uphold or reverse such denials;
7. To keep and maintain the Plan documents and all other records pertaining to the Plan;

8. To appoint and supervise a third party administrator to pay Claims;
9. To perform all necessary reporting as required by applicable law;
10. To ensure that the Plan is administered in accordance with applicable law;
11. To establish and communicate procedures to determine whether a Medical Child Support Order or national medical support notice is a QMCSO;
12. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
13. To perform each and every function necessary for or related to the Plan's administration.

DUTIES OF IMAGINE360

Imagine360 shall have the following duties with respect to the Referred Appeals and the Claim Review and Audit Program:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to benefits payable under the Plan and negotiating settlements, if appropriate;
6. To review Referred Appeals and to uphold or reverse any denials;
7. To keep and maintain records pertaining to the Referred Appeals;
8. To perform the duties in conjunction with the provisions of the Claim Review and Audit Program; and
9. To keep and maintain records pertaining to the Claim Review and Audit Program.

The duties of Imagine360 shall be limited to those set forth above.

PHYSICIAN-PATIENT RELATIONSHIP

The Plan is not intended to disturb the Physician-Patient relationship. Physicians and other healthcare Providers are not agents or delegates of the Plan Sponsor, Plan Administrator, Employer or Claims Administrator. The delivery of medical and other healthcare services on behalf of any Covered Person remains the sole prerogative and responsibility of the attending Physician or other healthcare Provider.

FREE CHOICE OF HOSPITAL AND PHYSICIAN

Nothing contained in this Plan shall in any way or manner restrict or interfere with the right of any person entitled to benefits hereunder to select a Hospital or to make a free choice of the attending Physician or professional Provider. However, benefits will be paid in accordance with the provisions of this Plan, and the Covered Person may have higher out-of-pocket expenses if the Covered Person uses the services of a Non-Preferred Provider Physician.

PREFERRED PROVIDER INFORMATION

The Preferred Provider Network (PPO) includes Physicians and other professional Providers who have contracted with the medical Provider Networks. For Physicians and all other professional Providers of service, this Plan contains provisions under which a Plan Participant may receive more benefits by using certain Providers. There is a section in the Schedule of Benefits which describes the benefits for PPO Providers (Level II). PPO Providers are individuals and entities that have contracted with the Plan to provide services to Plan Participants at pre-negotiated rates. A list of these Preferred Providers can be accessed on the PPO website free of charge. In addition, a Plan Participant may request a Preferred Provider list by contacting the Plan Administrator. The Preferred Provider list changes frequently; therefore, it is

recommended that a Plan Participant verify with the Provider that the Provider is still a Preferred Provider before receiving services.

The Preferred Provider Network (PPO) does **not** include services and supplies provided by Facilities such as Hospital Facilities, Ambulatory Surgery Center Facilities and dialysis clinics or Facilities. You may contact the Claims Administrator or the Plan Administrator with any questions regarding which Facilities may be included under the Claim Review and Audit Program, and which may be included under the PPO Network agreement.

For all Facility Providers and those Physicians and professional Providers not participating in the PPO, the Plan will identify the Reasonable cost for the services and supplies through its Claim Review and Audit Program. There is a section in this Summary Plan Description that fully describes the Claim Review and Audit Program. The benefits for Facility Providers are described in the Schedule of Benefits under Level I and the benefits for those Physicians and professional Providers not participating in the PPO (Non-PPO) are described in Level II.

This plan may use Allowable Claim Limits to determine Covered Charges in lieu of a PPO discount.

If a Participant receives information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative, indicating that a particular Provider is an In-Network Provider and the Participant receives such item or service in reliance on that information, the Participant's Coinsurance, Copayment, Deductible, and Out-of-Pocket Maximum will be calculated as if the Provider had been In-Network despite that information proving to be inaccurate.

EFFECTIVE DATE

Effective Date of the Plan: **September 1, 2017**; Amended and restated effective: **January 1, 2025**

CLAIMS ADMINISTRATOR

The Claims Administrator of the Plan is shown in the General Information and Purpose section.

NAMED FIDUCIARY

The named Fiduciary to the Plan is **Gunnison County, Colorado**, who, as Plan Administrator, shall have the authority to control and manage the operation and administration of the Plan. The Employer may delegate responsibilities for the operation and administration of the Plan. The Employer or Board of Directors of the Employer, if applicable, shall have the authority to amend or terminate the Plan, to determine its policies, to appoint and remove service Providers, adjust their compensation (if any), and exercise general administrative authority over them. The Employer has the sole authority and responsibility to review and make final decisions on all Claims to benefits hereunder.

CONTRIBUTIONS TO THE PLAN

Contributions to the Plan are to be made on the following basis:

The Employer shall from time to time evaluate the costs of the Plan and determine the amount to be contributed by the Employer and the amount to be contributed by each Covered Employee.

Notwithstanding any other provision of the Plan, the Employer's obligation to pay Claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraph. Payment of said Claims in accordance with these procedures shall discharge completely the Employer's obligation with respect to such payments.

In the event that the Employer, if applicable, terminates the Plan, then as of the effective date of termination, the Employer and Covered Employees shall have no further obligation to make additional contributions to the Plan and the Plan shall have no obligation to pay Claims incurred after the termination date of the Plan.

CLAIMS PROCEDURE

the Plan Administrator shall provide adequate notice in writing to any covered Plan Participant whose Claim for benefits under this Plan has been denied, setting forth the specific reasons for such denial and written in a manner calculated to be understood by the Plan Participant. Further, the Plan Administrator shall afford a reasonable opportunity to any Plan Participant, whose Claim for benefits has been denied, for a fair review of the decision denying the Claim by the person designated by the Plan Administrator for that purpose. Details of the Claims procedure are found in this Plan Document under the section entitled “Procedures for Claims and Appeals.”

PROTECTION AGAINST CREDITORS

No benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any Plan Participant, the Plan Administrator in its sole discretion may terminate the interest of such Plan Participant or former Plan Participant in such payment. And in such case the Plan Administrator shall apply the amount of such payment to or for the benefit of such Plan Participant or former Plan Participant, his/her spouse, parent, adult Child, guardian of a minor Child, brother or sister, or other relative of a Dependent of such Plan Participant or former Plan Participant, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of the Plan Administrator, benefit payments may be assigned to health care Providers.

AMENDING AND TERMINATING THE PLAN

This Document contains all the terms of the Plan. The Plan Sponsor expects to maintain this Plan indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan.

Any such amendment, suspension or termination shall be enacted, if the Plan Sponsor is a corporation, by written resolution of the Plan Sponsor's Board of Directors and officers, which shall be acted upon as provided in the Plan Sponsor's Articles of Incorporation or Bylaws, as applicable, and in accordance with applicable Federal and State law. In the event that the Plan Sponsor is a different type of entity, then such amendment, suspension or termination shall be taken and enacted in accordance with applicable Federal and State law and any applicable governing documents. In the event that the Plan Sponsor is a sole proprietorship, then such action shall be taken by the sole proprietor, in his own discretion.

If the Plan is terminated, the rights of the Covered Persons are limited to expenses incurred before termination. Previous contributions by the Employer shall continue to be used for the purpose of paying benefits under the provisions of this Plan with respect to Claims arising before such termination.

All amendments to this Plan shall become effective as of a date established by the Plan Sponsor and specified in the enabling resolution. Copies of all amendments shall be furnished by the Plan Administrator to the Trustees (if any) and any outside Provider of Plan administrative services.

SUMMARY OF MATERIAL REDUCTION (SMR)

A Material Reduction generally means any modification that would be considered by the average participant to be an important reduction in covered services or benefits. Examples include reductions in benefits or increases in Deductibles or copayments.

The Plan Administrator shall notify all Covered Employees of any Plan Amendment considered a Material Reduction in covered services or benefits provided by the Plan as soon as administratively feasible after its adoption, but no later than sixty (60) days after the date of adoption of the reduction. Covered Employees and beneficiaries must be furnished a summary of such reductions, and any changes so made shall be binding on each Covered Person. The sixty (60) day period for furnishing a summary of Material Reduction does not apply to any Employee covered by the Plan who would reasonably expect to receive a summary through other means within the next ninety (90) days.

Material Reduction disclosure provisions are subject to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any related amendments.

SUMMARY OF MATERIAL MODIFICATIONS (SMM)

A Summary of Material Modifications reports changes in the information provided within the Summary Plan Description. Examples include a change to Deductibles, eligibility or the addition or deletion of coverage.

The Plan Administrator shall notify all Covered Employees of any Plan Amendment considered a Summary of Material Modifications by the Plan as soon as administratively feasible after its adoption, but no later than within two hundred ten (210) days after the close of the Plan Year in which the changes became effective.

PLAN IS NOT A CONTRACT

This Plan Document constitutes the entire Plan. The Plan will not be deemed to constitute a contract of employment or give any Covered Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge or otherwise terminate the employment of any Covered Employee.

FEDERAL LAWS

Certain Federal laws apply to most group health programs. The following is an overview of the laws and their impact. The effect of these laws on the Plan is reflected in the provisions of the Plan. Should there be any conflict between the law and Plan provisions, the law will prevail.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (H.R. 3103, 1996)
The Health Insurance Portability and Accountability Act (HIPAA) was enacted, among other things, to improve portability and continuity of health care coverage.

HIPAA also requires that Plan Participants and beneficiaries receive a summary of any change that is a "Material Reduction in covered services or benefits under a group health plan" within sixty (60) days after the adoption of the modification or change, unless the Plan Sponsor provides summaries of modifications or changes at regular intervals of ninety (90) days or less.

PREGNANCY DISCRIMINATION ACT OF 1978
Most Employers must provide coverage for Pregnancy expenses in the same manner as coverage is provided for any other Illness. This requirement applies to Pregnancy expenses of an Employee or a covered Dependent spouse of an Employee.

FAMILY AND MEDICAL LEAVE ACT OF 1993(P.L. 103-3)
If a Covered Employee ceases active employment due to an Employer-approved Family Medical Leave of Absence in accordance with the requirements of Public Law 103, coverage availability will continue under the same terms and conditions which would have applied had the Employee continued in active employment. Contributions will remain at the same Employer/Employee levels as were in effect on the date immediately prior to the leave (unless contribution levels change for other Employees in the same classification).

OMNIBUS BUDGET RECONCILIATION ACT OF 1993 (OBRA 1993: PL 103-66)
OBRA 1993 requires that an eligible Dependent Child of an Employee will include a Child who is adopted by the Employee or placed with him for adoption prior to age eighteen (18) and a Child for whom the Employee or covered Dependent spouse is required to provide coverage due to a Medical Child Support Order (MCSO) which is determined by the Plan Sponsor to be a Qualified Medical Child Support Order (QMCSO). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under State law and having the force and effect of law under State law and which satisfies the QMCSO requirements.

Participants may obtain a copy of the QMCSO procedures from the Plan Sponsor or Plan Administrator without charge.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996
The Newborns' and Mothers' Health Protection Act of 1996 establishes restrictions on the extent to which group health plans and health insurance issuers may limit the length of stay for mothers and newborn Children following delivery, as follows:

Statement of Rights under the Newborns' and Mothers' Health Protection Act
"Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 vaginal delivery, or less than ninety-six (96) hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending Provider (i.e., 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 forty-eight (48) hour or ninety-six (96) hour stay is treated in a manner less favorable to the mother or newborn than any 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 of up to forty-eight (48) or ninety-six (96) hours. However, to use certain Providers or Facilities, or to reduce your out-of-pocket costs, you may be required to give notification. For information on notification, contact your Plan Administrator.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998
If you are receiving covered benefits for a mastectomy, you should know that your Plan complies with the Women's Health and Cancer Rights Act of 1998. The Act provides for:

1. Reconstruction of the breast(s) on which a covered mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and physical complications related to all stages of covered mastectomy, including lymphedema.

All applicable benefit provisions still apply, including existing Deductibles, Copays and/or Coinsurance.

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 ("GINA")
GINA prohibits the group health Plan from:

1. Adjusting premiums or contribution amounts for the group as a whole on the basis of Genetic Information.

2. Requesting or requiring an individual or a Family member to undergo a genetic test. However, subject to certain conditions, the Plan may request that an individual voluntarily undergo a genetic test as part of a research study as long as the results are not used for underwriting purposes.

3. Requesting, requiring or purchasing Genetic Information for underwriting purposes (which includes eligibility rules or determinations, computation of premium or contribution amounts and other activities related to the creation, renewal or replacement of coverage). The Plan is also prohibited from requesting, requiring or purchasing Genetic Information with respect to any individual prior to such individual's enrollment under the Plan or coverage. However, if the Plan obtains Genetic Information incidental to the collection of other information prior to enrollment, it will not be in violation of GINA as long as it is not used for underwriting purposes.

GINA allows the group health Plan to obtain and use the results of genetic tests for purposes of making payment determinations.

What is "Genetic Information" under GINA?

Under GINA, the term "Genetic Information" includes:

1. Information about an individual or his/her Family member's genetic tests (defined as analyses of the individual's DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations or chromosomal changes);

2. The manifestation of a Disease or disorder in the Family members of the individual. Family members are broadly defined under GINA to include individuals who are Dependents, as well as any other first, second, third or fourth degree relative. Further, Genetic Information includes that information of any fetus or embryo carried by a pregnant woman; and

3. Information obtained through genetic services (that is genetic tests, genetic counseling or genetic education) or participation in clinical research that includes genetic services.

Genetic Information does not include the sex or age of an individual.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 (MHPAEA)
The Mental Health Parity and Addiction Equity Act requires that, if a group health plan provides coverage for mental health conditions or for substance use disorders, benefits for such conditions must be provided in the same manner as benefits for any Illness. Also, the Plan may not have separate cost-sharing arrangements that apply only to mental health or substance use disorder benefits.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)
If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your Employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your Dependents are already enrolled in Medicaid or CHIP, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your Dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your Dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your State if it has a program that might help you pay the premiums for an Employer-sponsored plan.

If you or your Dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your Employer plan, your Employer must allow you to enroll in your Employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

For more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

PRIVACY OF PROTECTED HEALTH INFORMATION (PHI)
Effective April 14, 2004, the Plan will not use or disclose PHI except as permitted by this section or as otherwise permitted or required by law, including but not limited to the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA Privacy Standards"), as they may be amended from time to time. Nothing in this section shall be construed to prohibit the Plan Sponsor's receipt of "summary health information," as described in the HIPAA Privacy Standards, for certain Plan Sponsor-related purposes, including obtaining premium bids for health insurance, making Plan design and funding decisions, and modifying, amending or terminating the Plan.

PLAN SPONSOR'S OBLIGATIONS REGARDING PROTECTED HEALTH INFORMATION (PHI)
Effective April 14, 2004, the Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor to the Plan that the Plan has been amended to provide for the Plan Sponsor's receipt of PHI and that the Plan Sponsor agrees to comply with the following provisions:

1. The Plan Sponsor may use or disclose PHI for Plan enrollment purposes, including information as to whether an individual is enrolled in the Plan.

2. The Plan Sponsor may use or disclose PHI for Plan administration functions, including for payment or health care operations purposes (as those terms are defined by the HIPAA Privacy Standards), and including quality assurance, Claims processing, auditing and monitoring of the Plan.

3. The Plan Sponsor may not use or further disclose PHI other than as permitted or required by the Plan documents or by law.

4. The Plan Sponsor must ensure that any agents, including subcontractors, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with regard to the PHI.

5. The Plan Sponsor may not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or other Employee Benefit Plan of the Plan Sponsor.

6. The Plan Sponsor must report to the Plan any use or disclosure of the PHI of which the Plan Sponsor becomes aware that is inconsistent with the uses or disclosures provided for under the terms of the Plan.

7. The Plan Sponsor must make PHI available for access in accordance with the HIPAA Privacy Standards regarding an individual's right to access his/her PHI.

8. The Plan Sponsor must make PHI available for amendment and, if required by the HIPAA Privacy Standards, incorporate any amendment made to PHI in accordance with the HIPAA Privacy Standards regarding an individual's right to have his PHI amended.

9. The Plan Sponsor must make available information necessary to provide an accounting to an individual in accordance with the HIPAA Privacy Standards regarding an individual's right to receive an accounting of disclosures of his/her PHI.

10. The Plan Sponsor must make internal practices, books, and records relating to the use and disclosure of PHI available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Standards.

11. The Plan Sponsor must, if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Plan Sponsor must limit further uses and disclosures to those purposes that make the return or destruction not feasible.

12. The Plan Sponsor must ensure adequate separation between the Plan and the Plan Sponsor by restricting access to and use of the PHI to only those Employees of the Plan Sponsor with responsibilities related to the administrative functions the Plan Sponsor performs for the Plan, as such Employees may be designated or identified, by name, job title, or classification, from time to time in various Business Associate Agreements between the Plan and the Plan's Business Associates or in other documents governing the administration of the Plan.

13. The Plan Sponsor must ensure adequate separation between the Plan and the Plan Sponsor by maintaining a procedure for resolving any issues of noncompliance with provisions of the Plan document by persons described in paragraph 12 above through training, sanctions and other disciplinary action, as necessary.

14. The Plan Sponsor shall not directly or indirectly receive remuneration in exchange for any PHI without valid authorization that includes a specification of whether the PHI can be further exchanged for remuneration by the entity receiving PHI of the individual making authorization, except as otherwise allowed under the American Recovery and Reinvestment Act.

SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION (ePHI)

Effective April 20, 2006, the Plan will not use or disclose ePHI except as permitted by this section or as otherwise permitted or required by law, including but not limited to the requirements of 45 C.F.R. Sections 164.314(b)(1) and (2) and its implementing regulations, 45 C.F.R. parts 160, 162, and 164 of the Security Standards of the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA Security Standards"), as they may be amended from time to time. Nothing in this section shall be construed to

prohibit the Plan Sponsor's receipt of "summary health information," as described in the HIPAA Security Standards, for certain Plan Sponsor-related purposes, including obtaining premium bids for health insurance, making Plan design and funding decisions, and modifying, amending or terminating the Plan.

PLAN SPONSOR'S OBLIGATIONS REGARDING ELECTRONIC PROTECTED HEALTH INFORMATION (ePHI)

Effective April 20, 2006, the Plan will disclose ePHI to the Plan Sponsor only upon receipt of an amendment to the Plan that the Plan has been amended to provide for the Plan Sponsor's receipt of ePHI and that the Plan Sponsor agrees to comply with the following provisions:

1. The Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that the Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan.

2. The Plan Sponsor shall ensure the adequate separation that is required by 45 C.F.R. Section 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures.

3. The Plan Sponsor shall ensure any agent, including a subcontractor, to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect such information.

4. The Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:

    a. The Plan Sponsor shall report to the Plan within a reasonable time after the Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's ePHI.

    b. The Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis semi-annually, or more frequently upon the Plan's request.

BREACH AND SECURITY INCIDENTS

Effective September 23, 2009, the Health Information Technology for Economic and Clinical Health Act (HITECH) of the American Recovery and Reinvestment Act of 2009 (ARRA) imposes notification in the event of a Breach of unsecured Protected Health Information (PHI).

The Plan Sponsor will report to the Privacy Official of the Plan any use or disclosure of PHI not permitted by HIPAA, along with any Breach of unsecured Protected Health Information. The Plan Sponsor will treat the Breach as being discovered in accordance with HIPAA's requirements. The Plan Sponsor will make the report to the Privacy Official not more than thirty (30) calendar days after the Plan Sponsor learns of such non-permitted use or disclosure. If a delay is requested by a law enforcement official in accordance with 45 C.F.R. § 164.412, the Plan Sponsor may delay notifying the Privacy Official for the time period specified by such regulation. The Plan Sponsor's report will at least:

1. Identify the nature of the Breach or other non-permitted use or disclosure, which will include a brief description of what happened, including the date of any Breach and the date of the discovery of any Breach;

2. Identify Protected Health Information that was subject to the non-permitted use or disclosure or Breach (such as whether full name, social security number, date of birth, home address, account number or other information was involved) on an individual-by-individual basis;

3. Identify who made the non-permitted use or disclosure and who received the non-permitted disclosure;

4. Identify what corrective or investigational action the Plan Sponsor took or will take to prevent further non-permitted uses or disclosures, to mitigate harmful effects and to protect against any further Breaches;

5. Identify what steps the individuals who were subject to a Breach should take to protect themselves; and

6. Provide such other information, including a written report, as the Privacy Official may reasonably request.

The Plan Sponsor will report to the Privacy Official within thirty (30) calendar days any attempted or successful: a) unauthorized access, use, disclosure, modification, or destruction of Electronic Protected Health Information; and b) interference with the Plan Sponsor's system operations in the Plan Sponsor's information systems, of which the Plan Sponsor becomes aware. The Plan Sponsor will make this report upon the Privacy Official's request, except if any such Security Incident resulted in a disclosure or Breach of Protected Health Information or Electronic Protected Health Information not permitted by the HITECH Act, the Plan Sponsor will make the report in accordance with the above.

FAIR LABOR STANDARDS ACT (FLSA §18B)

FLSA §18B, as added by the Affordable Care Act §1512, provides that, beginning October 1, 2013, an applicable Employer must provide each Employee, regardless of plan enrollment status or of part-time or full-time status, at the time of hiring, a written notice:

1. Informing the Employee of the existence of the Marketplace (referred to in the statute as the Exchange) including a description of the services provided by the Marketplace, and the manner in which the Employee may contact the Marketplace to request assistance;
2. If the Employer Plan's share of the total allowed costs of benefits provided under the Plan is less than sixty (60) percent of such costs, that the Employee may be eligible for a premium tax credit under section 36B of the Internal Revenue Code (the Code) if the Employee purchases a qualified health plan through the Marketplace; and
3. If the Employee purchases a qualified health plan through the Marketplace, the Employee may lose the Employer contribution (if any) to any health benefits plan offered by the Employer and that all or a portion of such contribution may be excludable from income for Federal income tax purposes.

For 2014, the Department of Labor will consider a notice to be provided at the time of hiring if the notice is provided within fourteen (14) days of an Employee's start date. With respect to Employees who are current Employees before October 1, 2013, Employers are required to provide the notice not later than October 1, 2013.

The notice must be provided in writing in a manner calculated to be understood by the average employee, free of charge. Alternatively, it may be provided electronically if the requirements of the Department of Labor's electronic disclosure safe harbor at 29 CFR 2520.104b-1(c) are met.

For more information, please visit:

https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/technical-releases/13-02.

SCHEDULE OF BENEFITS – TRADITIONAL PLAN

MAJOR MEDICAL BENEFITS FOR COVERED PERSONS

NOTE: All Claims are subject to review and/or audit to ensure that charges are payable in accordance with the terms and limitations of this Plan.

LEVEL I PROVIDERS – Facilities and Providers billing as a Facility to include, but not limited to:

- Hospitals (Inpatient and Outpatient treatment)
- Inpatient Facilities (such as Rehabilitation Facilities, Skilled Nursing Facilities and Hospice)
- Inpatient and Outpatient Facilities for treatment of Mental Disorders, Chemical Dependency, Drug and Substance Abuse
- Ambulatory Surgery Centers
- Dialysis Clinics
- Ambulance (air and ground)

LEVEL II PROVIDERS – Physicians and all other Providers of service

Maximum Benefits	
Lifetime Maximum Dollar Benefit (All Covered Essential Health Benefits)	Unlimited
Annual Maximum Dollar Benefit (All Covered Essential Health Benefits)	Unlimited

Deductible and Annual Out-of-Pocket Maximum	Level I Benefit Level II PPO / Non-PPO Benefit
Calendar Year Deductible • Per Covered Person • Family Limit*	 $800 $1,600
Benefit Percentage (unless otherwise noted)	80%
Annual Out-of-Pocket Maximum (Includes Deductible and Medical Copays; excludes Prescription Drug Copays**) • Per Covered Person • Family Limit*	 $3,200 $6,400

NOTE: The Calendar Year Deductibles and Annual Out-of-Pocket Maximums are determined by combining both Level I and Level II (PPO and Non-PPO) Covered Charges. See Comprehensive Medical Benefits section. Upon reaching the Annual Out-of-Pocket Maximum, Covered Medical Expenses are payable at 100% for the remainder of the Calendar Year. Any applicable Maximums or Limitations for specified services are also determined by combining Level I and Level II (PPO and Non-PPO) Covered Charges. The Covered Person's Coinsurance is determined by the Plan's Benefit Percentage reflected in this Schedule of Benefits. The Covered Person is responsible for the difference between the Plan's Benefit Percentage and 100%.

*Applies collectively to all Covered Persons in the same Family.

** Prescription Drug Copays apply to satisfy a separate Prescription Drug Out-of-Pocket Maximum.

SCHEDULE OF BENEFITS – TRADITIONAL PLAN (Cont'd.)

LEVEL I BENEFITS – Payment Levels and Limits:
This section applies to covered services rendered by Hospitals and other Facilities shown in the preceding Level I Providers list and to charges for services rendered by Providers billing "as a Facility." The benefits shown apply to all such covered, licensed, accredited Providers of service **without regard to participation in a Preferred Provider Organization (PPO) network**.

NO SURPRISES ACT - Emergency Services and Surprise Bills
For Out-of-Network Claims subject to the No Surprises Act ("NSA") (part of the Consolidated Appropriations Act of 2021), a Participant's cost-sharing will be the same amount as would be applied if the Claim was provided by an Imagine Provider and will be calculated as if the Plan's Allowable Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Charge. The NSA prohibits Providers from pursuing Participants for the difference between the Maximum Allowable Charge and the Provider's billed charge for applicable services. Cost-sharing amounts will accrue toward In-Network Deductibles and Out-of-Pocket Maximums.

Benefits for Claims subject to the NSA will be denied or paid within thirty (30) days of receipt of an initial Claim and, if approved, will be paid directly to the Provider.

Claims subject to the NSA are those which are submitted for:

- Emergency Services; and
- Covered Out-of-Network air ambulance services.

Coordination of Care Requirements		
Coordination of Care required for the following services: • Inpatient Hospital/Facility Admissions • Inpatient Hospice • Home Health Care • Other Specified Level I and Level II Services	See Coordination of Care section for additional information.	
Benefit Percentage For:	**Level I Benefit**	**Maximum Benefits, Limits & Provisions**
Gunnison Valley Health Systems Inpatient / Outpatient Services		
Gunnison Valley Health Systems Inpatient / Outpatient Services	80% of negotiated rate Deductible applies	
Hospital/Facility Inpatient Services		
Inpatient Hospital Services	80% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Contact Utilization Review for Coordination of Care.
Maternity Inpatient Hospital Services	80% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Contact Utilization Review for Coordination of Care.
Routine Newborn Care Inpatient Hospital Services (to date of mother's discharge)	80% of Allowable Claim Limits for nursery Room and Board/ancillary charges Deductible applies	
Skilled Nursing Facility	80% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Limited to 120 days per Calendar Year. Contact Utilization Review for Coordination of Care.
Rehabilitation Facility	80% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Contact Utilization Review for Coordination of Care.

SCHEDULE OF BENEFITS – TRADITIONAL PLAN (Cont'd.)

Benefit Percentage For:	Level I Benefit	Maximum Benefits, Limits & Provisions
Mental Disorders/Chemical Dependency, Drug and Substance Abuse Inpatient Hospital Services/ Residential Treatment Center	80% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Contact Utilization Review for Coordination of Care.
Emergency Room (Hospital Emergency Room Services/ Independent Freestanding Emergency Department Services)		
Emergency Room	80% of Allowable Claim Limits Deductible applies	If admitted Inpatient, contact Utilization Review for Coordination of Care.
Hospital/Facility Outpatient Diagnostic/Preventive Screening Services		
Select Diagnostic Medical Procedures (MRI, CT scan, etc.; see list in Comprehensive Medical Benefits section) **All Other Diagnostic Lab and X-ray**	80% of Allowable Claim Limits Deductible applies 80% of Allowable Claim Limits Deductible applies	
Hospital/Facility Outpatient Diagnostic/Preventive Screening Services		
Routine Bone Density Test, Other Routine Diagnostic Lab and X-ray	100% of Allowable Claim Limits Deductible waived	Age and/or frequency limitations may apply.
Annual Mammogram (Routine screening) Additional Mammogram (Diagnostic)	100% of Allowable Claim Limits Deductible waived 80% of Allowable Claim Limits Deductible applies	
Colonoscopy (including polyp removal) (Routine or Diagnostic)	100% of Allowable Claim Limits Deductible waived	Benefit applies beginning at age 45 or Family history of colon cancer with or without diagnosis.
Women's Elective Sterilization Procedures		
All Covered Expenses	100% of Allowable Claim Limits Deductible waived	All FDA approved
Outpatient Surgery/Ambulatory Surgery Centers Covered Services and Supplies		
All Covered Expenses	80% of Allowable Claim Limits Deductible applies	
Outpatient Psychiatric Day Treatment Facility and Outpatient Chemical Dependency Drug Treatment Facility		
Day Treatment Facility/ Psychological Testing/ Outpatient Therapy (including group therapy)	80% of Allowable Claim Limits Deductible applies	
Physical, Occupational and Speech Therapy Services		
All Covered Expenses	80% of Allowable Claim Limits Deductible applies	Limited to 60 visits per therapy per Calendar Year.
Cardiac Rehabilitation		
All Covered Expenses	80% of Allowable Claim Limits Deductible applies	

SCHEDULE OF BENEFITS – TRADITIONAL PLAN (Cont'd.)

Benefit Percentage For:	Level I Benefit	Maximum Benefits, Limits & Provisions
Chemotherapy, Radiation Therapy, Infusion Therapy, Dialysis Facilities Covered Services and Supplies		
All Covered Expenses	80% of Allowable Claim Limits Deductible applies	For additional information regarding Infusion Therapy, see "Infusion Therapy" in the Major Medical Expense Benefit section. Contact Utilization Review for Coordination of Care.
Diabetic Self-Management Training		
All Covered Expenses	80% of Allowable Claim Limits Deductible applies	
Hospice		
All Covered Expenses	80% of Allowable Claim Limits Deductible applies	Contact Utilization Review for Coordination of Care for Inpatient and Homebound Hospice.
Home Health Care Services		
All Covered Expenses	80% of Allowable Claim Limits Deductible applies	Limited to 120 visits per Calendar Year. Contact Utilization Review for Coordination of Care.
Ambulance - Air or Ground Transportation		
All Covered Expenses	80% of Allowable Claim Limits Deductible applies	
Urgent Care Facility (Minor Emergency Medical Clinic)		
All Covered Expenses	80% of Allowable Claim Limits Deductible waived	
Outpatient Clinic Visit – Facility		
Facility Expenses	80% of Allowable Claim Limits Deductible waived	
All Other Covered Hospital/Facility Services and Supplies		
All Other Covered Expenses	80% of Allowable Claim Limits Deductible applies	Coordination of Care required for Inpatient and other specified Level I and Level II services.

SCHEDULE OF BENEFITS – TRADITIONAL PLAN (Cont'd.)

LEVEL II BENEFITS – Payment Levels and Limits:
This section applies to covered services rendered by Physicians and all other Providers not listed in Level I. Benefits shown are payable **based upon the Provider's participation in the Preferred Provider Organization (PPO) network.** Non-PPO Covered Charges are subject to Allowable Claim Limits.

The "Level II PPO Benefit" applies to services rendered by Preferred Providers in the designated PPO Network (In-Network); the "Level II Non-PPO Benefit" applies to services rendered by Providers other than Preferred Providers (Out-of-Network).

NO SURPRISES ACT - Emergency Services and Surprise Bills
For Out-of-Network Claims subject to the No Surprises Act ("NSA") (part of the Consolidated Appropriations Act of 2021), a Participant's cost-sharing will be the same amount as would be applied if the Claim was provided by an Imagine Provider and will be calculated as if the Plan's Allowable Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Charge. The NSA prohibits Providers from pursuing Participants for the difference between the Maximum Allowable Charge and the Provider's billed charge for applicable services. Cost-sharing amounts will accrue toward In-Network Deductibles and Out-of-Pocket Maximums.

Benefits for Claims subject to the NSA will be denied or paid within thirty (30) days of receipt of an initial Claim and, if approved, will be paid directly to the Provider.

Claims subject to the NSA are those which are submitted for:

- Emergency Services; and
- Covered Out-of-Network air ambulance services.

Maximum Benefits, Limits and Provisions are subject to all other Plan exclusions, limitations and provisions set forth in this Plan.

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
Physician Services			
Gunnison Valley Health Systems Inpatient/ Outpatient Physician Services	80% of negotiated rate Deductible applies		
Physician Hospital Visits/Surgeon	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
Physician Hospital Visit for Mental Disorders/ Chemical Dependency, Drug and Substance Abuse	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
Emergency Room Physician	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	

SCHEDULE OF BENEFITS – TRADITIONAL PLAN (Cont'd.)

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
Maternity (Including prenatal care, delivery and postnatal care, except initial visit) Lab and X-ray Benefit applies. Initial Visit	80% of PPO rate Deductible applies 100% of PPO rate Deductible waived	80% of Allowable Claim Limits Deductible applies 100% of Allowable Claim Limits Deductible waived	Contact Utilization Review for Coordination of Care.
Routine Newborn Care (Inpatient routine pediatric care to date of mother's discharge)	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
***Lab and X-ray Benefits** **Select Diagnostic Medical Procedures** (MRI, CT scan, etc.; see list in Comprehensive Medical Benefits section) • Outpatient Hospital Interpretation • Free-standing or Independent Facility (includes interpretation)	 80% of PPO rate Deductible applies 80% of PPO rate Deductible applies	 80% of Allowable Claim Limits 80% of Allowable Claim Limits Deductible applies	
All Other Lab/X-ray • Outpatient Hospital Interpretation	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
• Free-standing or Independent Facility (includes interpretation)	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
Gunnison County Family Physicians Office Expenses Including: • Office Visit • Examination • Treatment • Diagnostic tests • Office Surgery • Lab and X-rays • Allergy testing, serum/injections • Voluntary Second or Third Opinion (exam) • Medical Supplies	100% of contracted rate after $20 Copay Deductible waived		

SCHEDULE OF BENEFITS – TRADITIONAL PLAN (Cont'd.)

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
All Other non-Gunnison County Family Physicians Office Expenses Including: • Office Visit • Examination • Treatment • Diagnostic tests • Voluntary Second or Third Surgical Opinion (exam) • Medical Supplies • Telehealth Consultations	100% of PPO rate after $40 Copay PCP $60 Copay Specialist Deductible waived	100% of Allowable Claim Limits $40 Copay PCP $60 Copay Specialist Deductible waived	
NOTE: For purposes of this Plan, Physicians considered a Primary Care Physician (PCP) are: Family Practitioner, General Practitioner, Internist, Pediatrician and OB/Gyn. All other Physicians are considered Specialists. A referral from a Primary Care Physician to a Specialist is not required.			
Office Surgery	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
Allergy Testing, Serum and Injections	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
Office Lab and X-ray	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
Select Diagnostic Medical Procedures (performed in Physician's Office)	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
Mental Disorders/ Chemical Dependency, Drug and Substance Abuse Office Visit/ *Group Therapy/ *Psychological Testing	100% of PPO rate after $40 Copay Deductible waived	100% of Allowable Claim Limits after $40 Copay Deductible waived	
Chiropractic Services (Including x-rays)	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	Limited to $500 Calendar Year Maximum Benefit.
Complementary/ Alternative Medicine including Acupuncture, Therapeutic Massage, Nutrition Therapy, Rolfing and Naturopathy Care	100% of PPO rate after $40 Copay Deductible waived	100% of Allowable Claim Limits after $40 Copay Deductible waived	Limited to $1,000 Calendar Year Maximum Benefit.

SCHEDULE OF BENEFITS – TRADITIONAL PLAN (Cont'd.)

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
***Urgent Care Facility** (Minor Emergency Medical Clinic)	80% of PPO rate Deductible waived	80% of Allowable Claim Limits Deductible waived	
Retail Limited Service Clinics (Includes Redi Clinics, MinuteClinics and Take Care Clinics)	100% of PPO rate after $40 Copay Deductible waived	100% of Allowable Claim Limits after $40 Copay Deductible waived	
All Other Covered Physician Services	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	

*** If these services are rendered by Providers billing as a Facility, please refer to the appropriate category under Level I for the benefit.**

SCHEDULE OF BENEFITS – TRADITIONAL PLAN (Cont'd.)

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
Other Covered Services			
***Therapy Services** • Physical • Occupational • Speech	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	Limited to 60 visits per therapy per Calendar Year.
***Cardiac Rehabilitation**	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
***Chemotherapy/ Radiation Therapy/ Infusion Therapy/ Dialysis**	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	For additional information regarding Infusion Therapy, see "Infusion Therapy" in the Major Medical Expense Benefit section. Contact Utilization Review for Coordination of Care.
***Durable Medical Equipment**	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
***Orthotic Devices**	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
***Prosthetics**	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
Hearing Exams / Hearing Aids	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	Hearing aids are limited to $4,500 Calendar Year Maximum Benefit every five (5) years. Maximum Benefit does not apply to initial purchase of hearing aid/device if Medically Necessary due to Illness, Accidental Injury, Congenital Anomaly or Surgical Procedure.
***Home Health Care Services**	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	Limited to 120 visits per Calendar Year. Contact Utilization Review for Coordination of Care.

SCHEDULE OF BENEFITS – TRADITIONAL PLAN (Cont'd.)

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
***Home Infusion Therapy**	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	For additional information regarding Home Infusion Therapy, see " Home Infusion Therapy" in the Major Medical Expense Benefit section. Contact Utilization Review for Coordination of Care.
***Hospice**	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	Contact Utilization Review for Coordination of Care for Inpatient and Homebound Hospice.
Bereavement Counseling	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
Diabetic Self-Management Training	100% of PPO rate after $40 Copay PCP $60 Copay Specialist Deductible waived	100% of Allowable Claim Limits $40 Copay PCP $60 Copay Specialist Deductible waived	
***Temporomandibular Joint (TMJ) Disorders and Orthognathic Disorders (including Surgical and Non-Surgical Treatment)**	Related services will be considered at the applicable benefit level (Surgery, devices, diagnostic services, etc.)		
***Morbid Obesity**	Related services will be considered at the applicable benefit level (Surgery, devices, diagnostic services, etc.)		
***Ambulance — Air or Ground Transportation**	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
Recuro Health Telehealth (telephone or online – 24/7 unlimited access) Virtual urgent care Virtual primary care Virtual mental health services	100%; no Copay or Consultation fee 100% after $20 Copay Deductible waived 100% after $20 Copay Deductible waived		

SCHEDULE OF BENEFITS – TRADITIONAL PLAN (Cont'd.)

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
***All Other Covered Expenses**	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	

*** If these services are rendered by Providers billing as a Facility, please refer to the appropriate category under Level I for the benefit.**

Organ Transplant Services
Organ and Tissue Transplants, Donor Expenses Contact Utilization Review upon transplant evaluation for Coordination of Care. Refer to Employer's Organ Transplant Policy as Primary payer. See Major Medical Expense Benefits for additional information.

Preventive and Wellness Care Benefits

This benefit is payable for Covered Procedures incurred as part of a Preventive and Wellness Care Program and is not payable for treatment of a diagnosed Illness or Injury. Services must be identified and billed as routine or part of a routine physical exam or as specified below.

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Limits & Provisions
All Covered Wellness Benefits	100% of PPO rate Copay and Deductible waived	100% of Allowable Claim Limits Deductible applies	See age and frequency limits and other special provisions below

Examples of Covered Wellness Procedures to include but are not limited to:

1. Routine Physical Exam
2. Annual Well Woman Exam
3. *Annual Pap smear and other routine lab
4. *Annual Mammogram (routine)
5. *Bone Density test (routine)
6. *Annual PSA test (routine)
7. Well Baby Care Exam/Well Child Care Exam
8. Routine Immunizations
9. Flu vaccine/pneumonia vaccine
10. *Routine lab, x-ray, diagnostic testing and other medical screenings
11. Routine Vision Screening for Covered Dependent Children
12. Routine Hearing Screening for Covered Dependent Children
13. *Routine/Diagnostic Colonoscopy (including polyp removal - beginning at age 45 or Family history of colon cancer)
14. Tobacco Use Screening/Cessation Intervention (limited to two attempts per Calendar Year with four tobacco cessation counseling sessions per attempt)
15. *All FDA approved Women's Contraceptive methods and Women's elective Sterilization procedures

NOTE: Refer to the definition of "Preventive Care" for a link to a website that lists additional services that may be covered for preventive treatment.

*** If these services are rendered by Providers billing as a Facility, please refer to the appropriate category under Level I for the benefit.**

SCHEDULE OF BENEFITS – HIGH DEDUCTIBLE HEALTH PLAN

MAJOR MEDICAL BENEFITS FOR COVERED PERSONS

NOTE: All Claims are subject to review and/or audit to ensure that charges are payable in accordance with the terms and limitations of this Plan.

LEVEL I PROVIDERS – Facilities and Providers billing as a Facility to include, but not limited to:

- Hospitals (Inpatient and Outpatient treatment)
- Inpatient Facilities (such as Rehabilitation Facilities, Skilled Nursing Facilities and Hospice)
- Inpatient and Outpatient Facilities for treatment of Mental Disorders, Chemical Dependency, Drug and Substance Abuse
- Ambulatory Surgery Centers
- Dialysis Clinics
- Ambulance (air and ground)

LEVEL II PROVIDERS – Physicians and all other Providers of service

Maximum Benefits	
Lifetime Maximum Dollar Benefit (All Covered Essential Health Benefits)	Unlimited
Annual Maximum Dollar Benefit (All Covered Essential Health Benefits)	Unlimited

Deductible and Annual Out-of-Pocket Maximum	Level I Benefit Level II PPO / Non-PPO Benefit
Calendar Year Deductible (Includes Covered Medical and Prescription Drug Expenses) • Per Covered Person • Family Limit*	 $4,000 $8,000
Benefit Percentage (unless otherwise noted)	100%
Annual Out-of-Pocket Maximum (Includes Calendar Year Deductible, Covered Medical and Prescription Drug Expenses) • Per Covered Person • Family Limit*	 $4,000 $8,000

NOTE: The Calendar Year Deductibles and Annual Out-of-Pocket Maximums are determined by combining both Level I and Level II (PPO and Non-PPO) Covered Charges. See Comprehensive Medical Benefits section. Upon reaching the Annual Out-of-Pocket Maximum, Covered Medical Expenses and Prescription Drug Expenses are payable at 100% for the remainder of the Calendar Year. Any applicable Maximums or Limitations for specified services are also determined by combining Level I and Level II (PPO and Non-PPO) Covered Charges.

* The Calendar Year Deductible per Covered Person (individual Deductible) is embedded in the Deductible Family Limit and the Annual Out-of-Pocket Maximum per Covered Person (individual Annual Out-of-Pocket) is embedded in the Annual Out-of-Pocket Maximum Family Limit. Each covered Family member is only required to satisfy his/her own individual Deductible and individual Annual Out-of-Pocket, not the entire Family Limit, in order to receive Plan benefits. The Deductible Family Limit and Annual Out-of-Pocket Maximum Family Limit are satisfied by two (2) or more Family members collectively; however, each Family member cannot contribute more than his/her own individual Deductible or individual Annual Out-of-Pocket Maximum.

SCHEDULE OF BENEFITS – HIGH DEDUCTIBLE HEALTH PLAN (Cont'd.)

LEVEL I BENEFITS – Payment Levels and Limits:
This section applies to covered services rendered by Hospitals and other Facilities shown in the preceding Level I Providers list and to charges for services rendered by Providers billing "as a Facility." The benefits shown apply to all such covered, licensed, accredited Providers of service **without regard to participation in a Preferred Provider Organization (PPO) network**.

NO SURPRISES ACT - Emergency Services and Surprise Bills
For Out-of-Network Claims subject to the No Surprises Act ("NSA") (part of the Consolidated Appropriations Act of 2021), a Participant's cost-sharing will be the same amount as would be applied if the Claim was provided by an Imagine Provider and will be calculated as if the Plan's Allowable Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Charge. The NSA prohibits Providers from pursuing Participants for the difference between the Maximum Allowable Charge and the Provider's billed charge for applicable services. Cost-sharing amounts will accrue toward In-Network Deductibles and Out-of-Pocket Maximums.

Benefits for Claims subject to the NSA will be denied or paid within thirty (30) days of receipt of an initial Claim and, if approved, will be paid directly to the Provider.

Claims subject to the NSA are those which are submitted for:

- Emergency Services; and
- Covered Out-of-Network air ambulance services.

Coordination of Care Requirements		
Coordination of Care required for the following services: • Inpatient Hospital/Facility Admissions • Inpatient Hospice • Home Health Care • Other Specified Level I and Level II Services	See Coordination of Care section for additional information.	
Benefit Percentage For:	**Level I Benefit**	**Maximum Benefits, Limits & Provisions**
Gunnison Valley Health Systems Inpatient / Outpatient Services		
Gunnison Valley Health Systems Inpatient / Outpatient Services	100% of negotiated rate Deductible applies	
Hospital/Facility Inpatient Services		
Inpatient Hospital Services	100% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Contact Utilization Review for Coordination of Care.
Maternity Inpatient Hospital Services	100% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Contact Utilization Review for Coordination of Care.
Routine Newborn Care Inpatient Hospital Services (to date of mother's discharge)	100% of Allowable Claim Limits for nursery Room and Board/ancillary charges Deductible applies	
Skilled Nursing Facility	100% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Limited to 120 days per Calendar Year. Contact Utilization Review for Coordination of Care.
Rehabilitation Facility	100% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Contact Utilization Review for Coordination of Care.

SCHEDULE OF BENEFITS – HIGH DEDUCTIBLE HEALTH PLAN (Cont'd.)

Benefit Percentage For:	Level I Benefit	Maximum Benefits, Limits & Provisions
Mental Disorders/Chemical Dependency, Drug and Substance Abuse Inpatient Hospital Services/ Residential Treatment Center	100% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Contact Utilization Review for Coordination of Care.
Emergency Room (Hospital Emergency Room Services/ Independent Freestanding Emergency Department Services)		
Emergency Room	100% of Allowable Claim Limits Deductible applies	If admitted Inpatient, contact Utilization Review for Coordination of Care.
Hospital/Facility Outpatient Diagnostic/Preventive Screening Services		
Select Diagnostic Medical Procedures (MRI, CT scan, etc.; see list in Comprehensive Medical Benefits section) **All Other Diagnostic Lab and X-ray**	100% of Allowable Claim Limits Deductible applies 100% of Allowable Claim Limits Deductible applies	
Hospital/Facility Outpatient Diagnostic/Preventive Screening Services		
Routine Bone Density Test, Other Routine Diagnostic Lab and X-ray	100% of Allowable Claim Limits Deductible waived	Age and/or frequency limitations may apply.
Annual Mammogram (Routine screening) Additional Mammogram (Diagnostic)	100% of Allowable Claim Limits Deductible waived 100% of Allowable Claim Limits Deductible applies	
Colonoscopy (including polyp removal) (Routine or Diagnostic)	100% of Allowable Claim Limits Deductible waived	Benefit applies beginning at age 45 or Family history of colon cancer with or without diagnosis.
Women's Elective Sterilization Procedures		
All Covered Expenses	100% of Allowable Claim Limits Deductible waived	All FDA approved
Outpatient Surgery/Ambulatory Surgery Centers Covered Services and Supplies		
All Covered Expenses	100% of Allowable Claim Limits Deductible applies	
Outpatient Psychiatric Day Treatment Facility and Outpatient Chemical Dependency Drug Treatment Facility		
Day Treatment Facility/ Psychological Testing/ Outpatient Therapy (including group therapy)	100% of Allowable Claim Limits Deductible applies	
Physical, Occupational and Speech Therapy Services		
All Covered Expenses	100% of Allowable Claim Limits Deductible applies	Limited to 60 visits per therapy per Calendar Year.
Cardiac Rehabilitation		
All Covered Expenses	100% of Allowable Claim Limits Deductible applies	

SCHEDULE OF BENEFITS – HIGH DEDUCTIBLE HEALTH PLAN (Cont'd.)

Benefit Percentage For:	Level I Benefit	Maximum Benefits, Limits & Provisions
Chemotherapy, Radiation Therapy, Infusion Therapy, Dialysis Facilities Covered Services and Supplies		
All Covered Expenses	100% of Allowable Claim Limits Deductible applies	For additional information regarding Infusion Therapy, see "Infusion Therapy" in the Major Medical Expense Benefit section. Contact Utilization Review for Coordination of Care.
Diabetic Self-Management Training		
All Covered Expenses	100% of Allowable Claim Limits Deductible applies	
Hospice		
All Covered Expenses	100% of Allowable Claim Limits Deductible applies	Contact Utilization Review for Coordination of Care for Inpatient and Homebound Hospice.
Home Health Care Services		
All Covered Expenses	100% of Allowable Claim Limits Deductible applies	Limited to 120 visits per Calendar Year. Contact Utilization Review for Coordination of Care.
Ambulance - Air or Ground Transportation		
All Covered Expenses	100% of Allowable Claim Limits Deductible applies	
Urgent Care Facility (Minor Emergency Medical Clinic)		
All Covered Expenses	100% of Allowable Claim Limits Deductible waived	
Outpatient Clinic Visit – Facility		
Facility Expenses	100% of Allowable Claim Limits Deductible applies	
All Other Covered Hospital/Facility Services and Supplies		
All Other Covered Expenses	100% of Allowable Claim Limits Deductible applies	Coordination of Care required for Inpatient and other specified Level I and Level II services.

SCHEDULE OF BENEFITS – HIGH DEDUCTIBLE HEALTH PLAN (Cont'd.)

LEVEL II BENEFITS – Payment Levels and Limits:
This section applies to covered services rendered by Physicians and all other Providers not listed in Level I. Benefits shown are payable **based upon the Provider's participation in the Preferred Provider Organization (PPO) network.** Non-PPO Covered Charges are subject to Allowable Claim Limits.

The "Level II PPO Benefit" applies to services rendered by Preferred Providers in the designated PPO Network (In-Network); the "Level II Non-PPO Benefit" applies to services rendered by Providers other than Preferred Providers (Out-of-Network).

NO SURPRISES ACT - Emergency Services and Surprise Bills
For Out-of-Network Claims subject to the No Surprises Act ("NSA") (part of the Consolidated Appropriations Act of 2021), a Participant's cost-sharing will be the same amount as would be applied if the Claim was provided by an Imagine Provider and will be calculated as if the Plan's Allowable Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Charge. The NSA prohibits Providers from pursuing Participants for the difference between the Maximum Allowable Charge and the Provider's billed charge for applicable services. Cost-sharing amounts will accrue toward In-Network Deductibles and Out-of-Pocket Maximums.

Benefits for Claims subject to the NSA will be denied or paid within thirty (30) days of receipt of an initial Claim and, if approved, will be paid directly to the Provider.

Claims subject to the NSA are those which are submitted for:

- Emergency Services; and
- Covered Out-of-Network air ambulance services.

Maximum Benefits, Limits and Provisions are subject to all other Plan exclusions, limitations and provisions set forth in this Plan.

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
Physician Services			
Gunnison Valley Health Systems Inpatient / Outpatient Physician Services	100% of negotiated rate Deductible applies		
Physician Hospital Visits/Surgeon	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
Physician Hospital Visit for Mental Disorders/ Chemical Dependency, Drug and Substance Abuse	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
Emergency Room Physician	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	

SCHEDULE OF BENEFITS – HIGH DEDUCTIBLE HEALTH PLAN (Cont'd.)

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
Maternity (Including prenatal care, delivery and postnatal care, except initial visit)	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	Contact Utilization Review for Coordination of Care.
Initial Visit	100% of PPO rate Deductible waived	100% of Allowable Claim Limits Deductible waived	
Routine Newborn Care (Inpatient routine pediatric care to date of mother's discharge)	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
***Lab and X-ray Benefits Select Diagnostic Medical Procedures** (MRI, CT scan, etc.; see list in Comprehensive Medical Benefits section)			
• Outpatient Hospital Interpretation	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
• Free-standing or Independent Facility (includes interpretation)	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
All Other Lab/X-ray • Outpatient Hospital Interpretation	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
• Free-standing or Independent Facility (includes interpretation)	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	

SCHEDULE OF BENEFITS – HIGH DEDUCTIBLE HEALTH PLAN (Cont'd.)

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
All Covered Physician Office Expenses Including: • Office Visit • Examination • Treatment • Diagnostic tests • Office Surgery • Lab and X-rays • Allergy testing, serum/injections • Voluntary Second or Third Surgical Opinion (exam) • Medical Supplies • Retail Limited Services Clinic • Telehealth Consultations	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
Mental Disorders/ Chemical Dependency, Drug and Substance Abuse Office Visit/ *Group Therapy/ *Psychological Testing	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
Chiropractic Services (Including x-rays)	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	Limited to $500 Calendar Year Maximum Benefit.
Complementary/ Alternative Medicine including Acupuncture, Therapeutic Massage, Nutrition Therapy, Rolfing and Naturopathy Care	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	Limited to $1,000 Calendar Year Maximum Benefit.
***Urgent Care Facility** (Minor Emergency Medical Clinic)	100% of PPO rate Deductible waived	100% of Allowable Claim Limits Deductible waived	
All Other Covered Physician Services	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	

*** If these services are rendered by Providers billing as a Facility, please refer to the appropriate category under Level I for the benefit.**

SCHEDULE OF BENEFITS – HIGH DEDUCTIBLE HEALTH PLAN (Cont'd.)

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
Other Covered Services			
***Therapy Services** • Physical • Occupational • Speech	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	Limited to 60 visits per therapy per Calendar Year.
***Cardiac Rehabilitation**	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
***Chemotherapy/ Radiation Therapy/ Infusion Therapy/Dialysis**	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	For additional information regarding Infusion Therapy, see "Infusion Therapy" in the Major Medical Expense Benefit section. Contact Utilization Review for Coordination of Care.
***Durable Medical Equipment**	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
***Orthotic Devices**	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
***Prosthetics**	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
Hearing Exams/Hearing Aids	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	Hearing aids are limited to $4,500 Calendar Year Maximum Benefit every five (5) years. Maximum Benefit does not apply to initial purchase of hearing aid/device if Medically Necessary due to Illness, Accidental Injury, Congenital Anomaly or Surgical Procedure.
***Home Health Care Services**	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	Limited to 120 visits per Calendar Year. Contact Utilization Review for Coordination of Care.

SCHEDULE OF BENEFITS – HIGH DEDUCTIBLE HEALTH PLAN (Cont'd.)

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
***Home Infusion Therapy**	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	For additional information regarding Home Infusion Therapy, see " Home Infusion Therapy" in the Major Medical Expense Benefit section. Contact Utilization Review for Coordination of Care.
***Hospice**	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	Contact Utilization Review for Coordination of Care for Inpatient and Homebound Hospice.
Bereavement Counseling	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
Diabetic Self-Management Training	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
***Temporomandibular Joint (TMJ) Disorders and Orthognathic Disorders (including Surgical and Non-Surgical Treatment)**	Related services will be considered at the applicable benefit level (Surgery, devices, diagnostic services, etc.)		
***Morbid Obesity**	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
***Ambulance — Air or Ground Transportation**	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
Recuro Health Telehealth (telephone or online – 24/7 unlimited access) Virtual urgent care Virtual primary care Virtual mental health services	$10 Consultation Fee Fee applies to satisfy PPO Deductible and PPO Annual Out-of-Pocket Maximum. 100% after PPO Deductible 100% after PPO Deductible		

SCHEDULE OF BENEFITS – HIGH DEDUCTIBLE HEALTH PLAN (Cont'd.)

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
***All Other Covered Expenses**	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	

*** If these services are rendered by Providers billing as a Facility, please refer to the appropriate category under Level I for the benefit.**

Organ Transplant Services
Organ and Tissue Transplants, Donor Expenses Contact Utilization Review upon transplant evaluation for Coordination of Care. Refer to Employer's Organ Transplant Policy as Primary payer. See Major Medical Expense Benefits for additional information.

SCHEDULE OF BENEFITS – HIGH DEDUCTIBLE HEALTH PLAN (Cont'd.)

Preventive and Wellness Care Benefits This benefit is payable for Covered Procedures incurred as part of a Preventive and Wellness Care Program and is not payable for treatment of a diagnosed Illness or Injury. Services must be identified and billed as routine or part of a routine physical exam or as specified below.			
Benefit Percentage For:	**Level II PPO Benefit**	**Level II Non-PPO Benefit**	**Limits & Provisions**
All Covered Wellness Benefits	100% of PPO rate Deductible waived	100% of Allowable Claim Limits Deductible applies	See age and frequency limits and other special provisions below
Examples of Covered Wellness Procedures to include but are not limited to: 1. Routine Physical Exam 2. Annual Well Woman Exam 3. *Annual Pap smear and other routine lab 4. *Annual Mammogram (routine) 5. *Bone Density test (routine) 6. *Annual PSA test (routine) 7. Well Baby Care Exam/Well Child Care Exam 8. Routine Immunizations 9. Flu vaccine/pneumonia vaccine 10. *Routine lab, x-ray, diagnostic testing and other medical screenings 11. Routine Vision Screening for Covered Dependent Children 12. Routine Hearing Screening for Covered Dependent Children 13. *Routine/Diagnostic Colonoscopy (including polyp removal - beginning at age 45 or Family history of colon cancer) 14. Tobacco Use Screening/Cessation Intervention (limited to two attempts per Calendar Year with four tobacco cessation counseling sessions per attempt) 15. *All FDA approved Women's Contraceptive methods and Women's elective Sterilization procedures			
NOTE: Refer to the definition of "Preventive Care" for a link to a website that lists additional services that may be covered for preventive treatment.			

*** If these services are rendered by Providers billing as a Facility, please refer to the appropriate category under Level I for the benefit.**

ORGAN TRANSPLANT POLICY

Organ and tissue transplant coverage is provided under a separate insurance policy by Tokio Marine HCC – Stop Loss Group (TMHCC) and is issued either by National Union Fire Insurance Company of Pittsburgh, Pa. or HCC Life Insurance Company. Such coverage pays benefits for certain organ and tissue transplants without regard to any benefits that may or may not be provided by this Major Medical Plan. Please contact TMHCC's Transplant Unit toll-free at 1-888-449-2377 for benefit information, pre-authorization of transplant services, and transplant network Provider access.

Pre-Authorization of Transplant Services
Pre-authorization of transplant services is required prior to seeing a transplant Provider for a consult and/or evaluation. Failure to do so could result in reduced benefits.

NOTICE - Transplant Network
In order to obtain 100% in-network benefits, you must use Providers in a transplant network approved by and accessed through TMHCC's Transplant Unit. Expenses billed by the transplant network Provider that are not covered by the TMHCC policy are subject to this Medical Plan's benefits and the payment terms and conditions of the transplant network Provider's contracted rates.

For more information, contact your Medical Plan Administrator and/or human resources department.

NOTE: The Employer's fully insured Organ Transplant Policy is the Primary payer for Organ, Tissue and Bone Marrow Transplants. In the event the Employer's Organ Transplant Policy does not cover some or all transplant related charges incurred by a Covered Person due to a pre-existing condition exclusion limitation, this Plan will consider the charges based on benefits below as the Secondary payer. See Coordination With Organ Transplant Policy section of this Plan Document.

Traditional Plan Organ Transplant Plan Benefits – Secondary Payer			
Benefit Percentage For:	**Transplant Program**	**Non-Transplant Program**	**Limits & Provisions**
Organ, Tissue and Bone Marrow Transplants (Non-experimental transplants only)	80% of Program rate Deductible applies	80% of Usual and Customary fees Deductible applies	Contact Utilization Review upon transplant evaluation for Coordination of Care and access to the Transplant Program.
Donor Expenses Donor expenses covered if recipient is covered by this Plan. Payable under recipient's Claim.	80% of Program rate Deductible applies	80% of Usual and Customary fees Deductible applies	
Organ Transplant Travel/Lodging Benefit	100% Deductible waived	Not covered	Transplant Program Travel/Lodging limited to $10,000 Maximum Benefit per Transplant.

High Deductible Health Plan Organ Transplant Plan Benefits – Secondary Payer			
Benefit Percentage For:	**Transplant Program**	**Non-Transplant Program**	**Limits & Provisions**
Organ, Tissue and Bone Marrow Transplants (Non-experimental transplants only)	100% of Program rate Deductible applies	100% of Usual and Customary fees Deductible applies	Contact Utilization Review upon transplant evaluation for Coordination of Care and access to the Transplant Program.
Donor Expenses Donor expenses covered if recipient is covered by this Plan. Payable under recipient's Claim.	100% of Program rate Deductible applies	100% of Usual and Customary fees Deductible applies	
Organ Transplant Travel/Lodging Benefit	100% Deductible waived	Not covered	Transplant Program Travel/Lodging limited to $10,000 Maximum Benefit per Transplant.

CANCER CARE PROGRAM

The Plan provides benefit coverage for evidence-based cancer care services provided at local, regional and national cancer programs. The Cancer Care Program will utilize specialized care coordination nurses to provide patient education and support while coordinating with the patient, Providers, Center of Excellence (COE), and Plan benefits. The principles for Certified Case Management and the guidelines of nationally recognized organizations, MCG (formerly Milliman Care Guidelines) and National Comprehensive Cancer Network (NCCN), including the NCCN Compendium of Care, will be utilized in the review of care for Medical Necessity and evidence-based medicine. In the event care is requested that is outside of the nationally recognized criteria, independent medical reviews by a Board Certified and actively practicing Oncologist or Physician of like specialty will be completed to ensure standard of medical care is provided for Plan Participants. The Cancer Care Program may utilize a panel of three (3) Board Certified and actively practicing Oncologists or Physicians of like specialty in the event of appeals. Should oncology care at a Center of Excellence benefit the patient and Plan, the Cancer Care Program nurse will gather the data from at least two (2) independent COE contracting sources. The COE contracts will be reviewed for comprehensiveness of contract and the COE's quality outcomes before selection. The Cancer Care Program will not limit member participation based on type of cancer.

SECOND OPINION

The Plan provides coverage for a Second Opinion through utilization of the Pathology/DiagnosticCOE, which may include a review of the diagnosis, review of the treatment plan or both. Second Opinions may require travel to a Pathology/DiagnosticCOE to qualify for benefits. A Second Opinion may consist solely of having pathology slides reviewed by a specialized lab or may include other services. Molecular testing is a covered benefit when coordinated by the Cancer Care nurse.

CLINICAL TRIAL BENEFITS

Clinical Trials (Routine Patient Costs). Benefits are provided to Qualified Individuals for the Routine Patient Costs of items and services furnished in connection with participation in an Approved Clinical Trial. Routine Patient Costs include all items and services consistent with the coverage provided under this Plan that are typically covered for a Qualified Individual who is not enrolled in a clinical trial. Routine Patient Costs do not include:

1. The Investigational item, device, or service, itself;
2. Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

If one or more Participating Providers is participating in a clinical trial, the Plan may require that a Qualified Individual participate in the trial through such a Participating Provider if the Provider will accept the individual as a participant in the trial.

Approved Clinical Trial is a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and that is described in any of the following:

1. Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

    a. The National Institutes of Health.
    b. The Centers for Disease Control and Prevention.
    c. The Agency for Health Care Research and Quality.
    d. The Centers for Medicare & Medicaid Services.
    e. A cooperative group or center of any of the entities described in (a) through (d) above or the Department of Defense or the Department of Veterans Affairs.

f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
g. The Department of Veterans Affairs, the Department of Defense, or the Department of Energy, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines:

    i. to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and
    ii. assures unbiased review of the highest scientific standards by Qualified Individuals who have no interest in the outcome of the review; or

2. The study or investigation is conducted under an Investigational new Drug application reviewed by the Food and Drug Administration; or
3. The study or investigation is a Drug trial that is exempt from having such an Investigational new Drug application.

A Qualified Individual must meet the following conditions:

1. The individual must be eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition; and
2. Either:

    a. The referring health care professional is a Participating Provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or
    b. The individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

Covered Persons are encouraged to contact the Cancer Care Program at 1-800-843-6705 option 6 or cancercare@imagine360.com for further information on clinical trial coverage.

Questions: If there are any questions regarding coverage or a specific provision of the Cancer Care Program, please contact the Plan Administrator at 1-800-843-6705 option 6 or email cancercare@imagine360.com.

PRESCRIPTION DRUG PLAN BENEFITS

High Deductible Health Plan		
Prescription Drug Expenses apply to satisfy the Medical Plan's Level I/Level II Calendar Year Deductible. The Plan requires the Covered Person to pay the entire cost of Prescription Drug Expenses until the Deductible has been met. After the Calendar Year Deductible and Annual Out-of-Pocket Maximum have been met, covered Prescription Drugs will be payable at 100% for the remainder of the Calendar Year.		
	Supply Limit	**Benefit**
Prescription Card Service Generic and Brand Name Drugs	30 – 90 days	100% after Deductible
Mail Order Service Generic and Brand Name Drugs	90 days	100% after Deductible
Specialty Drugs Specialty drugs sourced through EPLS Progressive Sourcing are payable up to 100%. Contact your employer's Human Resources department to learn more about your options and potential incentives for working through EPLS (EPLS JCode Program) to obtain certain drugs when necessary, including administration of injectable drugs in an outpatient setting. Special Limitations – See the "Specialty Drugs" and "JCode" entries under "Definitions" and "Medical Benefit Exclusions" and "Drug Benefit Exclusions" for more information.		

Traditional Plan	
Prescription Drug Copays apply to satisfy a separate Prescription Drug Annual Out-of-Pocket Maximum. After the separate Prescription Drug Annual Out-of-Pocket Maximum has been met, covered Prescription Drugs will be payable at 100% for the remainder of the Calendar Year.	
Calendar Year Prescription Drug Deductible Per Covered Person	 $100
The Prescription Drug Deductible must be satisfied each Calendar Year before Copays apply.	
Prescription Drug Annual Out-of-Pocket Maximum Per Covered Person Family Limit*	 $3,000 $6,000
*Applies collectively to all Covered Persons in the same Family.	
Prescription Card Service <u>Supply Limit</u> Generic (Tier 1) Preferred Brand Name Drugs (Tier 2) Non-Preferred Brand Name Drugs (Tier 3)	**100% after applicable Copay** <u>30 days</u> $5 Copay 75% Copay with a minimum $35 Copay and up to a maximum $150 Copay 75% Copay with a minimum $70 Copay and up to a maximum $150 Copay
Prescription Card Service – Generic Drugs Only <u>Supply Limit</u> Generic Drugs (Tier 1)	 <u>90 days</u> $15 Copay
Mail Order Service <u>Supply Limit</u> Generic (Tier 1) Preferred Brand Name Drugs (Tier 2) Non-Preferred Brand Name Drugs (Tier 3)	**100% after applicable Copay** <u>90 days</u> $10 Copay 75% Copay with a minimum $80 Copay 75% Copay with a minimum $80 Copay

Traditional Plan (Continued)
Specialty Drugs*   Specialty drugs sourced through EPLS Progressive Sourcing are payable up to 100%.   Contact your employer's Human Resources department to learn more about your options and potential incentives for working through EPLS (EPLS JCode Program) to obtain certain drugs when necessary, including administration of injectable drugs in an outpatient setting.   Special Limitations – See the "Specialty Drugs" and "JCode" entries under "Definitions" and "Medical Benefit Exclusions" and "Drug Benefit Exclusions" for more information.

NOTE: Medications required for Preventive Care services may be covered at 100%, Copay and/or Deductible waived.

Non-Specialty Drugs sourced through EPLS partner pharmacies are payable at 100%, without application of any applicable copayment, coinsurance, or deductible (to the extent permitted by law). This program is voluntary and does not impact members' ability to use the member prescription benefit.

Brand Drugs may also be eligible for copay cards, which provide the Plan Participant certain assistance with payments. If provided to a Plan Participant, the Plan Participant must use the copay card, or benefits will be reduced by the amount of copay card.

EPLS will contact members who have qualifying medications. Members may also contact EPLS at 717-844-9030.

For Coordination of Benefits when this Plan is secondary, file the prescription receipt with the Drug Plan. Call the Prescription Claims Help Desk for a Claim form. See Plan Participant identification card for the phone number.

(Traditional Plan only) If the pharmacy charge is less than the Generic or Brand Copay, then the actual charge will become the Copay. Generic and Brand Name copayments apply separately to each prescription and refill and do not apply to the Calendar Year Deductible.

To be covered, Prescription Drugs must be:

1. Purchased from a participating licensed pharmacist;
2. Dispensed to the Covered Person for whom they are prescribed; and
3. Legally prescribed by a Qualified Prescriber.

DEFINITIONS

Brand Name Drugs (Tier 2 and Tier 3)
Trademark Drugs or substances marketed by the original manufacturer. Tier 2 Drugs are commonly used Preferred Brand Name Drugs shown on the Formulary Drug List as "Formulary Alternative(s)." Tier 3 Drugs are Non-Preferred Brand Name Drugs listed as "Non-Formulary" or not listed.

EPLS Progressive Sourcing
This program ensures Specialty Drugs are sourced at the lowest cost available to decrease costs for the Plan and Plan Participants. Participants are required to comply with all requests pursuant to EPLS Progressive Sourcing and provide any necessary documentation to receive Specialty Drug benefits.

EPLS JCode Program
The EPLS JCode Program is the process of evaluating medications for potential cost-reduction of the treatment. This may involve evaluating the appropriateness of the medication to be given in an alternative site of care, such as home infusion or alternative infusion center, and/or evaluating the cost of the medication if it was processed through the pharmacy benefit instead of the medical benefit.

Generic Drugs (Tier 1)
Drugs or substances which:

1. Are not trademark Drugs or substances; and
2. May be legally substituted for trademark Drugs or substances.

Over the Counter (OTC) Drugs
Drugs which do not require a prescription from a Qualified Prescriber, unless otherwise specified.

Prescription Drugs
Legend Drugs or medicines which are prescribed by a Qualified Prescriber for the treatment of Illness, Injury or Pregnancy.

Qualified Prescriber
A licensed Physician, Dentist, or other health care Practitioner who may, in the legal scope of his/her practice, prescribe Drugs or medicines.

Site of Care
The physical location of drug infusion/injection administration. Sites of Care include hospital inpatient, hospital outpatient, physician office, ambulatory infusion suite, or home-based setting.

Specialty Drugs
"Specialty Drug" shall mean a prescription medication, including a drug subject to HCPCS Level II billing code (see Appendix A for a list of such codes, including but not limited to drugs for cancer, rheumatoid arthritis, and multiple sclerosis), that costs more than $1,450 for a 30-day supply or $4,350 for a 90-day supply and is used to treat complex, chronic conditions. Specialty Drugs are only covered if pre-authorized.

Product Selection
The pharmacist substitutes more economically priced Generic equivalent Drugs whenever possible unless there is a specific request for a Brand Name by the prescribing Physician or when State law requires no substitution for the Brand Name Drug. **Under this program if the prescribing Physician does not specify the Brand Name, but the Covered Person requests the Brand product when there is a Generic substitute available, the Covered Person is required to pay the difference in cost between the Brand and Generic product in addition to the usual Brand Copay (applies to Prescription Card and Mail Order).**

Most pharmacists, as a courtesy to the patient, will ask whether a Generic Drug is acceptable to the Covered Person if the Physician has specified "product selection permitted" on the prescription. If the Physician has specified "dispense as written," no choice is given to the patient, and only the applicable Copay will be charged.

Miscellaneous Provisions
The following provisions may be included in your Prescription Drug Plan. Please contact the Prescription Card Service Customer Service phone number listed on the Plan Participant identification card for more information.
Step Therapy: The practice of starting Drug therapy for a medical condition with the most cost-effective and safest Drug available, then progressing to other more costly alternatives if necessary.

Therapeutic Substitution: A Physician-oriented service designed to increase the utilization of more cost-effective products. Substitutes are made for Non-Preferred Brand Name Drugs with either Generic or similar Preferred Brand Name Drugs in the same therapeutic class.

Drug Review
The Plan includes a Drug Review program which is automatically administered by the pharmacist through a nationwide computer network that verifies the eligibility of each Covered Person's card and protects the

Covered Person from conflicting prescriptions which might prove harmful if taken at the same time. This program also guards against duplication of medications and incorrect dosage levels.

Covered and Excluded Drugs

The following Covered and Excluded Drug listings are not all inclusive. To find out if a particular Drug is covered, please contact the Prescription Card Service Customer Service phone number listed on the Plan Participant identification card.

NOTE: Some Drugs may require authorization and may only be covered, and/or covered for certain ages, if Medically Necessary.

Prescription Drug Plan – Covered Drugs

1. Legend Drugs (Drugs requiring a prescription either by Federal or State law) (there are certain Legend Drugs that may be excluded);
2. Insulin on prescription;
3. Disposable insulin needles/syringes, test strips and lancets on prescription;
4. Compounded medications of which at least one ingredient is a prescription legend Drug;
5. All FDA approved women's contraceptive Drugs and methods (Generic covered at 100%, Copay and/or Deductible waived; if no Generic available, Brand covered at 100%, Copay and/or Deductible waived);
6. Tobacco deterrent medications or any other tobacco use OTC cessation aids, all dosage forms limited to a 168-day supply per Plan Calendar Year (Generic covered at 100%, Copay and/or Deductible waived); if no Generic available, Brand covered at 100%, Copay and/or Deductible waived); and
7. Weight loss medications (prior authorization is required).

NOTE: Quantity limitations may apply to some Covered Drugs in addition to those shown above.

Weight loss medications will be covered if all of the following conditions are met:

1. Prior authorization is required.
2. Covered Person has a BMI of 30 or higher.
   a. If a Covered Person has a BMI of 27-30, the Physician must also present and document a weight-related comorbidity. These include diabetes, high cholesterol, high blood pressure, coronary heart disease and sleep apnea.
3. Lifestyle modifications for at least three (3) consecutive months.
   a. This is to be documented with the Provider and included in clinical documentation.
4. Life modifications will continue while patient takes requested weight loss medication.

Initial therapy is typically approved for seven months. When continuation therapy is requested and a renewal is completed, the clinical department will ensure the patient has lost 4-5% body weight (depending on medication requested) from initial approval.

NOTE: Refer to the definition of "Preventive Care" for a link to a website that lists additional Drugs that may be covered for preventive treatment.

Prescription Drug Plan – Excluded Drugs

1. ***Specialty Drugs****. After a maximum of two (2) initial fills (each limited to a 30-day supply), the full amount charged or otherwise payable for any Specialty Drug which is eligible for EPLS Progressive Sourcing but which the Participant has not tried to source through said program.*
2. ***Generic Drugs.*** *Generic drugs costing more than $500 for a 30-day fill and $1,000 for a 90-day fill are excluded from most pharmacies. Participants should contact EPLS at 717-844-9030 for coverage.*

   This Plan requires a Plan Participant to obtain a generic drug whenever possible. When a medically appropriate generic or biosimilar option was available, but the Participant obtained a Specialty Drug instead, the Plan will exclude the difference between the cost of the Specialty Drug and the cost of the generic or biosimilar option. If a more affordable medically appropriate Specialty Drug is available that would achieve identical results and could have been obtained instead of the drug actually obtained, the Plan will exclude the difference between the cost of the Specialty Drug obtained and the less-costly option.

The Plan excludes any amount that would not have been payable by the Plan had the Plan Participant utilized a copay card if provided to the Plan Participant.

It is the Participant's responsibility to contact EPLS and satisfy the Plan's requirements for coverage. To begin the process, contact EPLS at 717-844-9030.

3. Abortifacients;
4. Drugs for Cosmetic purposes;
5. Immunization agents (except immunizations and vaccines as required for Preventive Care services; Generic covered at 100%, Copay and/or Deductible waived; if no Generic available, Brand covered at 100%, Copay and/or Deductible waived), biological sera, blood or blood plasma;
6. Therapeutic devices or appliances, including needles, syringes, support garments and other non-medical substances, regardless of intended use, except those listed above;
7. Charges for the administration or injection of any Drug;
8. Prescriptions which a Covered Person is entitled to receive without charge from any Workers' Compensation laws;
9. Drugs labeled "Caution-limited by Federal law to Investigational use," or Experimental Drugs, even though a charge is made to the individual;
10. Medication which is to be taken by or administered to an individual, in whole or in part, while he/she is a patient in a licensed Hospital, Extended Care Facility, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a Facility for dispensing pharmaceuticals; and
11. Any prescription refilled in excess of the number specified by the Physician, or any refill dispensed after one (1) year from the Physician's original order.

NOTE: Drugs excluded from the Prescription Drug Plan are not payable under Major Medical Expense Benefits.

(Traditional Plan only) A Prescription Drug dispensed by a retail pharmacy, Mail Order Service or Specialty Pharmacy for which a Copay applies is not considered a Claim for benefits under this Plan and, therefore, is not subject to the Plan's Claim Filing Procedures.

When Alternative Care and treatment are identified by Case Management as Medically Necessary and approved by the Plan Administrator, and where there is a reasonable expectation of savings to the Plan without sacrificing the quality of care to the Plan Participant (patient), the Plan may approve and pay for all or part of the charges not shown as a Covered Prescription Drug in this Plan Document.

PRESCRIPTION DRUG UTILIZATION REVIEW

The Prescription Drug benefit does not have unlimited coverage. As with all medical and Hospital services, Prescription Drug utilization is subject to determinations of Medical Necessity and appropriate use. Drug Utilization Review may be concurrent, retrospective or prospective.

Concurrent Drug Utilization Review generally occurs at the time of service and may include electronic Claim audits which may help to protect patients from potential Drug interactions or Drug-therapy conflicts or overuse/under use of medications.

Retrospective Drug Utilization Review generally involves Claim review and may include communication by the Prescription Drug Plan and/or Utilization Review with the prescribing Physician to coordinate care and verify diagnoses and Medical Necessity. It may include a peer review by a Physician of like specialty to the prescribing Physician reviewing the medical and pharmacy records to determine Medical Necessity.

Should Medical Necessity not be determined by the peer review Physician, the treating Physician and Plan Participant will be notified and provided with the peer review results. The Plan Participant and Physician will be forwarded information on the appeal process as outlined in this Plan.

Prospective Drug Utilization Review may include, among other things, Physician or pharmacy assignment in which one Physician and/or one pharmacy is selected to serve as the coordinator of prescription Drug services and benefits for the eligible Plan Participant. The Plan Participant will be notified in writing of this and will be required to designate a Physician and pharmacy as his/her Providers.

Discretionary Authority *– As it relates to Specialty Drugs, the Plan Administrator is specifically empowered on a case-by-case basis, in a non-discriminatory fashion and when it finds that doing so is in the best interest of the Participant and not unduly burdensome to the Plan, to deem a drug payable which would otherwise be excluded under the Plan.*

COORDINATION OF CARE

Coordination of Care may be indicated for medical treatment that is Medically Necessary and not Experimental. Coordination of Care is provided by a Registered Nurse (RN) to assist the Plan Participant with coordination of medical care, prevent duplicate diagnostic testing and/or treatment, and identify and refer patients with diagnoses that would benefit from further Plan programs such as Case Management, Disease Management and/or Maternity Support.

COORDINATION OF CARE REQUIREMENTS

Contact the Utilization Review Department for Coordination of Care prior to receiving the following services:

- **Inpatient Hospital/Facility admissions (including admissions for Mental Disorders, Chemical Dependency, Drug and Substance Abuse);**
- **Inpatient and Home Hospice;**
- **Maternity;**
- **Radiation therapy, chemotherapy, dialysis or infusion therapy;**
- **Home Health Care;**
- **Transplant evaluation.**

Specialty medications require Prior Authorization from your PBM. To assist Participants in determining whether prescriptions are covered under the Major-Medical plan or under the EPLS JCode Program see "Medical Benefit Exclusions" section, or Participants may call EPLS at 717-844-9030 to Pre-Authorize a prescription.

CASE MANAGEMENT

During the Utilization Review process, catastrophic cases such as transplants, burns, spinal cord Injuries, cancer and other large cases will be identified and Case Management may be initiated. Case Management is provided by Nurses with specialized training and/or advanced national certification. The Nurse may monitor the medical care, consult with the Physicians, coordinate with the health care Providers and Facilities, and communicate with the patient and Family to promote receipt of appropriate, cost effective care to expedite the recovery process.

When Out-of-Network fees are negotiated by Case Management and/or Utilization Review on behalf of the Plan, Out-of-Network Covered Charges may be considered at the PPO Benefit level.

ALTERNATIVE CARE

Through alternative care, Case Management may help the patient and the Plan Administrator obtain care/treatment for a serious Illness or Injury that is Medically Necessary and appropriate for the diagnosis. When alternative care and treatment are identified by Case Management as Medically Necessary and approved by the Plan Administrator, and where there is a reasonable expectation of savings to the Plan without sacrificing the quality of care to the patient, the Plan may approve and pay for all or part of the charges not shown as a Covered Expense or as a Covered Prescription Drug in this Plan Document. These expenses will be considered on the same basis as the care and treatment for which they are substituted. Benefits provided under this section are subject to all other limitations and provisions within the Plan. In exercising its authority, this Plan will act in a way so as not to discriminate against any Plan Participant. If the care is not being substituted for other Covered Expenses, it will be considered on the same basis as a same or similar Covered Expense or Covered Prescription Drug shown in this Plan Document, as determined by the Claims Administrator.

All benefits provided in this section are subject to Medical Necessity, Reasonableness, and Usual and Customary charges, the Allowable Claim Limits under the Claim Review and Audit Program.

DISEASE MANAGEMENT

Disease Management is an Employer sponsored voluntary program that is designed to help individuals with certain chronic health conditions to better manage their care. Utilization Review, provided through medical management, supports the relationship between the Physician and the patient by providing information regarding optimal treatment options. The objective is to help individuals stay healthy by providing customized health education information for the most appropriate medical care for each individual's Illness.

MATERNITY SUPPORT PROGRAM

A special Maternity Support Program is available from Utilization Review. The program is completely voluntary and provides educational tools to optimize the health of mothers and their newborns. To participate, Covered Persons should call Utilization Review as soon as they know they are pregnant, preferably during the first trimester. Benefits available are:

- Coordination of a proactive education program for maternity care;
- Assessment of the risk of a Pregnancy;
- Identification of personal health factors that could influence the Pregnancy; and
- Development of proactive, risk appropriate care delivery programs for covered Pregnancies and births.

COMPREHENSIVE MEDICAL BENEFITS

COVERED MEDICAL EXPENSES (COVERED EXPENSES)

Covered Medical Expenses mean the Reasonable and Usual and Customary charges, Allowable Claim Limit charges and/or contracted PPO charges incurred by or on behalf of a Covered Person for Hospital or other medical services listed below which are:

1. Ordered by a Physician or licensed Practitioner;
2. Medically Necessary for the treatment of an Illness or Injury;
3. Not of a luxury or personal nature; and
4. Not excluded under the Major Medical Exclusions and Limitations section of this Plan.

COVERED CHARGES

If a Covered Person incurs Covered Medical Expenses as the result of an Illness or Injury, all treatment is subject to benefit payment provisions shown in the Schedule of Benefits and as determined elsewhere in this document.

HOSPITALS, AMBULATORY SURGERY CENTERS AND OTHER FACILITIES

Facilities do not participate in the PPO Network. Charges for services rendered in these Facilities will be evaluated under the Claim Review and Audit Program, and Covered Charges will be determined based upon the Allowable Claim Limits. Please refer to the Claim Review and Audit Program section for additional information about the program and Allowable Claim Limits.

PHYSICIANS AND ALL OTHER COVERED PROVIDERS

Network Services (PPO): Network Services (PPO) are health care services provided by a Physician or other Provider in the designated PPO with which the Plan has contracted to provide services at specified fees. Network Covered Charges will be payable at the PPO benefit level.

This Plan may use Allowable Claim Limits to determine Covered Charges in lieu of a PPO discount.

Out-Of-Network Services (Non-PPO): Out-of-Network Services (Non-PPO) are health care services provided by a Physician or other Provider that is not in the Plan's designated PPO Network. Out-of-Network Covered Charges will be payable at the Non-PPO benefit level unless the Plan has a direct contract for discounting fees with an Out-of-Network Provider or Out-of-Network services are listed as a PPO benefit exception in the Schedule of Benefits, in which case, the PPO benefit level will apply.

HOSPITAL OR MEDICAL FACILITY FEES/PHYSICIAN FEES

The total cost for many medical services/procedures may be comprised of several components: Hospital or other medical Facility fees and Physician fees.

Hospital or Medical Facility Fees: The Hospital or medical Facility fees cover the cost of providing room and board and/or technicians, equipment, supplies and miscellaneous expenses involved in the care and treatment of a patient. Medical service fees billed by a Provider billing as a Facility may be separate from medical services billed by a Physician.

Physician Fees: The Physician fees cover the cost of medical services/procedures provided by a Physician or the professional fees billed by a Physician for the supervision, interpretation and consultation involved in the care and treatment of a patient. Each fee may be billed separately by the Physician providing the service.

SELECT DIAGNOSTIC MEDICAL PROCEDURES
The following is a list of Select Diagnostic Medical Procedures that may be performed in a Physician's office, the Outpatient department of a Hospital, freestanding center or an independent Facility. Benefits are available under the Plan as specified in the Schedule of Benefits:

1. Bone scan – Specialized x-ray of bone tissues using radioactive injection if more sensitive to bone irregularities than usual x-rays:
   a. Limited area;
   b. Multiple areas;
   c. Whole body;
   d. With vascular flow only;
   e. Three phase technique; or
   f. Tomographic (SPECT).
2. Cardiac stress test:
   a. Thallium – Use of radioactive dye to define areas of decreased blood flow in vessels of the heart while the patient exercises.
   b. Treadmill – Reading of the electrical patterns of the heart (EKG) while the patient exercises on a treadmill.
3. MCG – Myocardial imaging by magnetocardiography.
4. CT Scan – Computerized x-ray picture of a part of the body.
5. MRI (Magnetic Resonance Imaging) and MRA (Magnetic Resonance Angiography) – Diagnostic imaging modality that uses magnetic and radio frequency fields to image body tissue non-invasively.
6. PET Scan (Positron Emission Tomography) – A three-dimensional imaging technique that allows visual examination of the internal organs and illustrates organ function.
7. Ultrasound, Echography and Sonography – The use of inaudible sound waves to outline the shape of organs and tissues in the body. A sonogram during Pregnancy is not considered a Select Diagnostic Medical Procedure and is payable under the Plan's Lab/X-ray Benefit.
8. Myelogram – x-ray of the spine after injection of a contrast medium (dye) into a space in the spinal canal.
9. Aortography, Angiography, Lymphangiography, Venography, Transcatheter, Transluminal Atherectomy and Diskography.
10. Nuclear medicine scans.

CALENDAR YEAR MAXIMUM BENEFIT
The Maximum Amount payable for Covered Expenses during a Calendar Year Benefit Period for each Covered Person is limited to a specific dollar amount, number of days or visits as specified in the Schedule of Benefits. The Calendar Year is from January 1 through December 31 of the same year. The initial Calendar Year Benefit Period is from a Covered Person's effective date through December 31 of the same year. Level I and Level II (PPO and Non-PPO) Covered Charges are combined to determine is a Lifetime Maximum Benefit has been met.

CONTINUITY OF CARE
In the event a Participant is a continuing care patient receiving a course of treatment from a Provider which is In-Network or otherwise has a contractual relationship with the Plan governing such care and that contractual relationship is terminated, not renewed, or otherwise ends for any reason other than the Provider's failure to meet applicable quality standards or for fraud, the Participant shall have the following rights to continuation of care.

The Plan shall notify the Participant in a timely manner after termination that the Provider's contractual relationship with the Plan has terminated, and that the Participant has rights to elect continued transitional care from the Provider. If the Participant elects in writing to receive continued transitional care, Plan benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the Plan's notice of termination is provided and ending ninety (90) days later or when the Participant ceases to be a continuing care patient, whichever is sooner.

For purposes of this provision, "continuing care patient" means an individual who is:

- Undergoing a course of treatment for a serious and complex condition from a specific Provider;

- Undergoing a course of institutional or Inpatient care from a specific Provider;
- Scheduled to undergo non-elective surgery from a specific Provider, including receipt of postoperative care with respect to the surgery;
- Pregnant and undergoing a course of treatment for the Pregnancy from a specific Provider; or
- Determined (or was determined) to be terminally ill and is receiving treatment for such Illness from a specific Provider.

Note that during continuation, Plan benefits will be processed as if the termination had not occurred; however, the Provider may be free to pursue the Participant for any amounts above the Plan's benefit amount.

CHARGES RELATED TO ACCIDENTAL INJURIES
Prior to obtaining Accident details, the Maximum Benefit payable on charges arising from an Accidental Injury is $500. Once charges for the same related Claim equal or exceed $500, charges will be denied until expenses are determined to be an eligible benefit under this Plan.

TRADITIONAL PLAN

DEDUCTIBLE AMOUNT (LEVEL I and LEVEL II)
The Deductible amount for each Covered Person is the amount of Covered Expenses which must be incurred each Calendar Year before benefits are payable for Covered Medical Expenses incurred during the remainder of that year. It is the amount shown in the Schedule of Benefits as the Calendar Year Deductible. There is no Deductible carryover from one Calendar Year to the next for Covered Charges incurred and applied to the Deductible in the last three (3) months of a Calendar Year. Level I Covered Charges and Level II PPO and Non-PPO Covered Charges are combined to satisfy the Plan Calendar Year Deductible.

DEDUCTIBLE FAMILY LIMIT (LEVEL I and LEVEL II)
The Maximum Deductible amounts to be applied each Calendar Year to a Covered Employee and his/her covered Dependents will not be more than the Family Limit shown in the Schedule of Benefits. As soon as that limit is met (collectively) three (3) Family members have each satisfied their Deductible in the same Calendar Year, no further Deductibles will be applied to Covered Medical Expenses for any covered Family member during the remainder of that Calendar Year. To satisfy the Deductible Family Limit, each covered Family member can contribute no more than his/her own individual Deductible.

COINSURANCE
Coinsurance is the portion of Covered Medical Expenses shared by the Plan and the Covered Person in a specific ratio (i.e., 80%/20%) after the Calendar Year Deductible has been satisfied. The amount of Coinsurance paid by the Covered Person is applied to satisfy the Covered Person's Annual Out-of-Pocket Maximum.

ANNUAL OUT-OF-POCKET MAXIMUM (LEVEL I and LEVEL II)
The Annual Out-of-Pocket Maximum does not include expenses which are in excess of the Allowable Claim Limits (please refer to the Claim Review and Audit Program section for additional information regarding Allowable Claim Limits). The Annual Out-of-Pocket Maximum is the maximum dollar amount a Covered Person will pay for Covered Medical Expenses each Calendar Year including the Deductible and Medical Copays. Level I Covered Charges and Level II PPO and Non-PPO Covered Charges are combined to satisfy the Annual Out-of-Pocket Maximum. Upon reaching the Annual Out-of-Pocket Maximum, Covered Medical Expenses are payable at 100% for the remainder of the Calendar Year, excluding:

- Prescription Copays (subject to separate Prescription Drug Annual Out-of-Pocket Maximum);
- Any Covered Charges already paid at 100% in any one (1) Calendar Year period, unless otherwise specified in the Schedule of Benefits; and
- Charges in excess of Usual and Customary, Allowable Claim Limits, or charges for services that do not meet the Plan's definition of Reasonable.

ANNUAL OUT-OF-POCKET MAXIMUM FAMILY LIMIT (LEVEL I and LEVEL II)
The Annual Out-of-Pocket Maximum Family Limit is met when all covered Family members (collectively) incur the amount shown in the Schedule of Benefits as the Annual Out-of-Pocket Maximum Family Limit. To satisfy the Family Limit, each Covered Family member can contribute no more than his/her own individual Annual Out-of-Pocket Maximum.

OFFICE VISIT COPAY (PER VISIT)
The Office Visit Copay is the portion of Covered Medical Expenses, a flat dollar amount, payable by the Covered Person for Covered Charges provided by and billed by the Physician at the time of each Physician Office Visit. Whenever an Office Visit Copay applies, the Calendar Year Deductible is waived for that visit except for office procedures listed in the Schedule of Benefits which are not subject to the Office Visit Copay. The Office Visit Copay cannot be used to satisfy the Calendar Year Deductible but will apply to satisfy the Annual Out-of-Pocket Maximum.

Office Visit Copays for a Primary Care Physician and a Specialist are specified in the Schedule of Benefits. A referral from a Primary Care Physician to a Specialist is not required.

HIGH DEDUCTIBLE HEALTH PLAN

DEDUCTIBLE AMOUNT (LEVEL I and LEVEL II)
The Deductible amount for each Covered Person is the amount of Covered Medical and Prescription Drug Expenses which must be incurred each Calendar Year before benefits are payable for Covered Medical and Prescription Drug Expenses incurred during the remainder of that Calendar Year. It is the amount shown in the Schedule of Benefits as the Calendar Year Deductible. There is no Deductible carryover from one Calendar Year to the next for Covered Charges incurred and applied to the Deductible in the last three (3) months of a Calendar Year. Level I Covered Charges, Level II PPO/Non-PPO Covered Charges and Covered Prescription Drug Expenses are combined to satisfy the Calendar Year Deductible.

DEDUCTIBLE FAMILY LIMIT (LEVEL I and LEVEL II)
The Maximum Deductible amounts to be applied each Calendar Year to a Covered Employee and his/her covered Dependents will not be more than the Deductible Family Limit shown in the Schedule of Benefits. As soon as that limit is met (collectively), no further Deductibles will be applied to Covered Medical Expenses for any covered Family member during the remainder of that Calendar Year. To satisfy the Deductible Family Limit, each covered Family member can contribute no more than his/her own individual Deductible.

ANNUAL OUT-OF-POCKET MAXIMUM (LEVEL I and LEVEL II)
The Annual Out-of-Pocket Maximum does not include expenses which are in excess of the Allowable Claim Limits (please refer to the Claim Review and Audit Program section for additional information regarding Allowable Claim Limits). The Annual Out-of-Pocket Maximum is the maximum dollar amount a Covered Person will pay for Covered Medical and Prescription Drug Expenses each Calendar Year including the Deductible.

Level I Covered Charges, Level II PPO/Non-PPO Covered Charges and Covered Prescription Drug Expenses are combined to satisfy the Level I/Level II PPO/Non-PPO Annual Out-of-Pocket Maximum. Upon reaching the Annual Out-of-Pocket Maximum, Covered Medical and Prescription Drug Expenses are payable at 100% for the remainder of the Calendar Year, excluding:

- Any Covered Charges already paid at 100% in any one (1) Calendar Year period, unless otherwise specified in the Schedule of Benefits; and
- Charges in excess of Usual and Customary, Allowable Claim Limits or charges for services that do not meet the Plan's definition of Reasonable.

ANNUAL OUT-OF-POCKET MAXIMUM FAMILY LIMIT (LEVEL I and LEVEL II)

The maximum Annual Out-of-Pocket amounts to be applied each Calendar Year to a Covered Employee and his/her covered Dependents will not be more than the Annual Out-of-Pocket Maximum Family Limit shown in the Schedule of Benefits. As soon as that limit is met (collectively) no further Out-of-Pocket amounts will be applied to Covered Medical and Prescription Drug Expenses during the remainder of that Calendar Year. To satisfy the Family Limit, each Covered Family member can contribute no more than his/her own individual Annual Out-of-Pocket Maximum.

MAJOR MEDICAL EXPENSE BENEFITS

The following are Covered Medical Expenses under this Plan, unless specifically excluded under the Major Medical Plan Exclusions and Limitations. Benefits for these Covered Expenses will be payable as shown in the Schedule of Benefits. Charges are subject to the Reasonable and Usual and Customary amount, the Allowable Claim Limits under the Claim Review and Audit Program and/or the negotiated fee schedule of the Preferred Provider Organization (PPO).

Covered Medical Expenses are subject to any Maximum Benefit and/or limitation specified in the Schedule of Benefits.

Admit Kits. The charges for Hospital "admit kits."

Allergy Testing, Allergy Injections and Allergy Serums. The charges for allergy testing, allergy injections, allergy serums and treatment.

Ambulance Services. The charges for professional licensed ambulance service as follows:

1. Ground transportation when Medically Necessary and used locally to or from the nearest Facility qualified to render treatment;
2. Air ambulance where air transportation is medically indicated to transport a Covered Person to the nearest Facility qualified to render treatment (excluding commercial flights); or
3. "CARE" and "LIFE" flights in a life-threatening situation.

Ambulatory Surgery Center. The charges made by an Ambulatory Surgery Center.

Anesthesia. The charges for the cost and administration of an Anesthesia and/or anesthetic.

Assistant Surgeon. The charges for services of an assistant surgeon and/or Licensed Surgical Assistant when such a Provider is required to render technical assistance at an operation. The Covered Expense for such services shall be limited to 25% of the allowable surgical fee. See definition of Practitioner for covered Providers.

Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD). The charges for the diagnosis and treatment of Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD) with the exclusion of charges for education and training.

Audiologist. The charges of an Audiologist under direct supervision of a Physician for treatment of a hearing loss or an impaired hearing function.

Autism Spectrum Disorder. The charges for treatment of Autism Spectrum Disorder, not subject to the Plan's internal Therapy Maximums. Treatment includes all generally recognized services prescribed in relation to Autism Spectrum Disorder by the patient's Physician. "Generally recognized services" may include services such as evaluation and assessment, Applied Behavior Analysis (ABA) Therapy, behavior training and management, Speech Therapy, Occupational Therapy, Physical Therapy and medications or nutritional supplements used to address symptoms of Autism Spectrum Disorder.

Birthing Center. The charges incurred for services in a Birthing Center.

Blood or Blood Components. The charges for the processing and administration of blood or blood components, but not for the cost of the actual blood or blood components if the Facility receives any replacement of blood used for which the patient is not financially responsible.

Breast Reduction (Reduction Mammoplasty). The charges for a reduction mammoplasty, if Medically Necessary.

Cardiac Rehabilitation. The charges for cardiac rehabilitation as deemed Medically Necessary provided services are rendered:

1. Under the supervision of a Physician;
2. In connection with a myocardial infarction, coronary occlusion or coronary bypass Surgery;
3. Initiated within twelve (12) weeks after other treatment for the medical condition ends; and
4. In a Facility whose primary purpose is to provide medical care for an Illness or Injury.

Chemotherapy. The charges for chemotherapy.

Chiropractic Services. The charges for Chiropractic Services, to include x-rays.

Clinical and Pathological Laboratory Tests. The charges for clinical and pathological laboratory tests and examinations including fees for professional interpretation of their results.

Clinical Trials (Routine Patient Costs). Benefits are provided to Qualified Individuals for the Routine Patient Costs of items and services furnished in connection with participation in an Approved Clinical Trial. Routine Patient Costs include all items and services consistent with the coverage provided under this Plan that are typically covered for a Qualified Individual who is not enrolled in a clinical trial. Routine Patient Costs do not include:

1. The Investigational item, device, or service, itself;
2. Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

If one or more Participating Providers is participating in a clinical trial, the Plan may require that a Qualified Individual participate in the trial through such a Participating Provider if the Provider will accept the individual as a participant in the trial.

Approved Clinical Trial is a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and that is described in any of the following:

1. Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

    a. The National Institutes of Health.
    b. The Centers for Disease Control and Prevention.
    c. The Agency for Health Care Research and Quality.
    d. The Centers for Medicare & Medicaid Services.
    e. A cooperative group or center of any of the entities described in (a) through (d) above or the Department of Defense or the Department of Veterans Affairs.
    f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    g. The Department of Veterans Affairs, the Department of Defense, or the Department of Energy, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines:

        i. to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and
        ii. assures unbiased review of the highest scientific standards by Qualified Individuals who have no interest in the outcome of the review; or

2. The study or investigation is conducted under an Investigational new Drug application reviewed by the Food and Drug Administration; or

3. The study or investigation is a Drug trial that is exempt from having such an Investigational new Drug application.

A Qualified Individual must meet the following conditions:

1. The individual must be eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition; and
2. Either:

    a. The referring health care professional is a Participating Provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or
    b. The individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

A *life-threatening condition* means any Disease or condition from which the likelihood of death is probable unless the course of the Disease or condition is interrupted.

Complementary/ Alternative Medicine including Acupuncture, Therapeutic Massage, Nutrition Therapy, Rolfing and Naturopathy Care. The charges for complementary/alternative medicine including Acupuncture, therapeutic massage, nutrition therapy, rolfing and naturopathy care.

Contraceptives. The charges for all FDA approved women's contraceptive methods.

Corneal Transplants. The charges for services and supplies in connection with corneal transplants on the same basis as any other Illness.

Cosmetic Surgery. The charges for Cosmetic Surgery only in the following situations:

1. Reconstructive Surgery as a result of an accidental bodily Injury;
2. The surgical correction required as a result of a congenital Disease or Congenital Anomaly;
3. Reconstructive Surgery following neoplastic (cancer) Surgery;
4. Reconstruction of the breast on which a mastectomy has been performed;
5. Surgery and reconstruction of the other breast to produce symmetrical appearance;
6. Coverage for prostheses and physical complications related to all stages of covered mastectomy including lymphedema, in a manner determined in consultation with the attending Physician and patient; and
7. Removal of breast implants if deemed to be Medically Necessary and reconstructive breast Surgery after implant removal. Breast reconstruction is not covered if the original implants were for cosmetic reasons. However, the removal of the implant is covered, if Medically Necessary, even if the original implant was for cosmetic reasons.

NOTE: The Plan's breast reconstruction Surgery benefits are subject to the requirements of the mastectomy provision of the Women's Health and Cancer Rights Act of 1998.

Custom Bras for Prostheses. The charges for custom bras for prostheses following a mastectomy, limited to six (6) per Calendar Year.

Dental Expenses and Oral Surgery Procedures. The charges for the following Dental expenses and Oral Surgery procedures:

1. Excision of impacted or partially impacted teeth;
2. Cutting procedures in the oral cavity for excision of tumors and cysts of the jawbone;
3. External incision and drainage of cellulitis;
4. Open or closed reduction of a fracture or dislocation of the jaw; and
5. Treatment necessitated by Accidental Injury to sound natural teeth if services are performed within one (1) year from the date of the Accident.

If Medically Necessary for Dental work or Oral Surgery to be performed at an Outpatient Facility or Hospital, only the Facility and related anesthesia fees are Covered Charges.

Diabetic Supplies. The charges for glucometers and insulin pumps and insulin pump supplies when ordered by a Physician. The charges for insulin, insulin syringes, insulin pump supplies, test strips and lancets on prescription are covered by the Prescription Drug Card or Mail Order Service.

Diabetic Training. The charges for diabetic self-management medical and nutritional training for diagnosed cases of diabetes rendered by a licensed Practitioner when recommended as a course of treatment by a Physician.

Diagnostic Tests. The charges for electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar well established diagnostic tests generally approved by Physicians throughout the United States.

Diagnostic X-Rays. The charges for radiation services including diagnostic x-rays and interpretation.

Dialysis. The charges for dialysis. Dialysis charges may be subject to Medicare rules and reimbursement rates.

Dietitian. The charges for services of a licensed Dietitian when recommended by a licensed MD or DO except for services which are otherwise excluded by the Plan.

Drugs. The charges for Drugs requiring the written prescription of a licensed Physician; such Drugs must be Medically Necessary for the treatment of an Illness or Injury. See Prescription Drug Plan section. Prescription Drugs are covered by the Prescription Drug Card, Mail Order Service, or Specialty Pharmacy and not payable under Major Medical Expense Benefits.

Durable Medical Equipment. The charges for rental or purchase of a wheelchair, Hospital bed and other Durable Medical Equipment prescribed by a Physician and required for therapeutic use, whichever is most cost effective. Benefits will be provided for the repair, adjustment or replacement of purchased Durable Medical Equipment or components only within a reasonable time period of purchase subject to the life expectancy of the equipment.

Elastic/Surgical Stockings. The charges for elastic/surgical stockings when ordered by a Physician, limited to three (3) pairs per Calendar Year.

Genetic Testing. The charges for genetic testing, if Medically Necessary and indicated under nationally accepted guidelines, and genetic testing as required under Preventive Services.

Group Therapy. The charges for group therapy for treatment of Mental Disorders, Chemical Dependency, Drug and Substance Abuse.

Hearing Exam and Aids/Devices. The charges for an Annual routine hearing examination and charges for hearing aids, as specified in the Schedule of Benefits.

Hearing Screening. The charges for hearing screening as required for Preventive Care for Children.

Heart Valve Replacements. The charges for heart valve replacements on the same basis as any other Illness.

Home Health Care. The charges by a Home Health Care Agency for care for a Homebound patient in accordance with a Home Health Care Plan. Home Health Care Visit means a visit by a member of a home health care team. Each visit that lasts for a period of four (4) hours or less is treated as one (1) home health care visit. If the visit exceeds four (4) hours, each period of four (4) hours is treated as one (1) visit and any part of a four (4) hour period that remains is treated as one (1) home health care visit.

Home Health Care Plan Covered Services and Supplies are limited to:

1. Part-time or intermittent nursing care visits by a Registered Nurse (RN), a Licensed Practical Nurse (LPN), a Licensed Vocational Nurse (LVN), or Public Health Nurse who is under the direct supervision of a Registered Nurse (RN);
2. Part-time or intermittent Home Health Aide services which consist primarily of caring for the patient;
3. Physical, Occupational, Speech and respiratory Therapy services by licensed therapists;
4. Services of a Licensed Clinical Social Worker (LCSW); and
5. Medical supplies, Drugs and medications prescribed by a Physician, and laboratory services provided by or on behalf of a Hospital, but only to the extent that they would have been covered under this Plan if the patient had remained in the Hospital. **NOTE:** Home Infusion Therapy is a separate benefit and charges are not considered under Home Health Care.

Home Infusion Therapy. The charges for Home Infusion Therapy by a licensed Provider to include intravenous infusion or injection of fluids, nutrition or medication furnished in the home setting.

The purpose of this Site of Care Policy is to ensure that patients receive infused/injectable drugs administered by healthcare professionals in the most cost-effective and clinically appropriate setting. By identifying and promoting settings with the lowest administration fees for infused drugs, this policy aims to optimize healthcare resources and minimize financial burden on patients and payers.

This policy applies to all specialty infused/injected drugs. Medication must meet applicable medical necessity criteria for coverage. When coverage criteria are met, the Plan requires that this policy is followed. It encompasses drugs administered in outpatient settings, including but not limited to hospitals, physician offices, infusion centers, and patients' homes.

Cost-Effective Site Selection: This Plan limits payments for infused and injectable drugs to the lowest net cost of treatment based on available sites of care with the same level of clinical appropriateness and efficacy.

NOTE: Though ideally healthcare providers should educate patients about the cost implications of different drug infusion or injection settings, many do not, so in order for patients to obtain optimal benefits from this Plan, patients are encouraged to become actively involved in the decision-making process regarding the site of care for infused/injected drugs. This Plan urges its participants to speak with their medical providers about the site of care for their infused or injectable drugs, and to ask their medical providers whether the site of care that the provider has chosen is the most cost-effective at the same level of efficacy, or if there are lower-cost alternatives such as a physician office, ambulatory infusion suite, or a home-based setting.

Hospice Care. The charges relating to Hospice care provided that the Covered Person has a life expectancy of six (6) months or less. Covered Hospice expenses are limited to:

1. Room and Board for confinement in a Hospice;
2. Ancillary charges furnished by the Hospice while the Covered Person is confined therein, including rental of Durable Medical Equipment which is used solely for treating an Injury or Illness;
3. Medical supplies, Drugs and medicines prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition;
4. Physician services and/or nursing care by a Registered Nurse (RN), a Licensed Practical Nurse (LPN) or a Licensed Vocational Nurse (LVN);
5. Home health aide services;
6. Charges for home care furnished by a Hospital or Home Health Care Agency, under the direction of a Hospice, including Custodial Care if it is provided during a regular visit by a Registered Nurse (RN), a Licensed Practical Nurse (LPN), a Licensed Vocational Nurse (LVN) or a home health aide;
7. Medical social services by licensed or trained social workers, psychologists or counselors;
8. Nutrition services provided by a licensed Dietitian; and
9. Bereavement counseling.

Hospital. The charges for:

1. The actual Room and Board expenses incurred for confinement in a regular Hospital room;
2. The actual expense incurred for confinement in an Intensive Care Unit, a Cardiac Care Unit or Burn Unit;
3. Miscellaneous Hospital services and supplies during Hospital confinement;
4. Inpatient Charges for nursery Room and Board;
5. Outpatient Hospital services and supplies; and
6. Hospital Emergency Room services and supplies.

Immunizations. The charges for Immunizations and vaccinations to include complications incurred as a result of such Immunizations.

Independent Freestanding Emergency Department. The charges for an Independent Freestanding Emergency Department and for services rendered therein.

Infertility. The charges for diagnostic testing for the initial diagnosis of infertility. Also covered are the charges for Surgery to treat the underlying cause of infertility.

Infusion Therapy. The charges for infusion therapy.

The purpose of this Site of Care Policy is to ensure that patients receive infused/injectable drugs administered by healthcare professionals in the most cost-effective and clinically appropriate setting. By identifying and promoting settings with the lowest administration fees for infused drugs, this policy aims to optimize healthcare resources and minimize financial burden on patients and payers.

This policy applies to all specialty infused/injected drugs. Medication must meet applicable medical necessity criteria for coverage. When coverage criteria are met, the Plan requires that this policy is followed. It encompasses drugs administered in outpatient settings, including but not limited to hospitals, physician offices, infusion centers, and patients' homes.

Cost-Effective Site Selection: This Plan limits payments for infused and injectable drugs to the lowest net cost of treatment based on available sites of care with the same level of clinical appropriateness and efficacy.

NOTE: Though ideally healthcare providers should educate patients about the cost implications of different drug infusion or injection settings, many do not, so in order for patients to obtain optimal benefits from this Plan, patients are encouraged to become actively involved in the decision-making process regarding the site of care for infused/injected drugs. This Plan urges its participants to speak with their medical providers about the site of care for their infused or injectable drugs, and to ask their medical providers whether the site of care that the provider has chosen is the most cost-effective at the same level of efficacy, or if there are lower-cost alternatives such as a physician office, ambulatory infusion suite, or a home-based setting.

Maternity Care. The charges for maternity care, on the same basis as any Illness covered under this Plan for Covered Employees and covered Dependents. Plan coverage for a Hospital stay in connection with childbirth for both the mother and the newborn Child will be no less than: forty-eight (48) hours following a normal vaginal delivery, or ninety-six (96) hours following a cesarean section, unless a shorter stay is agreed to by both the mother and her attending Physician.

Medical Services Outside the United States. The charges for medical services incurred outside the United States and its territories provided that:

1. Treatment is a result of a Medical Emergency, and services are Medically Necessary and recognized as usual treatment for that condition;

2. Medical expenses are considered Reasonable and Usual and Customary based on the nearest U.S. geographic location to point of service;
3. Procedures are approved by the AMA;
4. All usual Plan provisions, Maximum Benefits, exclusions and limitations apply;
5. Expenses must be filed in U.S. dollar amounts;
6. Services must be translated into English; and
7. Benefits may not be assigned to a Provider.

Medical Supplies. The charges for dressings, sutures, casts, splints, trusses, crutches, braces (except dental braces), Corrective Shoes and other necessary medical supplies.

Mental Disorders, Chemical Dependency, Drug and Substance Abuse. The charges for treatment of Mental Disorders, Chemical Dependency, Drug and Substance Abuse to include Inpatient, Outpatient Psychiatric Day Treatment Facility, Outpatient Chemical Dependency/Drug Treatment Facility, Outpatient therapy and Office Visit expenses. Benefits for Mental Disorders are subject to the provisions of the Mental Health Parity Act and any related amendments.

Midwife. The charges for the services of a Certified Nurse Midwife (CNM).

Morbid Obesity. The charges for the treatment of Morbid Obesity only when the treatment meets Utilization Review's criteria for Medical Necessity to include surgical treatment, non-surgical treatment and complications from such treatment.

Multiple Surgical Procedures. The charges for multiple Surgical Procedures when two (2) or more procedures are performed during the same operation. The Covered Expenses are as follows:

1. When multiple or bilateral Surgical Procedures that increase the time and amount of patient care are performed, the Covered Expense is the allowable fee for the major procedure plus 50% of the allowable fee for each of the lesser ones or the actual fee charged, whichever is less. This provision will not apply to those procedures which are not subject to the Multiple Procedures Reduction Rules per Medicare; and
2. When an incidental procedure is performed through the same incision, the Covered Expense is the fee for the major Surgical Procedure only. Examples of incidental procedures are: excision of a scar, appendectomy, lysis of adhesions, etc.

Nerve Stimulators. The charges for nerve stimulators and TENS units.

Occupational Therapy. The charges for Occupational Therapy for treatment rendered by a licensed Occupational Therapist under supervision of a Physician at a Facility whose primary purpose is to provide medical care for an Injury or Illness.

Organ and Tissue Transplants. The charges related to or in connection with human Organ and Tissue Transplants and organ Donor expenses will be considered first by the Employer's fully-insured Organ and Tissue Transplant Policy as the Primary payer. Such insurance policy will be referred to as the "Organ Transplant Policy" throughout this Plan Document. If charges related to human organ and tissue transplants and organ Donor expenses incurred by a Covered Person on this Plan are not covered by the Employer's fully-insured Organ Transplant Policy, the charges will be considered by this Plan. See Coordination With Organ Transplant Policy section. Covered Charges will be payable based on the information shown in the Organ Transplant Policy section. All charges are subject to the Eligibility provisions of this Plan at the time care and services are provided.

Orthotic Devices. The charges for Orthotic Devices when Medically Necessary and prescribed by a Physician or licensed Practitioner, medically designed for a given patient and used to support, align, prevent or correct deformities or to improve the function of movable parts of the body.

Oxygen. The charges for oxygen and other gases and their administration.

Phenylketonuria. The charges for formulas necessary for the treatment of phenylketonuria or other heritable Diseases. The benefits will be paid on the same basis that benefits would be paid for Drugs ordered by a Physician. Phenylketonuria means an inherited condition that may cause severe intellectual disability if not treated.

Physical Therapy. The charges for Physical Therapy for the treatment or services rendered by a licensed Physical Therapist under direct supervision of a Physician at a Facility or institution whose primary purpose is to provide medical care for an Illness or Injury.

Physician. The charges for the services of a legally qualified Physician for medical care and/or surgical treatment including Office Visits, home visits, Hospital Inpatient care, Hospital Outpatient visits/exams, clinic care and second/third opinion consultations.

Prosthetics. The charges for Prosthetics including artificial limbs and eyes to replace natural limbs and eyes and other necessary prosthetic devices, but not the replacement thereof, unless the replacement is necessary because of physiological changes.

Psychological Testing. The charges for psychological testing.

Radiation Therapy. The charges for radiation therapy.

Recuro Health Telehealth. The charges for Virtual Urgent Care and Virtual Primary Care/Virtual Mental Health Services consultation (telephone or online) with a Physician and/or other Provider through Recuro Health Telehealth.

To contact Recuro Health Telehealth call (844) 715-1724, or access their webpage at www.member.recurohealth.com for additional information.

Telehealth services not Incurred through Recuro Health Telehealth will be a Covered Medical Service subject to the same deductible, copayment, or coinsurance requirements that apply to comparable health services provided in person.

Rehabilitation Facility. The charges incurred for rehabilitative and habilitative services and devices and/or confinement in a Rehabilitation Facility.

Residential Treatment Center. The charges for treatment of Mental Disorders, Chemical Dependency, Drug and Substance Abuse in a Residential Treatment Center.

Routine Newborn Care. The charges for Routine Newborn Care for a well newborn Child for Nursery Room and Board and routine Inpatient services required for the healthy newborn following birth. Covered Expenses will also include charges for pediatric services, newborn hearing exams and circumcision. Benefits will be payable from the date of birth until the date the mother is discharged. Covered Charges are subject to a separate Calendar Year Deductible and considered an expense of the Child.

Sales Tax. The applicable sales tax for covered services and supplies.

Second or Third Surgical Opinion. The charges incurred for a second or third surgical opinion when Surgery or other non-surgical treatment has been recommended.

Skilled Nursing Facility/Extended Care Facility. The charges incurred for confinement in a Skilled Nursing Facility/Extended Care Facility; however, the attending Physician must certify that confinement is Medically Necessary and only charges incurred in connection with care related to the Injury or Illness for which the Covered Person was Hospital confined will be eligible.

Sleep Disorders. The charges for the treatment of Sleep Disorders and sleep apnea to include sleep studies/diagnostic testing, Surgery, Facility, devices and equipment. However, Surgical Procedures to correct snoring are not covered.

Speech Language Pathologist/Speech Therapy. The charges of a legally qualified Speech Language Pathologist under direct supervision of a Physician for restorative Speech Therapy for speech loss or speech impairment due to an Illness, Injury or Congenital Anomaly or due to Surgery performed because of an Illness or Injury, other than a functional nervous disorder (i.e., stuttering, repetitive speech).

Sterilization. The charges for all FDA approved women's elective sterilization procedures. Also covered are the charges for elective vasectomies for Covered Employees, covered Dependent spouses and Domestic Partners.

Surgical Lens Implants. The charges for surgical lens implants for cataracts and other Diseases of the eye.

Surgical Procedure. The charges incurred for a Medically Necessary Surgical Procedure.

Telehealth. Charges for telephone or online consultations with a Physician and/or other Providers.

Telehealth/Telemedicine Consultations. The charges for a consultation (telephone or online) with a Physician and/or other Providers through the Plan's telehealth/telemedicine vendor(s), to include Virtual Emergent and Urgent Care and Virtual Primary Care/Virtual Mental Health Services.

Temporomandibular Joint (TMJ) Disorders and Orthognathic Disorders. The charges for medical treatment of Temporomandibular Joint (TMJ) Syndrome, orthognathic disorders (including Surgical and non-Surgical treatment) and related services to include the initial diagnostic visit, x-rays of the joint, injections into the joint and surgical repair of the temporomandibular joint, to exclude dental and orthodontic services.

Tobacco Use Screening/Cessation Intervention. The charges for tobacco use screening/cessation intervention.

Total Parenteral Nutrition (TPN). The charges for hyperalimentation or total parenteral nutrition (TPN) for persons recovering from or preparing for Surgery.

Urgent Care Facility (Minor Emergency Medical Clinic). The charges for an Urgent Care Facility and for services rendered therein.

Vision Screening. The charges for routine vision screening as required for Preventive Care for Children.

Wellness Procedures. The charges for covered wellness procedures listed as Preventive and Wellness Care Benefits.

MAJOR MEDICAL PLAN EXCLUSIONS AND LIMITATIONS

GENERAL EXCLUSIONS AND LIMITATIONS

The following exclusions and limitations apply to expenses incurred by all Covered Persons:

Abortion. Charges for services or supplies rendered to any Covered Employee or Dependent in connection with an elective abortion, unless the elective abortion is Medically Necessary and the life of the Covered Person would be endangered if the fetus were carried to term, or if Pregnancy was the result of a criminal act such as rape or incest, or if a fetal or chromosomal abnormality existed which was diagnosed prior to the abortion. Benefits for treatment of complications arising from, or as the result of, any elective abortion will be payable on the same basis as an Illness.

Adoption Fees. Charges for adoption fees.

Blood Procurement. Charges incurred for procurement and storage of one's own blood except for procurement and storage of one's own blood if obtained within three (3) months prior to a scheduled Surgery.

Botox. Charges for Botox injections unless Medically Necessary and not Cosmetic.

Chiropractic Maintenance Therapy. Charges for Chiropractic Services for maintenance therapy in accordance with Utilization Review's criteria for maintenance care.

Claim Received After Filing Deadline. Charges for a Claim received after twelve (12) months from the date the service was rendered.

Close Relative. Charges for treatment, services and supplies provided by a Close Relative of the Covered Person, as defined in this Plan.

Continuous Passive Motion Equipment. Charges for purchase or rental of Continuous Passive Motion (CPM) equipment, unless used for post surgical rehabilitation.

Cosmetic. Charges incurred in connection with the care or treatment of, or operations which are performed for, Cosmetic purposes of any kind, including treatment or Surgery for complications or correction of Cosmetic Surgery or treatment, *except* for Cosmetic Surgery procedures listed as covered in Major Medical Expense Benefits.

Counseling. Charges for marriage counseling and Family counseling.

Custodial Care. Charges for Custodial Care and maintenance care. Unless specifically mentioned otherwise, the Plan does not provide benefits for services and supplies intended primarily to maintain a level of physical or mental function.

Deductible/Coinsurance. Any portion of the billed charges for services or supplies which the Provider offers to waive, such as the portion which would not be paid by the Plan due to Deductible or Coinsurance provisions.

Dental. Charges incurred for treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue or alveolar processes; however, benefits will be payable for covered Oral Surgery procedures and treatment required because of Accidental Injury to sound natural teeth. This exception shall not in any event be deemed to include charges for treatment for the repair or replacement of a denture or bridgework. Injury to teeth from chewing or biting is not considered an Accidental Injury.

Education. Charges for education or training of any type including those for learning disabilities, except diabetic self-management medical training for diagnosed cases of diabetes and Applied Behavior Analysis (ABA) Therapy and/or behavior training for treatment of Autism Spectrum Disorder.

Excess. Charges that are not payable under the Plan due to application of any Plan maximum or limit or because the charges are in excess of the Usual and Customary amount, Allowable Claim Limits or are for services not deemed to be Reasonable or Medically Necessary, based upon the Plan Administrator's determination as set forth by and within the terms of this document.

Experimental. Charges for research studies and Experimental medical procedures, treatment, Drugs, devices and related services considered to be Experimental/Investigational in nature as defined in the Plan Definitions except clinical trials listed as covered in Major Medical Expense Benefits. The Claims Administrator retains the right to have such medical expenses reviewed by an independent panel of peer reviewers to determine whether such expenses are considered accepted, standard medical treatment or are Experimental/Investigational.

Experimental Transplants. Charges related to or in connection with Experimental Organ, Tissue and Bone Marrow Transplants including any animal organ transplants.

Fees. Charges for completion of form fees, missed appointment fees or late fees.

Foot Care. Charges for callus or corn paring or excision, toenail trimming, any manipulative procedure for weak or fallen arches, flat or pronated foot, foot strain, Orthopedic Shoes (unless attached to a brace), orthotic insoles or other devices for support of the feet, except for:

1. An open cutting operation for the treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions;
2. Removal of nail roots; or
3. Foot treatment required because of a metabolic or peripheral vascular Disease.

Gender Reassignment. Charges related to or in connection with gender reassignment procedures.

Government. Charges for Hospital confinement, medical or surgical services or other treatment furnished or paid for by or on behalf of the United States, or any State, province or other political subdivision unless there is an unconditional requirement to pay such charges whether or not there is insurance.

Hair Loss/Wigs. Charges for treatment of hair loss including wigs, hairpieces and hair transplants.

Home Health Care Plan Exclusions. Charges for:

1. Services and supplies not included in the Home Health Care Plan;
2. Services of a person who is a Close Relative of the Covered Person;
3. Services of any social worker unless designated LCSW;
4. Transportation services;
5. Food or home delivered meals; and
6. Custodial Care and housekeeping.

Hypnotherapy, Behavior Training and Biofeedback. Charges for hypnotherapy, Applied Behavior Analysis (ABA) Therapy and/or behavior training (except ABA Therapy and/or behavior training for treatment of Autism Spectrum Disorder) and biofeedback.

Illegal Acts. Charges for Injury or Illness incurred as a result of illegal acts involving violence or threat of violence to another person, or in which the Covered Person illegally used a firearm, explosive or other weapon likely to cause physical harm or death, whether or not the Covered Person was charged, convicted or received any type of fine, penalty, imprisonment or other sentence or punishment, unless such Injury is the result of a medical condition (either physical or mental) or is the result of the Covered Person being the victim of an act of domestic violence.

Illegal in the United States. Charges for any services or supplies not considered legal in the United States.

Incurred by Other Persons. Charges for expenses actually incurred by other persons.

Infertility. Charges related to or in connection with the treatment of infertility to include fertility studies, sterility studies, procedures to restore or enhance fertility (except Surgical Procedures to treat the underlying cause of infertility), artificial insemination or in-vitro fertilization or other similar procedures.

I.Q. Testing. Charges for I.Q. testing.

JCodes. *Certain prescription drugs (1) listed on the EPLS Appendix A drug exclusion list and (2) prescribed in an outpatient, office visit, or home setting are excluded under the Medical provisions of the Plan and may only be eligible for coverage under, and subject to, the terms of the EPLS JCode Program. This exclusion will not apply to High-Cost Prescription Drug and select injectable medications administered to a Covered Person while confined on an Inpatient basis, or while a Covered Person is receiving treatment from an ambulatory surgical center or an emergency room. As it relates to this benefit and the EPLS JCode Program, the term "Specialty (Prescription) Drug" means a high-cost drug subject to HCPCS Level II (JCode) billing codes listed in EPLS Appendix A. This list may not be all-inclusive and is subject to change. For the most current EPLS Appendix A drug exclusion list, please contact EPLS at 717-844-9030. The terms of the EPLS JCode Program include the processes and procedures issued by the Pharmacy Benefit Manager to administer Specialty Drugs.*

It is the Participant's responsibility to contact EPLS and satisfy the Plan's requirements for coverage. To begin the process or obtain an up-to-date formulary (Appendix A), contact EPLS at 717-844-9030.

Medicare. Charges for benefits that are provided, or which would have been provided had the Participant enrolled in, applied for, or maintained eligibility for such care and service benefits, under Title XVIII of the Federal Social Security Act of 1965 (Medicare), including any amendments thereto, or under any Federal law or regulation, except as provided in the sections entitled "Coordination of Benefits" and "Medicare."

Negligence. Charges for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any licensed Provider.

Newborns of Dependent Children. Charges related to or in connection with newborns of Dependent Children, unless the newborn Child meets the definition of an Eligible Dependent.

Not Acceptable. Charges that are not accepted as standard practice by the AMA, ADA, or the FDA.

Not Certified/Authorized. Charges for treatment, services or supplies that are not certified by a Physician or Practitioner who is attending the Covered Person as being required for the treatment of Injury or Disease, and performed by an appropriate Practitioner.

Not Connected with Active Illness. Charges for hospitalization primarily for x-rays, laboratory tests, diagnostic study, physiotherapy, hydrotherapy, medical observation, convalescent or rest care, or any medical examination or test not connected with an active Illness or Injury, unless otherwise specified for Preventive and Wellness Care Benefits or otherwise specified as covered in this Plan.

Not Legally Obligated to Pay. Charges incurred for which the Covered Person, in the absence of this coverage, is not legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage.

Not Medically Necessary. Charges incurred in connection with services and supplies which are not Medically Necessary for treatment of an active Illness or Injury unless listed as Covered Wellness Procedures in the Preventive and Wellness section of the Schedule of Benefits or otherwise specified as covered in this Plan.

Not Rendered by/Provided under Supervision of Physician. Charges for Physicians' fees for any treatment which is not rendered by or provided under the supervision of a Physician.

Nutritional Supplements. Charges for nutritional supplements and related supplies, whether or not prescribed by a Physician. The Plan will consider charges for nutritional supplements, feeding tubes and

related supplies only if a Covered Person is unable to get nutrition by any other means and nutritional supplements for treatment of Autism Spectrum Disorder.

Occupational. Charges arising out of or in the course of any occupation for wage or profit, whether or not the Covered Person is entitled to benefits under any Workers' Compensation or Occupational Disease Law, or any such similar law.

Organ Transplant Policy. Charges for all transplant services covered under the Employer's fully-insured Organ Transplant Policy. See Organ Transplant Policy section.

Personal Convenience. Charges incurred for services or supplies which constitute personal comfort or beautification items, television or telephone use, or charges in connection with Custodial Care.

Portable Uterine Monitors. Charges for portable uterine monitors unless approved by Utilization Review and/or Case Management.

Prior to Coverage. Charges for services that are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein.

Prior to Effective Date. Charges incurred prior to the effective date of coverage under the Plan, or after coverage is terminated.

Private Duty Nursing. Charges for Private Duty Nursing except as payable under Home Health Care.

Provider Error. Charges for services required as a result of unreasonable Provider error.

Riot/Civil Insurrection. Charges resulting from or sustained as a result of participation in a riot or civil insurrection.

Self-inflicted. Charges incurred in connection with any self-inflicted Injury or Illness unless the Injury or Illness is a result of a medical condition (either physical or mental) or is the result of the Covered Person being the victim of an act of domestic violence.

Sexual Dysfunctions. Charges for treatment of sexual dysfunctions or inadequacies that do not have a physiological or organic basis.

Speech Therapy. Charges for Speech Therapy to correct pre-speech deficiencies or therapy to improve speech skills not fully developed unless related to an Illness or Injury.

Sterilization Reversal. Charges resulting from or in connection with the reversal of a sterilization procedure.

Subrogation, Reimbursement, and/or Third Party Responsibility. Charges for treatment of an Injury or Illness not payable by virtue of the Plan's subrogation, reimbursement, and/or third party responsibility provisions.

Surrogate Fees. Charges for surrogate fees.

Travel Outside the United States. Charges incurred as the result of travel outside the United States or its territories specifically to receive medical treatment.

Vision Correction Surgery. Charges for any Surgical Procedure for the correction of a visual refractive problem including radial keratotomy, lasik or similar Surgical Procedures.

Vision Exam and Eyewear. Charges incurred in connection with routine vision exams or eye refractions, and the purchase or fitting of eyeglasses and contact lenses. This exclusion/limitation shall not apply to routine vision screenings as required for Preventive Care for Children or the initial purchase of eyeglasses or contact lenses following cataract Surgery.

War. Charges incurred as a result of war or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country.

Weight Loss Programs. Charges for weight loss programs even when recommended by a Physician.

NOTE: With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Injury if the Injury results from being the victim of an act of domestic violence or a documented medical condition. To the extent consistent with applicable law, this exception will not require this Plan to provide particular benefits other than those provided under the terms of the Plan.

COORDINATION OF BENEFITS

The Coordination of Benefits provision is intended to prevent the payment of benefits which exceed Covered Expenses. It applies when the Plan Participant is also covered by another plan or plans. When more than one coverage exists, one plan (primary plan) normally pays its benefits in full and the other plans (secondary plans) pay a reduced benefit. This Plan may pay either its benefits in full or at a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of Allowable Expenses. Only the amount paid by this Plan will be charged against the Plan Benefit Maximums.

For organ and tissue transplants, see Coordination With Organ Transplant Policy section. The reduced Benefits payable under this Plan for organ and tissue transplants which, when added to the benefits payable by the Organ Transplant Policy, will not exceed benefits payable under this Plan, if this Plan were primary.

The Coordination of Benefits provision applies whether or not a Claim is filed under the other plan or plans. If needed, authorization must be given to this Plan to obtain information as to benefits or services available from the other plan or plans, or to recover overpayments.

All benefits contained in the Plan Document are subject to this provision except Prescription Drug expenses.

EXCESS INSURANCE

If at the time of Injury, Illness, Disease or disability there is available, or potentially available, any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage.

For purposes of this Coordination of Benefits provision, the term "plan" as used herein will mean any plan providing benefits or services for medical or dental treatment, and such benefits or services are provided by:

1. Group insurance or any other arrangement for coverage for Covered Persons in a group whether on an insured or uninsured basis, including but not limited to:
   a. Hospital indemnity benefits; and
   b. Hospital reimbursement-type plans which permit the Covered Person to elect indemnity at the time of Claims;
2. Hospital or medical service organizations on a group basis, group practice and other group pre-payment plans;
3. Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision;
4. A Licensed Health Maintenance Organization (HMO);
5. Any Coverage for students which is sponsored by, or provided through, a school or other educational institution;
6. Any coverage under a governmental program, and any coverage required or provided by any statute;
7. Group automobile insurance;
8. Individual automobile insurance coverage on an automobile leased or owned by the Employer; or
9. Any individual automobile insurance, including No-Fault Automobile Insurance on an individual basis.

"Plan" will be construed separately with respect to each policy, contract, or other arrangement for benefits or services, and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

"Allowable Expense" is the Usual and Customary charge within Allowable Claim Limits for any Medically Necessary, Reasonable, eligible item of expense, at least a portion of which is covered under this Plan. When some other plan provides benefits in the form of services rather than cash payments, the Reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any other plan include the benefits that would have been payable had Claim been duly made.

In the case of HMO (Health Maintenance Organization) plans, this Plan will not consider any charges in excess of what an HMO Provider has agreed to accept as payment in full. Further, when an HMO is primary and the Covered Person does not use an HMO Provider, this Plan will not consider as allowable expenses any charges that would have been covered by the HMO had the Covered Person used the services of an HMO Provider.

"Claim Determination Period" is a Calendar Year, a Plan Year or that portion of a Calendar or Plan Year during which the Covered Person, for whom Claim is made, has been covered under this Plan.

COORDINATION PROCEDURES

Notwithstanding the other provisions of this Plan, benefits that would be payable under this Plan will be reduced so that the sum of benefits payable under this Plan and all benefits payable under all other plans will not exceed the total of Allowable Expenses incurred during any Claim Determination Period with respect to Covered Persons eligible for:

1. Benefits, either as an insured person or Employee or as a Dependent, under any other plan which has no provision similar in effect to this provision.

2. Dependents' benefits under this Plan who are also eligible for benefits:

    a. As an insured person or Employee under any other plan; or
    b. As a Dependent Child of an insured person or Employee covered under any other plan.

3. A Covered Person under this Plan who is also eligible for benefits as an insured person or Employee under any other plan and has been covered continuously for a longer period of time under such other plan.

For the purpose of determining the applicability of and for implementing this provision or any provision of similar purpose in any other plan, the Plan Administrator may, without the consent of or notice to any person, release to or obtain from any other insurance company or other organization or person any information with respect to any person which the Plan Administrator deems to be necessary for such purposes. Any Covered Person claiming benefits under this Plan will furnish to the Plan Administrator such information as may be necessary to implement this provision or to determine its applicability.

ORDER OF BENEFIT DETERMINATION

Each plan makes its Claim payment according to where it falls in this order, if Medicare is not involved:

1. If a plan contains no provision for Coordination of Benefits, then it pays primary before all other plans.

2. The plan which covers the Covered Person as an Employee (or named insured) pays primary as though no other plan existed; remaining recognized charges are paid under a secondary plan which covers the Claimant as a dependent.

3. If the Covered Person is a Dependent Child:

    a. Whichever parent has a birthday anniversary which occurs earlier in the Calendar Year shall be considered to have the primary plan;
    b. If birthday anniversaries are the same, then the plan of the parent who has been covered under his/her plan for the longer period of time will be primary; and
    c. If the plan with which this Plan is to be coordinated does not include the requirements shown above, then the plan without such requirements will be primary.

4. If the Covered Person is a Dependent Child and the parents are divorced, then:

    a. The plan of the parent with custody pays first, unless a court order or decree specifies the other parent to have financial responsibility, in which case that parent's plan would pay first; or
    b. The plan of a step-parent with whom the Child lives pays second (if applicable).

5. If the order set out in 1, 2, 3 or 4 above does not apply in a particular case, then the plan which has covered the Covered Person for the longest period of time will pay first.

FACILITY OF PAYMENT

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plan or plans, the Plan Administrator will have the right, exercisable alone and in its sole discretion, to pay to any insurance company or other organization or person making such other payments any amounts it will determine in order to satisfy the intent of this provision, and amounts so paid will be deemed paid under this Plan and to the extent of such payments, the Plan Administrator will be fully discharged from liability under this Plan.

The benefits that are payable will be charged against any applicable Maximum payment or benefit of this Plan rather than the amount payable in the absence of this provision.

RIGHT OF RECOVERY

In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the Maximum Amount of payment necessary at that time to satisfy the intent of this Article, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the Covered Person or his or her Dependents. **Please see the Recovery of Payments provision for more details.**

COORDINATION WITH ORGAN TRANSPLANT POLICY

Covered Persons who are eligible for the Employer's fully-insured Organ Transplant Policy will be entitled to benefits under this Plan only after consideration of transplant expenses by the Employer's Organ Transplant Policy. The Organ Transplant Policy is always the Primary payer and pays before any benefits under this Plan are considered unless the insured person is eligible for Medicare or is a Dependent covered by another employer's group plan. This Plan will always be the Secondary payer unless charges are not covered by the Organ Transplant Policy. This Plan may pay either its benefits in full or a reduced amount which, when added to the benefits payable by the Organ Transplant Policy, will not exceed the benefits payable under this Plan if this Plan were Primary. Only the amount paid by this Plan will be charged against the Plan Maximums. This Plan will fully coordinate its benefits, as Secondary payer, against the benefits provided under the above referenced transplant policy.

COORDINATION WITH MEDICARE

Notwithstanding all other provisions of this Plan, Covered Persons who are eligible for Medicare benefits may be entitled to benefits under this Plan which will be coordinated with Medicare in accordance with the Coordination of Benefits provision of this Plan and subject to the rules and regulations as specified by the Tax Equity and Fiscal Responsibility Act of 1982 as they may be amended from time to time. This Plan is

primary to Medicare coverage for all active Employees and Dependents (regardless of age) unless Medicare states otherwise for certain medical conditions. In the event that this Plan is secondary to Medicare, benefits payable under this Plan will be reduced by benefits that would be payable for the same services under Medicare Parts A and B whether or not the Covered Person is enrolled in Medicare Parts A and B.

COORDINATION WITH AUTOMOBILE INSURANCE COVERAGE

The Plan's liability for expenses arising out of an automobile Accident is based on the type of automobile insurance law enacted by the Covered Person's State. Nationally, there are three types of State automobile insurance laws:

1. No-Fault Automobile Insurance laws;
2. Financial responsibility laws; or
3. Other automobile liability insurance laws.

COORDINATION WITH AUTOMOBILE NO-FAULT COVERAGE

Except as required by law, the Plan is secondary to any No-Fault Automobile coverage. It is not intended to reduce the level of coverage that would otherwise be available through a No-Fault Automobile Insurance policy nor does it intend to be primary in order to reduce the premiums or cost of No-Fault Automobile coverage.

If the Covered Person or his/her covered Dependent incur Covered Charges as a result of an automobile Accident (either as driver, passenger or pedestrian), the amount of Covered Charges that the Plan will pay is limited to:

1. Any Deductible under the automobile coverage;
2. Any Copayment under the automobile coverage;
3. Any expense properly excluded by the automobile coverage that is a Covered Charge; and
4. Any expense that the Plan is required to pay by law.

An individual is considered to be covered under an automobile insurance policy if he/she is either:

1. An owner or principal named insured of the policy;
2. A Family member of a person insured under the policy; or
3. A person who would be eligible for medical expense benefits under an automobile insurance policy if this Plan did not exist.

COORDINATION WITH FINANCIAL RESPONSIBILITY LAW

The Plan is secondary to automobile coverage or to any other party who may be liable for the Covered Person's medical expenses resulting from the automobile Accident.

If the Covered Person's State has a "financial responsibility" law which does not allow the Plan to pay benefits as secondary or which does not allow the Plan to advance payments with the intent of subrogating or recovering the payment, the Plan will not pay any benefits related to an automobile Accident for the Covered Person or their Dependents.

COORDINATION WITH OTHER AUTOMOBILE LIABILITY INSURANCE

If the Covered Person's State does not have a No-Fault Automobile Insurance law or a "financial responsibility" law, this Plan is secondary to their automobile insurance coverage or to any other party who may be liable for the Covered Person's medical expenses resulting from the automobile Accident.

COORDINATION WITH UNDERINSURED/UNINSURED MOTORIST COVERAGE

If the Covered Person is involved in an automobile Accident and, as a result of the Accident, the Plan pays benefits, and if the Covered Person receives a settlement from their underinsured or uninsured motorist policy, the Plan is entitled to receive, from the proceeds of the settlement with the underinsured or uninsured motorist coverage, the expenses of the Plan. The Plan is not entitled to receive any recovery that is in excess of its expenses. The Plan agrees to payment of benefits prior to the receipt by the Covered Person of any recovery from their underinsured or uninsured motorist policy. The Covered Person agrees to notify the Plan of the existence of a recovery from an underinsured or uninsured motorist policy and further agrees to remit to the Plan the proceeds of any recovery received from an underinsured or uninsured motorist policy up to the expenditures made by the Plan. Any expenses by the Plan which are in excess of the proceeds received by the underinsured/uninsured motorist policy will be the responsibility of the Plan pursuant to the terms and conditions of the Plan.

SUBROGATION AND REIMBURSEMENT PROVISIONS

PAYMENT CONDITION

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness or disability is caused in whole or in part by, or results from the acts or omissions of Covered Persons, Plan Beneficiaries and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereafter in this section as "Covered Person(s)") or a third party, where another party may be responsible for expenses arising from an incident and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance and/or guarantor(s) of a third party (collectively "Coverage").

2. A Covered Person(s), his/her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Covered Person(s) and/or his/her attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Covered Person(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Covered Person shall be a trustee over those Plan assets.

3. In the event a Covered Person(s) settles, recovers, or is reimbursed by any Coverage, the Covered Person(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s) for charges Incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Covered Person(s) fails to reimburse the Plan out of any judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

4. If there is more than one party responsible for charges paid by the Plan, or that may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, in regards to an unallocated settlement fund meant to compensate multiple injured parties of which the Covered Person(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the Plan may seek reimbursement.

SUBROGATION

1. As a condition to participating in and receiving benefits under this Plan, the Covered Person(s) agrees to assign to the Plan the right to subrogate and pursue any and all Claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Covered Person(s) fails to so pursue said rights and/or action.

2. If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any Claim which any Covered Person(s) may have against any Coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Person is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

3. The Plan may, at its discretion, in its own name or in the name of the Covered Person(s) commence a proceeding or pursue a Claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

4. If the Covered Person(s) fails to file a Claim or pursue damages against:

   a. The responsible party, its insurer, or any other source on behalf of that party;
   b. Any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
   c. Any policy of insurance from any insurance company or guarantor of a third party;
   d. Workers' Compensation or other liability insurance company; or
   e. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverages;

   then the Covered Person(s) authorizes the Plan to pursue, sue, compromise and/or settle any such Claims in the Covered Person(s) and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such Claims. The Covered Person(s) assigns all rights to the Plan or its assignee to pursue a Claim and the recovery of all expenses from any and all sources listed above.

RIGHT OF REIMBURSEMENT

1. The Plan shall be entitled to recover 100% of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Covered Person(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Covered Person(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If the Covered Person's/Covered Persons' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Covered Person are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or Claim on the part of the Covered Person(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery, will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person(s).

5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Illness, Injury or disability.

PARTICIPANT IS A TRUSTEE OVER PLAN ASSETS

1. Any Covered Person who receives benefits and is, therefore, subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is, therefore, deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any Injury or Accident. By virtue of this status, the Covered Person understands that he/she is required to:

    a. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;
    b. Instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;
    c. In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Plan Participant obtains a settlement, judgment or other source of coverage to include the Plan or its authorized representative as a payee on the settlement draft; and
    d. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

2. To the extent the Covered Person disputes this obligation to the Plan under this section, the Covered Person or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorney's fees, for which he/she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

3. No Covered Person, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section, will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

RELEASE OF LIABILITY

The Plan's right to reimbursement extends to any incident related care that is received by the Covered Person(s) ("Incurred") prior to the liable party being released from liability. The Covered Person's/Covered Persons' obligation to reimburse the Plan is therefore tethered to the date upon which the Claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Covered Person has an obligation to review the "lien" provided by the Plan and reflecting Claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care Incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be Incurred, and for which the Plan will be asked to pay.

EXCESS INSURANCE

If at the time of Injury, Illness or disability there is available, or potentially available, any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section. The Plan's benefits shall be excess to:

1. The responsible party, its insurer, or any other source on behalf of that party;
2. Any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
3. Any policy of insurance from any insurance company or guarantor of a third party;
4. Workers' Compensation or other liability insurance company; or
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

SEPARATION OF FUNDS

Benefits paid by the Plan, funds recovered by the Covered Person(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person(s), or filing of bankruptcy by the Covered Person(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

WRONGFUL DEATH CLAIMS

In the event that the Covered Person(s) dies as a result of his/her injuries and a wrongful death or survivor Claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply.

OBLIGATIONS

1. It is the Covered Person(s) obligation at all times, both prior to and after payment of medical benefits by the Plan to:

    a. Cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
    b. Provide the Plan with pertinent information regarding the Illness, disability or Injury, including Accident reports, settlement information and any other requested additional information;
    c. Take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
    d. Do nothing to prejudice the Plan's rights of subrogation and reimbursement;
    e. Promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received;
    f. Notify the Plan or its authorized representative of any incident related claims or care which may not be identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan;
    g. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement;
    h. Not settle or release, without the prior consent of the Plan, any Claim to the extent that the Plan Beneficiary may have against any responsible party or Coverage;
    i. Instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft;
    j. In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft; and
    k. Make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Covered Person over settlement funds is resolved.

2. If the Covered Person(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid, to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person(s).

3. The Plan's right to reimbursement and/or subrogation is in no way dependent upon the Covered Person(s)' cooperation or adherence to these terms.

OFFSET

If timely repayment is not made, or the Covered Person(s) and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Covered Person's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Covered Person(s) in an amount equivalent to any outstanding amounts owed by the Covered Person to the Plan. This provision applies even if the Covered Person has disbursed settlement funds.

MINOR STATUS

1. In the event the Covered Person(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his/her estate insofar as these subrogation and reimbursement provisions are concerned.

2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

LANGUAGE INTERPRETATION

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

SEVERABILITY

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

CLAIM REVIEW AND AUDIT PROGRAM

The Plan has arranged with Imagine360 for a program of Claim review and auditing in order to identify charges billed in error, charges for excessive or unreasonable fees and charges for services which are not medically appropriate. Benefits for Claims which are selected for review and auditing will be reduced for any charges that are determined to be in excess of Allowable Claim Limits (as defined below). The determination of Allowable Claim Limits under this Program will supersede any other Plan provisions related to application of a Usual and Customary fee determination.

Medical care Providers will be given a fully detailed explanation of any charges that are found to be in excess of Allowable Claim Limits, and allowed the rights and privileges to file an appeal of the determination in accordance with the same rights and privileges accorded to Plan Participants, in exchange for the Provider's agreement not to bill the Plan Participant for charges which were not covered as a result of the Claim review and audit.

Any Plan Participant who continues to receive billings from the medical care Provider for these charges should contact Imagine360 or the Plan Administrator right away for assistance.

The Plan Administrator is identified in the General Information and Purpose section of this Summary Plan Description. Imagine360 may be contacted at:

Imagine360 Administrators, LLC
1550 Liberty Ridge, Suite 330
Wayne, PA 19087
Phone: 610-321-1030
Fax: 610-321-1031

The Plan Participant must pay for any normal cost-sharing features of the Plan, such as Deductibles, Coinsurance and Copayments, and any amounts otherwise excluded or limited according to the terms of the Plan.

The success of this program will be achieved through a comprehensive review of detailed records including, for example, itemized charges and descriptions of the services and supplies provided. Without this detailed information, the Plan will be unable to make a determination of the amount of Covered Medical Expenses that may be eligible for reimbursement. Any additional information required for the audit will be requested directly from the Provider of service and the Claimant. In the event that the Plan Administrator does not receive information adequate for the Claim review and audit within the time limits required under the Plan, it will be necessary to deny the Claim. Should such a denial be necessary, the Claimant and/or the Provider of service may appeal the denial in accordance with the provisions which may be found in the section, "Procedures for Claims and Appeals," in this Summary Plan Description.

In the following provisions of the Claim Review and Audit Program, the term "Plan Administrator" shall be deemed to mean Imagine360:

"Allowable Claim Limits" means the charges for services and supplies, listed and included as Covered Medical Expenses under the Plan, which are Medically Necessary for the care and treatment of Illness or Injury, but only to the extent that such fees are within the Allowable Claim Limits. Examples of the determination that a charge is within the Allowable Claim Limit include, but are not limited to, the following guidelines:

1. **Errors, Unbundled and/or Unsubstantiated Charges.** Allowable Claim Limits will not include the following amounts:

    a. Charges identified as improperly coded, duplicated, unbundled and/or for services not performed;
    b. Charges for treating Injuries sustained or Illnesses contracted, including infections and complications, which, in the opinion of the Plan Administrator, can be attributed to medical errors by the Provider;

c. Charges that cannot be identified or understood; and
d. Charges that cannot be verified from audits of medical records.

2. **Guidelines.** The following guidelines will be used when determining Allowable Claim Limits:

a. Facilities. The Allowable Claim Limit for Claims by a Facility, including but not limited to, Hospitals, emergency and urgent care centers, rehabilitation and skilled nursing centers, and any other health care Facility, shall be the greater of (I) 112% of the Facility's most recent departmental cost ratio, reported to the Centers for Medicare and Medicaid Services ("CMS") and published in the American Hospital Directory as the "Medicare Cost Report" (the "CMS Cost Ratio"), or (II) the Medicare allowed amount for the services in the geographic area plus an additional 20%. The Allowable Claim Limit for (I) shall not exceed 250% of the federal non-commercial Medicare allowed amount, except for children's hospitals, which shall not exceed 350% of the federal non-commercial Medicare allowed amount. If insufficient information is available to identify either the Facility's most recent departmental cost ratio or the Medicare allowed amount, the Allowable Claim Limit shall be either (I) or (II) herein that can be identified.

b. Ambulatory Health Care Centers. The Allowable Claim Limit for ambulatory health care centers, including Ambulatory Surgery Centers, which are independent Facilities shall be the Medicare allowed amount for the services in the geographic area plus an additional 20%. In the event that insufficient information is available to identify the Medicare allowed amount, the Allowable Claim Limit for such services shall be to the extent available either the Outpatient or Inpatient Medicare allowed amount for the service, plus an additional 20%.

c. Out-of-Network Professional Providers. The Allowable Claim Limits for Out-of-Network professional Providers shall be determined using the following:

i. For general medical and primary care Claims, the Medicare allowed amount in the geographic area plus an additional 40%;
ii. For Specialist medical and surgical care Claims, the Medicare allowed amount in the geographic area plus an additional 55%;
iii. For anesthesiologist Claims, the Medicare allowed amount in the geographic area plus an additional 100%; or
iv. For ambulance and air ambulance Claims, the Medicare allowed amount in the geographic area plus an additional 20%; or
v. For other non-Facility Claims and supplies (such as, but not limited to, Durable Medical Equipment, laboratory services and supplies, and mid-level Providers, etc.), the Medicare allowed amount in the geographic area.

For purposes of determining the proper Allowable Claim Limits for professional Providers in categories (i), (ii), (iii), (iv) or (v) above, the Plan Administrator shall determine the applicable category for each Claim based on the taxonomy code used by the professional Provider for that Claim. The Plan Administrator determines, in its sole discretion, the type of Provider for determining Allowable Claim Limits, as detailed above.

While this Plan typically pays professional Providers based on the Medicare allowed amounts above, certain services may be reimbursed at 110% of the Medicare allowed amount for the service. These services may include, but are not limited to, routine diagnostic tests, evaluation services, telehealth and services for ongoing therapy. A full list of services subject to this rule can be found here: www.planlimit.com/prof1. This list will be updated at least annually to reflect the Plan's current plan design.

d. Directly Contracted Providers. The Allowable Claim Limits for Directly Contracted Providers shall be the negotiated rate as agreed under the Direct Agreement.

e. Insufficient Information to Determine Allowable Claim Limit. In the event that insufficient information is available to determine Allowable Claim Limits for specific services or supplies using the guidelines listed in Section 2 above as may be applicable, Imagine360 may apply the following guidelines:

i. General Medical and/or Surgical Services. The Allowable Claim Limit for any covered services may be calculated based upon industry-standard resources including, but not limited to, published and publicly available fee and cost lists and comparisons, or any combination of such resources that, in the opinion of the Plan Administrator, results in the determination of a Reasonable expense under the Plan.
ii. Medical and Surgical Supplies, Implants, Devices. The Allowable Claim Limit for charges for medical and surgical supplies made by a Provider may be based upon the invoice price (cost) to the Provider, plus an additional 12%. The documentation used as the resource for this determination will include, but not be limited to, invoices, receipts, cost lists or other documentation as deemed appropriate by the Plan Administrator.
iii. Physician, Medical and Surgical Care, Laboratory, X-ray, and Therapy. The Allowable Claim Limit for these services may be determined based upon the 60th percentile of Fair Health (FH®) Allowed Benchmarks.

Comparable Services or Supplies. In the event that insufficient information is available to determine Allowable Claim Limits for specific services or supplies using the guidelines listed in Section 2 above, Allowable Claim Limits will be determined considering the most comparable services or supplies based upon comparative severity and/or geographic area to determine the Allowable Claim Limit. The Plan Administrator reserves the right, in its sole discretion, to determine any Allowable Claim Limit amount for certain conditions, services and supplies using accepted industry-standard documentation, applied without discrimination to any Covered Person.

In the event that a determination of Allowable Claim Limit for a Claim exceeds the actual Charges billed for the services and/or supplies, the actual Charges billed for the Claim shall be the Allowable Claim Limit.

PROCEDURES FOR CLAIMS AND APPEALS

The procedures outlined below must be followed by Claimants to obtain payment of benefits under this Plan.

NOTICE AND PROOF OF CLAIM

Written notice and proof of an incurred Claim should always be filed with the Claims Administrator as soon as possible. **Claims must be filed within twelve (12) months from the date of service to be covered by the Plan.** If an individual's coverage under the Plan ceases, all Claims incurred prior to termination of coverage **must** be filed within twelve (12) months from the date of service, or the Claims will not be covered by the Plan.

Claims **must** be filed sooner in certain circumstances:

- If the Plan is terminated, all Claims incurred prior to the Plan termination **must** be received within ninety (90) days after the termination or the Claims will not be covered.

Any Claims incurred after termination of Plan coverage for any reason are not covered under the Plan.

Customarily, there are four types of Claims: Pre-service (Urgent), Pre-service (Non-urgent), Concurrent Care, and Post-service.

- A “Pre-service Claim” is a Claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. Because the Plan does not require Claimants to obtain approval of a medical service prior to getting treatment on an urgent or non-urgent basis, there are no “Pre-service Claims.” The Claimant simply follows the Plan's procedures with respect to notice that is required after receipt of treatment, and files the Claim as a Post-service Claim.

- A “Concurrent Claim” arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either: (a) the Plan determines that the course of treatment should be reduced or terminated, or (b) the Claimant requests an extension of the course of treatment beyond that which the Plan has approved. Because the Plan does not require Claimants to obtain approval of medical services prior to getting treatment, there is no need to contact Utilization Review to request an extension of a course of treatment. The Claimant simply follows the Plan's procedures with respect to notice that is required after receipt of treatment, and files the Claim as a Post-service Claim.

- A “Post-service Claim” is a Claim for a benefit under the Plan after the services have been rendered.

A Post-service Claim is considered to be filed when the following information is received by the Claims Administrator with a Form CMS-1500 or Form UB-04 or any successor forms:

1. The date of service;
2. The name, address, telephone number, and tax identification number of the Provider of the services or supplies;
3. The place where the services were rendered;
4. The diagnosis and procedure codes;
5. The amount of charges (including any PPO re-pricing information);
6. The name of the Plan;
7. The name of the Covered Employee; and
8. The name of the patient.

Each Claimant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses

were incurred, or that the benefit is covered under the Plan. This includes any substantiating documentation, Coordination of Benefits information or other information that may be required by the Plan as proof. If the Plan Administrator in its sole discretion determines that the Claimant has not incurred a Covered Expense, or that the benefit is not covered under the Plan, or if the Claimant fails to furnish such proof as is requested, no benefits shall be payable under the Plan.

CLAIMS DETERMINATION

The Plan Administrator shall notify the Claimant, in accordance with the provisions set forth below, of any Adverse Benefit Determination within the following timeframes:

- If the Claimant has provided all of the information needed to process the Claim in a reasonable period of time, but not later than thirty (30) days after receipt of the Claim. This period may be extended by the Plan for up to fifteen (15) days, provided that the Plan Administrator: (a) determines that such an extension is necessary due to matters beyond the control of the Plan, and (b) notifies the Claimant, prior to the expiration of the initial thirty (30) day processing period, of the circumstances requiring the extension of time, and the date by which the Plan expects to render a decision. If an extension has been requested, then the Plan Administrator shall notify the Claimant of any Adverse Benefit Determination prior to the end of the fifteen (15) day extension period.

- If additional information is requested from the Claimant to process the Claim during the initial processing period, then the Claimant will be notified of a determination of benefits prior to the end of the extension period. If additional information is requested from the Claimant during the extension period, then the Claimant will be notified of the determination by a date agreed to by the Plan Administrator and the Claimant.

- Notice to the Claimant of a rescission of coverage will be provided at least thirty (30) days in advance of the retroactive termination of coverage by the Plan.

A Benefit Determination is required to be made within the period of time beginning when a Claim is deemed to be filed in accordance with the procedures of the Plan.

For purposes of the Plan's provisions for internal Claims and appeals and external review processes, a "Claim" for benefits is defined as a request for a plan benefit made by a Claimant in accordance with a plan's reasonable procedure for filing benefit Claims. A call from a Provider who wants to know if an individual is covered under the Plan, or if a certain procedure or treatment is a covered expense before the treatment is rendered, is not a "Claim" since an actual Claim for benefits is not being filed with the Plan. Likewise, presentation of a prescription to a pharmacy does not constitute a Claim.

An "Adverse Benefit Determination" is defined as a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, rescission of coverage, termination, or failure to provide or make a payment for a Claim that is based on:

1. A determination of an individual's eligibility to participate in a plan or health insurance coverage;
2. A determination that a benefit is not a covered benefit;
3. The imposition of a source-of-Injury exclusion, PPO Provider network exclusion, or other limitation on otherwise covered benefits; or
4. A determination that a benefit is Experimental, Investigational, or not Medically Necessary or appropriate.

Although it is not a Claim for benefits, the definition of an adverse benefit determination also includes a rescission of coverage under the Plan. A "rescission of coverage" is defined as a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

NOTICE OF ADVERSE BENEFIT DETERMINATION

If the initial Benefit Determination is an Adverse Benefit Determination, notification will be sent to the Claimant and will include the following information:

1. Information sufficient to identify the Claim involved, including the date of the service, the health care Provider, the Claim amount (if applicable), and, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

2. The reason or reasons for the Adverse Benefit Determination or final internal Adverse Benefit Determination, including the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, used in denying the Claim. In the case of a final internal Adverse Benefit Determination, this description must also include a discussion of the decision;

3. References to the Plan specific provisions on which the Adverse Benefit Determination is based;

4. A description of any additional material or information necessary for the Claimant to perfect the Claim, and an explanation of why such material or information is necessary;

5. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action following an Adverse Benefit Determination on final review;

6. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's Claim;

7. The identity of any medical or vocational experts consulted in connection with a Claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided upon request);

8. If an internal rule, guideline, protocol, or other similar criterion was relied on in making the Adverse Benefit Determination, either the specific rule, guideline, protocol or other similar criterion, or a statement that such information was relied on in making the Adverse Benefit Determination, and that a copy of the rule, guideline, protocol or other criterion will be provided free of charge on request; and

9. If the Adverse Benefit Determination is based on a medical judgment (such as Medical Necessity or whether the treatment was Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon written request.

PHYSICAL EXAMINATION

The Plan Administrator or Claims Administrator has the right to have the Claimant examined as often as reasonably necessary while a Claim is pending. Benefits are payable under this Plan only if they are Medically Necessary for the Illness or Accidental Injury of the Covered Person. This Plan reserves the right to make a Utilization Review to determine whether services are Medically Necessary for the proper treatment of the Covered Person. All such information will be confidential.

CLAIMS AUDIT

Once a written Claim for benefits is received, the Claims Administrator, acting on the discretionary authority of the Plan Administrator, may elect to have such Claim reviewed or audited for accuracy and reasonableness of charges as part of the adjudication process. This process may include, but may not be limited to, identifying: (a) charges for items/services that may not be covered or may not have been delivered, (b) duplicate charges and (c) charges beyond the reasonable, necessary and Usual and Customary guidelines as determined by the Plan. In addition, please refer to the section entitled "Claim

Review and Audit Program" for information regarding Plan provisions related to the audit and adjudication of certain eligible Claims under that Program.

PAYMENT OF CLAIMS

Plan benefits are payable to the Covered Employee, unless the Claimant gives written direction, at the time of filing proof of such loss, to pay directly the health care Provider rendering such services. Such payment to a health care Provider is subject to the approval of the Plan Administrator. If any such benefit remains unpaid at the death of the Covered Employee, if the Claimant is a minor, or if the Claimant is (in the opinion of the Plan Administrator) legally incapable of giving a valid receipt and discharge for any payment, the Plan Administrator may, at its option, pay such benefits to any one or more of the following relatives of the Claimant: wife, husband, mother, father, Child or Children, brother or brothers, sister or sisters. Such payment will constitute a complete discharge of the Plan's obligation to the extent of such payment, and the Plan Administrator will not be required to follow-up and determine how such paid money was used.

APPEAL PROCESS

The Plan provides for two (2) levels of appeal following an Adverse Benefit Determination. The Claimant has one hundred eighty (180) days following an initial Adverse Benefit Determination to file an appeal of that determination, and sixty (60) days following a second Adverse Benefit Determination to file an appeal of that determination. The appeal process will provide the Claimant with a reasonable opportunity for a full and fair review of the Claim and Adverse Benefit Determination and will include the following:

1. Receipt of written request by the Claims Administrator from the Claimant, or an Authorized Representative of the Claimant, with the proper form for review of Adverse Benefit Determination, which initiates the appeal process.

2. The Claimant will have the opportunity to submit written comments, documents, records, and other information relating to the Claim.

3. The Claimant will have the opportunity to review the Claim file and to present evidence and testimony as part of the internal Claims and appeals process.

4. The Claimant will be provided, free of charge and sufficiently in advance of the date that the notice of final internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Claimant to respond to such new evidence or rationale.

5. The Claimant will be provided, on request and free of charge: (a) reasonable access to, and copies of all documents, records, and other information relevant to the Claimant's Claim in possession of the Plan Administrator, Imagine360 or the Claims Administrator; (b) information regarding any rule, guideline, protocol, or other similar criterion relied upon in making the Adverse Benefit Determination; (c) information regarding any voluntary appeals procedures offered by the Plan; (d) information regarding the Claimant's right to an external review process; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances.

6. The review of the Adverse Benefit Determination will take into account all comments, documents, records and other information submitted by the Claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination.

7. No deference will be afforded to the previous Adverse Benefit Determination.

8. The party reviewing the appeal may be neither the party who made the prior Adverse Benefit Determination, nor a subordinate of the party who made the prior Adverse Benefit Determination.

9. In deciding an appeal on which the Adverse Benefit Determination was based in whole or in part on a medical judgment, including whether a particular treatment, Drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the Claims Administrator, Imagine360 or the Plan Administrator, as appropriate depending on the level of appeal, will consult with a health care professional who has appropriate training and experience in the field of medicine involving the medical judgment. The health care professional consulted for the appeal will not be the health care professional or a subordinate of the health care professional consulted in connection with the Adverse Benefit Determination that is the subject of the appeal.

10. Medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination will be identified, even if the Plan did not rely upon their advice.

11. The first level of appeal will be the responsibility of the Claims Administrator and will be decided within thirty (30) days of the Claims Administrator's receipt of the request. The second level of appeal will be the responsibility of Imagine360 and will be decided within thirty (30) days of the Plan's receipt of the request.

NOTE: When the dispute of a Claim payment or denial only involves payment amounts due from the Plan to the Out-of-Network Provider, and the Provider has no recourse against the Plan Participant under the No Surprises Act (NSA), the payment dispute may only be resolved through open negotiation, or the Independent Dispute Resolution (IDR) process as outlined in the NSA. There may be instances when a Plan Participant may appeal a Claim through this section concurrently with an Out-of-Network Provider's payment dispute through the IDR process.

For questions about appeal rights or for assistance, Claimants can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). Consumer assistance may be available in your State. Contact your State Department of Insurance to find out if consumer assistance for Claim appeals is available. See Appendix I for additional information.

FIRST APPEAL LEVEL

Requirements for First Appeal

The Claimant must file the first appeal, in writing, within one hundred eighty (180) days following receipt of the notice of an Adverse Benefit Determination. The Claimant's appeal must be addressed as follows:

Appeals Department
Imagine360 Administrators, LLC
Park Central 8
12770 Merit Drive, Suite 200
Dallas, Texas 75251

It shall be the responsibility of the Claimant to submit proof that the Claim is covered and payable under the provisions of the Plan. An appeal must include:

1. The name of the Employee/Claimant;
2. The Employee's/Claimant's Social Security number;
3. The group name or identification number;
4. All facts and theories supporting the Claim for benefits. **Failure to include any theories or facts in the appeal will result in such facts being inadmissible. In other words, the Claimant will lose the right to raise such factual arguments and theories which support this Claim if the Claimant fails to include them in the appeal;**
5. A statement in clear and concise terms of the reason or reasons for the disagreement with the handling of the Claim; and
6. Any material or information that the Claimant has which indicates that the Claimant is entitled to benefits under the Plan.

If the Claimant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on First Appeal
The Plan shall notify the Claimant of the Plan's Benefit Determination on review within a reasonable period of time, but not later than thirty (30) days after receipt of the appeal.

The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Notice of Benefit Determination on First Appeal
The Claimant will be notified of the Benefit Determination on appeal. If there is an Adverse Benefit Determination on appeal, the notification will include the following information:

1. The reason or reasons for the Adverse Benefit Determination;

2. References to the Plan provisions on which the Adverse Benefit Determination is based;

3. A description of any additional material or information necessary for the Claimant to perfect the Claim, and an explanation of why such material or information is necessary;

4. 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;

5. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action following an Adverse Benefit Determination on final review;

6. A description of voluntary appeal procedures offered by the Plan and, upon the Claimant's request, any additional information about the voluntary appeal procedures;

7. If an internal rule, guideline, protocol, or other similar criterion was relied on in making the Adverse Benefit Determination, either the specific rule, guideline, protocol or other similar criterion or a statement that such was relied on in making the Adverse Benefit Determination, and that a copy of the rule, guideline, protocol or other criterion will be provided free of charge on request;

8. If the Adverse Benefit Determination is based on a medical judgment (such as Medical Necessity or whether or not treatment is Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge on request;

9. The identity of any medical or vocational experts consulted in connection with the Claim, even if the Plan did not rely upon their advice; and

10. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State Insurance Regulatory Agency.

Furnishing Documents in the Event of an Adverse Determination
In the case of an Adverse Benefit Determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to Notice of Benefit Determination on First Appeal, as appropriate.

SECOND APPEAL LEVEL

Adverse Decision on First Appeal; Requirements for Second Appeal
Upon receipt of notice of the Plan's Adverse Benefit Determination regarding the first appeal, the Claimant has sixty (60) days to file a second appeal of the denial of benefits. The Claimant again is entitled to a "full and fair review" of any denial made at the first appeal, which means the Claimant has the same rights during the second appeal as he or she had during the first appeal. As with the first appeal, the Claimant's second appeal must be in writing and must include all of the items set forth in the section entitled "Requirements for First Appeal."

Timing of Notification of Benefit Determination on Second Appeal
The Plan shall notify the Claimant of the Plan's Benefit Determination on review within a reasonable period of time, but not later than thirty (30) days after receipt of the second appeal.

The period of time within which the Plan's determination is required to be made shall begin at the time the second appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Second Appeal
The same information must be included in the Plan's response to a second appeal as a first appeal, except for: (a) a description of any additional information necessary for the Claimant to perfect the Claim and an explanation of why such information is needed; and (b) a description of the Plan's review procedures and the time limits applicable to the procedures. See the section entitled "Notice of Benefit Determination on First Appeal."

Furnishing Documents in the Event of an Adverse Determination
In the case of an Adverse Benefit Determination on the second appeal, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to the Notice of Benefit Determination on First Appeal, as appropriate.

Decision on Second Appeal to be Final
If, for any reason, the Claimant does not receive a written response to the appeal within the appropriate time period set forth above, the Claimant may assume that the appeal has been denied. The decision will be final, binding and conclusive, and will be afforded the maximum deference permitted by law. **All Claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within three (3) years after the Plan's Claim review procedures have been exhausted. Any action with respect to a Fiduciary's Breach of any responsibility, duty or obligation hereunder must be brought within three (3) years after the date of service.**

Appointment of Authorized Representative
A Claimant is permitted to appoint an Authorized Representative to act on his behalf with respect to a benefit Claim or appeal of an Adverse Benefit Determination. An Assignment of Benefits by a Claimant to a Provider will not constitute appointment of that Provider as an Authorized Representative. To appoint such a representative, the Claimant must complete a form which can be obtained from the Plan Administrator or the Claims Administrator. In the event a Claimant designates an Authorized Representative, all future communications from the Plan will be with the Authorized Representative, rather than the Claimant, unless the Claimant directs the Plan Administrator, in writing, to the contrary.

PROVIDER OF SERVICE APPEAL RIGHTS

A Claimant may appoint the Provider of service as the Authorized Representative with full authority to act on his or her behalf in the appeal of a denied Claim. An Assignment of Benefits by a Claimant to a Provider of service will not constitute appointment of that Provider as an Authorized Representative. However, in an effort to ensure a full and fair review of the denied Claim, and as a courtesy to a Provider of service that is not an Authorized Representative, the Plan will consider an appeal received from the Provider in the same manner as a Claimant's appeal, and will respond to the Provider and the Claimant with the results of the

review accordingly. Any such appeal from a Provider of service must be made within the time limits and under the conditions for filing an appeal specified under the section, "Appeal Process," above. **Providers requesting such appeal rights under the Plan must agree to pursue reimbursement for Covered Medical Expenses directly from the Plan, waiving any right to recover such expenses from the Claimant, and comply with the conditions of the section, "Requirements for First Appeal," above.**

For purposes of this section, the Provider's waiver to pursue Covered Medical Expenses does not include the following amounts, which will remain the responsibility of the Claimant:

- Deductibles;
- Copayments;
- Coinsurance;
- Penalties for failure to comply with the terms of the Plan;
- Charges for services and supplies which are not included for coverage under the Plan; and
- Amounts which are in excess of any stated Plan maximums or limits. **Note: This does not apply to amounts found to be in excess of Allowable Claim Limits, as defined in the section, "Claim Review and Audit Program."** The Provider must agree to waive the right to balance bill for these amounts.

Also, for purposes of this section, if a Provider indicates on a Form UB-04 or on a Form CMS-1500 (or similar Claim form) that the Provider has an Assignment of Benefits, then the Plan will require no further evidence that benefits are legally assigned to that Provider.

Contact the Claims Administrator or the Plan Administrator for additional information regarding Provider of service appeals.

EXTERNAL REVIEW OF ADVERSE BENEFIT DETERMINATION

When the internal appeals procedures have been exhausted, the Claimant may elect to have an additional and final opportunity for a review of an Adverse Benefit Determination (including a final internal Adverse Benefit Determination) by an independent review organization (IRO). The IRO will be accredited by URAC or a similar nationally recognized accrediting organization for the purpose of conducting an independent and unbiased review.

The request for an external review must be filed by the Claimant within four (4) months following the Claimant's receipt of the notice of Adverse Benefit Determination or final internal Adverse Benefit Determination. However, if the Plan fails to strictly adhere to all the requirements of the internal claims and appeals process with respect to a Claim, the Claimant will be deemed to have exhausted the internal claims and appeals process, and the Claimant may initiate an external review and pursue any available remedies under applicable law, such as judicial review.

The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Claimant or beneficiary failed to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process, in accordance with the current Affordable Care Act regulations and other applicable law, applies only to:

1. Any eligible Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; its determination that a treatment is Experimental or Investigational; its determination whether a Claimant or beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program; its determination whether a plan or issuer is complying with the nonquantitative treatment limitation provisions of Code section 9812 and §

54.9812-1, which generally require, among other things, parity in the application of medical management techniques), as determined by the external reviewer.

2. An Adverse Benefit Determination that involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in the No Surprises Act.

3. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

There are two (2) types of external reviews; standard and expedited. An external review is a standard external review unless the timing required to perform a standard external review involves circumstances that would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the final internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency services but has not yet been discharged from the Facility. In such cases, the Plan will consider the external review to be an expedited review.

EXPEDITED EXTERNAL REVIEW FOR URGENT OR EMERGENCY CARE

This Plan does <u>not</u> require a Claimant to obtain prior approval for pre-service urgent care Claims or Emergency care services before getting treatment; therefore, neither the internal appeals nor the external review procedures will apply to these Claims. In an Emergency or urgent care situation, the Claimant should follow instructions from his/her health care Provider, and file the Claim as a post-service Claim. If the post-service Claim results in an Adverse Benefit Determination, the Claimant may file an appeal in accordance with the Plan's provisions for "Appeal Process," which are explained above.

Appeals of Claims involving concurrent care will be subject to the Plan's provisions for expedited external review, as explained below.

PROCEDURES FOR INITIATION OF AN EXTERNAL REVIEW

<u>Standard External Review</u>
A request for an external review must include the same information that is required for an internal appeal, listed above in the section, "Appeal Process."

Once the request for a standard external review is filed, the Plan will have five (5) business days to do a preliminary review of the request to determine whether it is eligible and whether all of the information and forms required to process the external review have been provided.

Within one (1) business day following completion of the preliminary review, the Plan will notify the Claimant in writing whether the request is eligible for external review.

- If the request is complete but is not eligible for external review, the notice will contain an explanation of the reason that the request is ineligible.

- If the request is incomplete, the notice will describe the information or materials needed to make the request complete. The Claimant must submit the information or materials needed within forty-eight (48) hours following receipt of the notice, or the expiration of the original four (4) month filing period, whichever is later.

An eligible request which is complete and timely filed will be assigned to an independent review organization (IRO) by the Plan. The Plan will have arrangements to access at least three (3) accredited IROs to which external reviews will be assigned on a random or rotated basis to ensure an independent and unbiased review.

The assigned IRO will notify the Claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the Claimant may submit to the IRO, in writing and within

ten (10) business days following receipt of the notice, any additional information that the IRO must consider when conducting the external review.

Within five (5) business days after the date of assignment of the IRO, the Plan must provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or final internal Adverse Benefit Determination. Failure by the Plan to timely provide the documents and information will not delay the conduct of the external review, and the IRO may decide to reverse the Adverse Benefit Determination or final internal Adverse Benefit Determination. In this case, the IRO will notify the Plan and the Claimant within one (1) business day following the decision to reverse the determination.

The assigned IRO will forward any information which is submitted by the Claimant to the Plan, and the Plan may reconsider its Adverse Benefit Determination or final internal Adverse Benefit Determination; however, reconsideration by the Plan will not delay the external review. If the Plan decides to reverse its Adverse Benefit Determination or final internal Adverse Benefit Determination, it may terminate the external review and notify the IRO and the Claimant within one (1) business day of the decision.

The IRO will provide written notice to the Claimant and the Plan of the final external review decision within forty-five (45) days following receipt of the request for review. The notice will contain:

- A general description of the reason for the request for external review, including information sufficient to identify the Claim (including the date or dates of service, the health care Provider, the Claim amount (if applicable), and, upon request, the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial;

- The date the IRO received the request for external review and the date on which it made the decision;

- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and the evidence-based standards that were relied on in making the decision;

- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the Claimant;

- A statement that judicial review may be available to the Claimant; and

- Current contact information, including a phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793. See Appendix I for additional information.

Expedited External Review

A final internal Adverse Benefit Determination concerning an admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency services but has not yet been discharged from the Facility will be considered for an expedited external review. These are considered to be pre-service **non-urgent** care Claims and concurrent Claims.

The procedures that apply to standard external reviews will apply to expedited external reviews, except that:

- The preliminary review of the request to determine whether it is eligible and whether all of the information and forms required to process the external review have been provided must be conducted immediately, and the Plan must immediately notify the Claimant regarding the eligibility determination;

- Upon a determination that a request is eligible for external review following the preliminary review, the Plan will immediately assign an IRO pursuant to the requirements set forth for standard external reviews;

- The Plan must provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or final internal Adverse Benefit Determination to the assigned IRO electronically, by phone, facsimile or any other available expeditious method; and

- The IRO must provide notice of the final external review decision as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO received the request for an expedited external review. If the notice is not in writing, the assigned IRO must provide written confirmation of the decision to the Claimant and the Plan within forty-eight (48) hours following the notice.

DECISION FOLLOWING AN EXTERNAL REVIEW

Upon receipt of a notice from the IRO reversing the decision of an Adverse Benefit Determination or final internal Adverse Benefit Determination, the Plan will immediately provide coverage or payment for the Claim. An external review decision is binding on the Plan as well as the Claimant, except to the extent other remedies are available under State or Federal law.

RECOVERY OF PAYMENTS

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such, this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Covered Person or Dependent on whose behalf such payment was made.

A Covered Person, Dependent, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within thirty (30) days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Covered Person or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any Claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agree to be bound by the terms of this Plan and agree to submit Claims for reimbursement in strict accordance with their State's health care practice acts, ICD-10 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on Claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within thirty (30) days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Covered Person, Provider or other person or entity to enforce the provisions of this section, then that Covered Person, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Covered Persons and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Covered Persons) shall assign, or be deemed to have assigned, to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Covered Person(s) are entitled, for or in relation to Facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

1. In error;
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
3. Pursuant to a misstatement made to obtain coverage under this Plan within two (2) years after the date such coverage commences;
4. With respect to an ineligible person;
5. In anticipation of obtaining a recovery if a Covered Person fails to comply with the Plan's Subrogation and Reimbursement Provisions; or
6. Pursuant to a Claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or Disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any Claim for benefits under this Plan by a Covered Person or by any of his covered Dependents if such payment is made with respect to the Covered Person or any person covered or asserting coverage as a Dependent of the Covered Person.

If the Plan seeks to recoup funds from a Provider due to a Claim being made in error, a Claim being fraudulent on the part of the Provider, and/or the Claim is the result of the Provider's misstatement, said Provider shall, as part of its Assignment of Benefits from the Plan, abstain from billing the Covered Person for any outstanding amount(s).

GENERAL PROVISIONS

RIGHT OF RECOVERY
In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan in a total amount, at any time, in excess of the Maximum Amount of benefits payable under this Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such amount, and any future benefits payable to the Covered Person or his or her Dependents. See the Recovery of Payments provision for full details.

MISSTATEMENT OF AGE
If age is a factor in determining eligibility or amount of coverage and there has been a misstatement of age, the coverages or amounts of benefits, or both, for which the person is covered shall be adjusted in accordance with the Covered Person's true age. Any such misstatement of age shall neither continue coverage otherwise validly terminated, nor terminate coverage otherwise validly in force. Benefits will be adjusted following the date of the discovery of such misstatement.

WAIVER OR ESTOPPEL
No term, condition or provision of the Plan shall be waived, and there shall be no estoppel against the enforcement of any provision of the Plan, except by written direction of the Plan Administrator. No such waiver shall be deemed a continuing waiver unless specifically stated. Each waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than that specifically waived.

WORKERS' COMPENSATION NOT AFFECTED
This Plan is not in lieu of and does not affect any requirement for coverage by Workers' Compensation Insurance or, where permitted and applicable, any other alternative form of Workers' Compensation benefits.

CONFORMITY WITH LAW
This Plan shall be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay Claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Plan Document.

CONFORMITY WITH STATUTE(S)
Any provision of the Plan which is in conflict with statutes that are applicable to this Plan is hereby amended to conform to the minimum requirements of said statute(s).

NOTICES
All payments or notices of any kind to Employees, Participants, beneficiaries, or Plan officials may be mailed to the address for that person last appearing on the records of the Plan Administrator. When such a notice is mailed by first class mail, it is deemed to have been: (a) duly delivered on the date post-marked; and (b) duly received three (3) calendar days after being deposited, postage prepaid, in the United States Mail. When such a notice is delivered in person, it is deemed to have been received the same day as delivery. Each person must keep the Plan Administrator notified of his current address. If there is doubt about the accuracy of an address, the Plan may give notice, by registered mail, to any such person's last address,

that payments and other mail are being withheld pending receipt of a proper mailing address from that person.

STATEMENTS
All statements made by the Employer or by a Covered Person will, in the absence of fraud, be considered representations and not warranties, and no statements made for the purpose of obtaining benefits under this document will be used in any contest to avoid or reduce the benefits provided by the document unless contained in a written application for benefits and a copy of the instrument containing such representation is or has been furnished to the Covered Person.

Any Covered Person, who knowingly and with intent to defraud the Plan, files a statement of Claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any material fact, commits a fraudulent act. The Covered Person may be subject to prosecution by the United States Department of Labor. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both.

FRAUD
The following actions by a Covered Person or a Covered Person's knowledge of such actions being taken by another, constitute fraud and will result in immediate, indefinite and permanent termination of all coverage under this Plan for the entire Family unit of which the Covered Person is a member:

1. Attempting to submit a Claim for benefits (which includes attempting to fill a prescription) for a person who is not a Covered Person in the Plan;
2. Attempting to file a Claim for a Covered Person for services that were not rendered or Drugs or other items that were not provided;
3. Providing false or misleading information in connection with enrollment in the Plan; or
4. Providing any false or misleading information to the Plan.

MISCELLANEOUS
Section titles are for convenience of reference only and are not to be considered in interpreting this Plan.

No failure to enforce any provision of this Plan shall affect the right thereafter to enforce such provision, nor shall such failure affect its right to enforce any other provision of this Plan.

ALLOCATION AND APPORTIONMENT OF BENEFITS
The Plan reserves the right to allocate the Deductible amount to any Covered Charges and to apportion the benefits to the Covered Person and any assignees. Such allocation and apportionment shall be conclusive and shall be binding upon the Covered Person and all assignees.

FACILITY OF PAYMENT
If a Claimant is a minor or is physically or mentally incapable of giving a valid release for payment, the Claims Administrator, at its option, may make payment to a party who has assumed responsibility for the care of such person. Such payments will be made until Claim is made by a guardian. If a Claimant dies while benefits remain unpaid, benefits will be paid at the Claim Administrator's option to:

1. The person or institution on whose charges Claim is based; or
2. A surviving relative (wife, husband, mother, father, Child or Children, brother or brothers, sister or sisters).

Such payment will release the Plan Administrator and Claims Administrator of all further liability to the extent of payment.

ELIGIBILITY FOR COVERAGE

Coverage provided under this Plan for Employees and their Dependents shall be in accordance with the Eligibility, Effective Date, and Termination provisions as stated in this Plan Document as follows.

NOTE: A Covered Person previously terminated under this Plan due to fraud, or the actions being taker by another which constituted fraud, as addressed within the Fraud section of this Plan, will be immediately, indefinitely and permanently terminated from all coverage under this Plan and ineligible for future enrollment in this Plan.

EMPLOYEE ELIGIBILITY

An Employee will be considered eligible for coverage on the first day of the month following the Date of Hire provided he/she:

1. Is a Non-variable Hour Employee regularly scheduled to work for the Employer on a Full-time or Part-time Employment basis for at least thirty (30) hours per week; or
2. Is a Variable Hour Employee who averages at least thirty (30) hours per week or 1,560 hours per year for a complete Measurement Period and is currently in a Stability Period, as determined by the Plan Sponsor. An Employee will remain eligible throughout the Stability Period regardless of a change in employment status (including, but not limited to, a reduction in hours) provided the individual continues to be an employee in accordance with the Affordable Care Act (as amended).

MEASUREMENT PERIOD INFORMATION FOR VARIABLE HOUR AND ONGOING EMPLOYEES

Initial Administrative Period:	zero (0) days
Ongoing Administrative Period:	zero (0) days
Initial Measurement Period:	three (3) months
Initial Measurement Period starts on:	The first day of the month following the Date of Hire
Standard Measurement Period for Ongoing Employees:	twelve (12) months
Standard Measurement Period starts each year on:	January 1
Stability Period:	twelve (12) months

See the “Definitions” section for the definitions of “Administrative Period,” “Measurement Period” and “Stability Period.”

DEPENDENT ELIGIBILITY

A Dependent, **as defined in the Plan Definitions**, will be considered eligible for coverage on the date the Employee becomes eligible for Dependent coverage or the date the Dependent is acquired, subject to all limitations and requirements of this Plan, and in accordance with the following:

1. A newborn or adopted Child of a Covered Employee will be considered eligible and will be covered from the moment of birth or from the date of adoption or Placement for Adoption for **thirty (30) days** for Injury or Illness, including the Medically Necessary care and treatment of medically diagnosed congenital defects, birth abnormalities and prematurity, Routine Newborn Care and Well Baby Care. Written notification must be received by the Plan Administrator within thirty (30) days after the Child's date of birth, date of adoption or Placement for Adoption for continued coverage. A newborn

Child of a Dependent Child is not eligible for this Plan unless the newborn Child meets the definition of an Eligible Dependent.

2. A new spouse of a Covered Employee and any Dependent Children of a new spouse who meet the Plan's definition of Dependent will be considered eligible and will be covered on the date of the Covered Employee's marriage, provided the spouse and/or his/her Children are enrolled as Dependents of the Covered Employee within thirty (30) days after the date of marriage.

3. A Domestic Partner of a Covered Employee who meets the Plan's definition of a Dependent will be considered eligible for this Plan on the date the "Statement of Domestic Partnership" is executed.

4. A Child of a Covered Employee who meets the Plan's definition of a Dependent will be considered eligible if the Child is under twenty-six (26) years of age.

5. If a Dependent of a Covered Employee is to be enrolled in the Plan, other than at the time of his/her eligibility or birth, adoption, court order or marriage to the Covered Employee, that Dependent would be considered a Late Enrollee unless he/she qualifies for a Special Enrollment.

6. A spouse and/or Child of a Covered Employee who previously was not eligible for the Plan will be considered eligible on the date he/she meets the Plan's definition of Dependent.

The Eligibility provisions are subject to the requirements of the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993), effective August 10, 1993, as the same may be later amended.

If an Employee or Dependent has a change in eligibility while covered under this Plan (i.e., from Employee to Dependent, from Dependent to Employee) and no interruption in coverage has occurred, the Plan will consider that coverage has been continuous.

A person cannot be covered as a Dependent of more than one (1) Employee under this Plan. In addition, an Employee cannot be covered as both an Employee and a Dependent under this Plan.

NOTE: A Dependent who was enrolled on the most recent restated date of this Plan, January 1, 2025, and who was previously covered by the Plan, will also be considered eligible to continue coverage under this Plan. However, a Dependent Child will only be considered eligible until the qualifying age of twenty-six (26) unless otherwise specified in the definition of Dependent.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS / PLACEMENT FOR ADOPTION

The Plan will comply with the rules relating to adopted Children, Children placed for adoption, Qualified Medical Child Support Orders ("QMCSO"), and National Medical Support Notices (“NMSN”). The Plan will use the following rules related to Children placed for adoption, QMCSOs and NMSNs.

This Plan will provide benefits in accordance with the applicable requirements of any QMCSO or NMSN. A QMCSO is a Medical Child Support Order of a court or of certain administrative agencies that creates, recognizes or assigns to a Child of a Plan Participant the right to receive health benefit coverage under the Plan. A NMSN is an order issued by a State agency requiring the Plan to cover a Child. To be qualified, a Medical Child Support Order must comply with State and Federal laws and contain the following:

1. The name and last known mailing address (if any) of both the Plan Participant and the Child covered under the order except that, to the extent provided in the order, the name and mailing address of an official of a State or a political subdivision thereof may be substituted for the mailing address of any such Alternate Recipient.

2. A reasonable description of the type of coverage to be provided by the Plan for each Child (or the manner in which the type of coverage will be determined).

3. The period of coverage to which the order applies.

In addition, a QMCSO or NMSN will generally not be considered qualified if it requires the Plan to provide certain benefits or options which are not otherwise provided by the Plan. The Plan Administrator will notify the Plan Participant of the receipt of a Medical Child Support Order and the procedures for determining whether it is a Qualified Medical Child Support Order or a NMSN. The Plan Administrator will then determine within a reasonable period of time whether the Medical Child Support Order is a QMCSO or NMSN.

Plan Participants may request and receive, free of charge, a copy of Plan procedures relating to QMCSOs and NMSNs.

If an Employee is not enrolled in the Plan, and the Employee would otherwise be eligible for coverage, the Plan must enroll the Eligible Employee and the Child(ren) covered by the QMCSO.

This Plan will also provide benefits to Dependent Children placed for adoption on the same basis as natural Children even prior to the adoption becoming final. A Child will be considered "Placed for Adoption" with a Plan Participant if the Plan Participant has assumed a legal obligation for total or partial support of the Child in anticipation of adoption of the Child. For this reason, if a Child is placed with a Plan Participant for adoption by an adoption agency or other entity, the Plan Participant must provide to the Plan Administrator documentation (e.g., signed court order) that the adoption agency or other entity had legal custody of the Child on the date that the Child was placed with the Plan Participant for adoption. The Plan Administrator will determine within a reasonable period of time whether a Child has been "Placed for Adoption."

The Plan Administrator has final, discretionary authority to determine: (1) whether a Medical Child Support Order qualifies as a QMCSO or NMSN; and (2) whether a Child has been "Placed for Adoption.”

EFFECTIVE DATE OF COVERAGE

EMPLOYEE EFFECTIVE DATE

An Eligible Employee, properly enrolled in the Plan, will be referred to as a "Covered Employee."

Each Employee's coverage under the Plan shall become effective on the first day of the month following the Date of Hire provided the Employee completes the eligibility requirement(s) of the Plan and written or electronic application for coverage is made on or before or within thirty (30) days after the date the Employee eligibility requirement(s) are met.

DEPENDENT EFFECTIVE DATE

Dependent coverage under the Plan shall become effective on the date Dependent eligibility requirements are met, provided the Employee makes written or electronic application for Dependent coverage on or before or within thirty (30) days after the date Dependent eligibility requirements are met subject to the enrollment requirements as follows:

1. In order to become covered under the Plan, Eligible Dependents must be identified on an Enrollment and/or Change form.

2. If the Employee makes a request for Dependent coverage on or before or within thirty (30) days immediately following his/her own effective date, then each Eligible Dependent will become effective on the same date the Employee's coverage is effective.

3. If an Employee makes a request to add a Dependent Child to the Plan in accordance with a Qualified Medical Child Support Order (QMCSO), the effective date of coverage for the Dependent Child will be the date specified in the QMCSO. Child(ren) covered by QMCSOs may be enrolled in this Plan if the Employee would otherwise be eligible for coverage regardless of whether the Employee is currently enrolled. The Plan must enroll the Eligible Employee and the Child(ren) covered by the Notice without any enrollment restrictions (i.e., they will not be considered Late Enrollees).

4. If the Covered Employee makes a request to add a Dependent spouse and/or Child who previously was not eligible for the Plan within thirty (30) days of such Dependent becoming entitled to Special Enrollment rights, the effective date of coverage is the date the individual meets the Plan's definition of Dependent.

LATE ENROLLEE

An Employee or Dependent who enrolls in the Plan more than thirty (30) days after the date of his/her initial eligibility is considered a Late Enrollee unless he/she qualifies for a Special Enrollment.

EMPLOYEE AND DEPENDENT SPECIAL ENROLLMENT PERIODS

The Plan provides Special Enrollment rights and Special Enrollment Periods for Employees and their Dependents who previously declined to enroll in the Plan and who remain eligible for the Plan.

SPECIAL ENROLLMENT PERIOD FOR LOSS OF ELIGIBILITY FOR OTHER COVERAGE

Eligible Employees and Eligible Dependents who do not enroll in the Plan at their initial opportunity because of other health coverage and subsequently lose eligibility for that other coverage (except for cause or nonpayment of premium) have Special Enrollment rights. Special Enrollment in this Plan must be requested within thirty (30) days after the date eligibility for other coverage ends. If an individual enrolls during a Special Enrollment Period, he/she is considered a Special Enrollee; he/she will not be considered a Late Enrollee.

Individuals who previously declined coverage in the Plan because of other coverage may be eligible to enroll in the Plan during the Special Enrollment Period if eligibility for other coverage is lost as a result of one of the following:

1. Legal separation, divorce, death, termination of employment or reduction in the number of hours worked;
2. Loss of Dependent status;
3. The plan no longer offers any benefits to a class of similarly situated individuals;
4. Moving out of an HMO service area with no other coverage option available;
5. Termination of a benefit package option, unless a substitute is offered;
6. Employer contributions were terminated; or
7. COBRA Continuation Coverage was exhausted.

Loss of coverage due to an individual's failure to pay premiums or contributions does not qualify for a Special Enrollment Period. Voluntarily dropping coverage does not trigger Special Enrollment rights because there is no loss of eligibility.

Length of Special Enrollment Period for Loss of Eligibility for Other Coverage
A request for a Special Enrollment due to loss of eligibility for other coverage must be made no later than thirty (30) days after the exhaustion of COBRA coverage or the termination of other non-COBRA coverage as a result of the loss of eligibility or termination of Employer contributions toward that coverage.

Effective Date of Coverage Following Special Enrollment for Loss of Eligibility for Other Coverage
The effective date of coverage for an Eligible Employee and his/her Eligible Dependents who make written or electronic application for coverage during a Special Enrollment Period will be the day following the date of loss of other coverage.

SPECIAL ENROLLMENT PERIOD FOR NEW DEPENDENT

1. An Employee who previously declined enrollment and who remains eligible for coverage under the Plan has Special Enrollment rights when the Eligible Employee acquires a new Dependent through marriage, birth, adoption or Placement for Adoption.

2. A new spouse is entitled to Special Enrollment rights when he/she becomes the spouse of a Covered Employee or when a Child becomes a Dependent of a Covered Employee through birth, adoption or Placement for Adoption.

3. A person is entitled to Special Enrollment rights when the person becomes a Dependent of a Covered Employee through marriage, birth, adoption or Placement for Adoption.

4. An Employee who previously declined enrollment and remains eligible for coverage under the Plan has Special Enrollment rights for himself/herself and the Employee's spouse if a Child becomes a Dependent of the Employee through birth, adoption or Placement for Adoption.

Length of Special Enrollment Period for New Dependents
A request for a Special Enrollment due to acquiring new Dependents must be made no later than thirty (30) days after the date of marriage, birth, adoption or Placement for Adoption.

Effective Date of Coverage Following New Dependent Special Enrollment
The effective date of coverage for an Eligible Employee and his/her Eligible Dependents who make written or electronic application for coverage during a New Dependent Special Enrollment Period will be as follows:

1. In the case of marriage: the date of marriage;

2. In the case of a Dependent's birth: the date of birth; or

3. In the case of a Dependent's adoption or Placement for Adoption: the date of such adoption or Placement for Adoption.

NOTE: Proof of Qualifying Event for Special Enrollment will be required.

SPECIAL ENROLLMENT PERIOD UNDER THE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009 (CHIPRA)

Eligible Employees and Eligible Dependents who do not enroll in the Plan at their initial opportunity because of the Eligible Employee's and/or Eligible Dependent's coverage under Medicaid or a State Children's Health Insurance Program (CHIP) and subsequently lose eligibility for Medicaid or CHIP coverage have Special Enrollment rights. Special Enrollment in this Plan must be requested within sixty (60) days after the date eligibility for Medicaid or CHIP ends. If an individual enrolls during a Special Enrollment Period, he/she is considered a Special Enrollee; he/she will not be considered a Late Enrollee.

Eligible Employees and Eligible Dependents who do not enroll in the Plan at their initial opportunity but become eligible for a premium assistance subsidy under Medicaid or CHIP have Special Enrollment rights. Special Enrollment in this Plan must be requested within sixty (60) days after the date eligibility for Medicaid or CHIP premium assistance is determined. If an individual enrolls during a Special Enrollment Period, he/she is considered a Special Enrollee; he/she will not be considered a Late Enrollee.

ANNUAL OPEN ENROLLMENT PERIOD FOR THE EMPLOYEE MEDICAL BENEFIT PLAN

The Annual Open Enrollment Period for the Plan is a period of time designated by the Employer each year for coverage to become effective January 1, provided written or electronic application for coverage is made before the end of the Annual Open Enrollment Period or within thirty (30) days after the Annual Open Enrollment Period. All Eligible Employees and Dependents not currently enrolled in the Plan may do so during the Annual Open Enrollment Period. All Covered Employees are required to re-enroll in the Plan. If application to enroll is made more than thirty (30) days after the Annual Open Enrollment Period ends, the Employee and/or Dependent must wait until the Plan's next Open Enrollment Period to enroll.

The Plan allows a choice of Plan Options: High Deductible Health Plan and Traditional Plan. An Eligible Employee can elect one (1) Plan Option for himself/herself and the same option for his/her Eligible Dependents.

LATE ENROLLEE

A Late Enrollee is an Employee or Dependent who gave up his/her initial opportunity to enroll in the Plan. A Late Enrollee can only enroll once a year during the Annual Open Enrollment Period for the Plan unless he/she qualifies for a Special Enrollment.

EMPLOYEE LATE ENROLLEE

An Employee is considered a Late Enrollee if:

1. He/she makes written or electronic application for coverage under the Plan more than thirty (30) days after the date of his/her initial eligibility;
2. He/she is not eligible for a Special Enrollment; or
3. He/she failed to enroll by the end of a Special Enrollment Period.

Effective Date of Coverage for Employee Late Enrollees
The effective date of coverage for an Employee who is a Late Enrollee will be the effective date of the Annual Open Enrollment for the Plan.

DEPENDENT LATE ENROLLEE

A Dependent is considered a Late Enrollee if:

1. The Covered Employee makes written or electronic application for Dependent coverage after the thirty (30) day period immediately following his/her effective date of coverage and the Dependent was not enrolled by the end of a Special Enrollment Period;

2. The Covered Employee makes a written or electronic request to add a Dependent after the thirty (30) day period immediately following the date of birth, date of marriage, date of adoption or date of Placement for Adoption; or

3. An Eligible Employee (not currently enrolled in the Plan) makes a written or electronic request to add a new Dependent more than thirty (30) days after the Dependent's date of birth, date of marriage, date of adoption or date of Placement for Adoption.

Effective Date of Coverage for Dependent Late Enrollees
The effective date of coverage for each Dependent who is a Late Enrollee will be the effective date of the Annual Open Enrollment for the Plan.

The Eligibility and Effective Date provisions are subject to the requirements of the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as they may be amended.

COVERAGE CHANGES

A request for coverage change (addition or deletion of coverage) can be made as follows:

1. A written request for deletion of coverage can be made by signing and completing a Change Form. Deletion of coverage is subject to the Plan's Termination provisions; or
2. A written request for addition of coverage can be made by signing and completing an Enrollment or Change Form. The Effective Date of Coverage is subject to the Plan's Annual Open Enrollment, Eligibility, Effective Date, Special Enrollment Period and Late Enrollee provisions.

PLAN OPTION CHANGES

The Plan allows a choice of Plan Options. Plan Option changes can only be made once a year during the Annual Open Enrollment Period for the Plan unless there is a Special Enrollment. See section entitled Employee and Dependent Special Enrollment Periods.

TERMINATION OF COVERAGE

EMPLOYEE COVERAGE TERMINATION

An Employee's coverage shall automatically terminate at midnight on the earliest of the following dates:

1. The date employment terminates;
2. The date the Employee ceases to be eligible or ceases to be in a class of Employees eligible for coverage;
3. The end of the Stability Period for Employees failing to qualify during the previous Standard Measurement Period;
4. The date the Employee fails to make any required contribution for coverage;
5. The date the Plan is terminated; or with respect to any Employee's benefit of the Plan, the date of termination of such benefit;
6. The date the Employee enters the Uniformed Services of the United States or armed forces of any country or international organization on a full-time active duty basis if active duty is to exceed thirty-one (31) days;
7. The date the Employee requests termination of coverage, unless prohibited by law (i.e., when election changes cannot be made due to Internal Revenue Code Section 125 "change in status" guidelines)." NOTE: The Employer may offer these benefits in conjunction with a cafeteria plan under Section 125 of the Internal Revenue Code and, if so, a voluntary termination must comply with the requirements of the Code and the cafeteria plan;
8. The date the Employee fails to return to Full-time Employment following an approved Leave of Absence. See Coverage During Leave of Absence section;
9. The date the Employee takes an unapproved Leave of Absence from work; or
10. The date the Employee dies.

DEPENDENT COVERAGE TERMINATION

The Dependent coverage of an Employee shall automatically terminate at midnight on the earliest of the following dates:

1. The date the Dependent (other than a Dependent Child age twenty-six (26) or older) ceases to be an Eligible Dependent as defined in the Plan;
2. The date of termination of the Employee's coverage under the Plan;
3. The date the Employee ceases to be in a class of Employees eligible for Dependent coverage;
4. The date the Employee fails to make any required contribution for Dependent coverage;
5. The date the Plan is terminated; or with respect to any Dependent's benefit of the Plan, the date of termination of such benefit;
6. The date the Employee or Dependent enters the Uniformed Services of the United States or armed forces of any country or international organization on a full-time active duty basis if active duty is to exceed thirty-one (31) days;
7. The date the Employee requests termination of Dependent coverage, unless prohibited by law (i.e., when election changes cannot be made due to Internal Revenue Code Section 125 "change in status" guidelines)." NOTE: The Employer may offer these benefits in conjunction with a cafeteria plan under Section 125 of the Internal Revenue Code and, if so, a voluntary termination must comply with the requirements of the Code and the cafeteria plan;
8. The date the Employee fails to return to Full-time Employment following an approved Leave of Absence. See Coverage During Leave of Absence section;
9. The date the Employee takes an unapproved Leave of Absence from work;
10. The last day of the month in which the Dependent Child reaches age twenty-six (26);
11. The date the unmarried adult Dependent Child age twenty-six (26) or older for whom coverage is being continued due to the Child being Physically Handicapped or Intellectually Disabled and incapable of earning his/her own living, upon the earliest to occur of: a. cessation of such inability; b. failure to furnish any required proof of the uninterrupted continuance of such inability or to submit to any required examination; c. the Child no longer being dependent on the Employee for his/her support; or d. the

Child's marriage. However, if such earliest event occurs before the last day of the month in which such Dependent Child reaches age twenty-six (26), then coverage will terminate on the last day of the month in which such Dependent Child reaches age twenty-six (26); or

12. The date the Employee dies.

Coverage may be continued under COBRA, but continuation of coverage is not automatic upon the occurrence of a Qualifying Event. A Covered Employee or a covered Dependent is responsible for notifying the Plan Administrator within sixty (60) days after the date of certain Qualifying Events (including loss of coverage due to divorce, legal separation, or a Dependent Child ceasing to qualify as a Dependent). A change form may be obtained from the Employer. Failure to provide such notice will result in loss of eligibility to elect COBRA coverage. See Continuation of Group Health Coverage (COBRA) section for further information.

A Domestic Partner does not qualify as a spouse under Federal law. Although the Plan will treat a Domestic Partner as a "Qualified Beneficiary," this treatment does not qualify a Domestic Partner as a "Qualified Beneficiary" under IRS 1999 final regulations.

NOTE: The Termination provisions are subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA), Public Law 99-272.

COVERAGE DURING LEAVE OF ABSENCE

If, after depletion of sick leave, vacation time or Paid Time Off (PTO), whichever is appropriate (if any) active work ceases due to an Employer approved non-medical temporary Leave of Absence, lay-off, an Employer approved Medical and Disability Leave, an approved Leave of Absence subject to the Family and Medical Leave Act (FMLA), an approved leave as a reasonable accommodation under the Americans with Disabilities Act (ADA) or approved leave required by applicable State law (Family, Medical, Disability and/or other temporary leave), the Plan Administrator may, while the Plan is in force, continue the Employee's coverage (Employee and Dependent) during the period after cessation of active work due to:

1. Employer approved non-medical temporary personal Leave of Absence, or lay-off but not to exceed a period of one (1) year provided any required Employee contributions are made; or

2. Employer approved Medical and Disability Leave of Absence, but not to exceed a period of one (1) year provided any required Employee contributions are made; or

3. Approved Family and Medical Leave (FMLA), but not to exceed a period of twelve (12) weeks (or twenty-six (26) weeks in the case of a Family service member medical leave) provided any required Employee contributions are made; or

4. Approved leave as a reasonable accommodation under the Americans with Disabilities Act (ADA), as amended, for the timeframe approved by the Employer when leave is the only available accommodation; or

5. Approved leave required by applicable State law (Family, Medical, Disability and/or other temporary leave) for up to the minimum amount of time required by such State law provided any required Employee contributions are made.

The above Employer approved non-medical Leave of Absence and Employer approved Medical and Disability Leave are not concurrent with, and are not in addition to, the twelve (12) week (or twenty-six (26) weeks in the case of a Family service member medical leave) approved Family and Medical Leave (FMLA), an approved leave as a reasonable accommodation under the Americans with Disabilities Act (ADA) or the minimum amount of time required by an approved leave required by applicable State law (Family, Medical, Disability and/or other temporary leave).

NOTE: If applicable State law requires a longer Leave of Absence than FMLA or any other approved Leave of Absence, then State law will prevail.

If the Employee has not returned to Employment that meets the eligibility requirements after completion of an approved Leave of Absence, or if the Employee notifies the Employer that he/she will not be returning to Employment that meets the eligibility requirements following the Leave of Absence, coverage terminates and COBRA continuation becomes available on the basis of reduction in hours. See Continuation of Group Health Coverage (COBRA) section. Failure of the Employee to make any required Employee contributions during an approved Leave of Absence will also result in termination of coverage.

Family and Medical Leave is subject to the requirements of the Family and Medical Leave Act (FMLA).

ACTIVE DUTY IN THE ARMED FORCES

If a Covered Employee and/or his/her covered Dependent(s) would lose Plan coverage as a result of the Employee being called for active duty in the armed forces of the United States, such a reduction in hours (or termination of employment) would be a COBRA Qualifying Event. Any coverage mandated under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended by the Veterans Benefits Improvement Act of 2004, will run concurrently with federally mandated COBRA coverage. For additional information, see the sections entitled Continuation of Group Health Coverage (COBRA) and Continuation of Coverage under USERRA.

The Civilian Reservist Emergency Workforce Act of 2021 ("CREW") provides eligible Employees, who are called to services by the Federal Emergency Management Agency (FEMA), rights under USERRA.

REHIRES / REINSTATEMENT OF COVERAGE

A terminated Employee who is rehired will be treated as a new hire and will be required to satisfy all Eligibility and enrollment requirements of the Plan, unless the Employee was credited with an Hour of Service with the Employer (or any member of the controlled or affiliated group) during a period of the lesser of:

1. At least thirteen (13) consecutive weeks immediately preceding the date of rehire; or
2. At least four (4) consecutive weeks or the number of consecutive weeks of the Employee's immediately preceding period of employment, whichever is greater.

If a terminated Employee is rehired by the Employer within a thirteen (13) week period immediately following the date of such termination, the Employee shall become eligible for reinstatement of coverage on the first day of the month following the date the Employee resumes employment, and the Employee's Dependents shall also become eligible for reinstatement on that date, provided that the Employee enrolls or waives enrollment within thirty (30) days of such date.

An Employee who is terminated and rehired will be treated as an Ongoing Employee upon rehire only if the Employee's break in service did not exceed thirteen (13) weeks.

For an approved Leave of Absence, an Employee will remain eligible for coverage under the Plan as long as the Employee is otherwise eligible (and enrolled) under the Plan. Note that for an approved Leave of Absence, an Employee will be treated as an Ongoing Employee, even if the Employee's absence was longer than thirteen (13) weeks.

NOTE: An exception applies for a terminated Employee on COBRA who is rehired and returns to work after expiration of the above reinstatement period. Coverage will be continuous from the date he/she resumes employment.

An Employee whose coverage would terminate due to active duty in the Uniformed Services of the United States, and who qualifies for military leave under the Uniformed Services Employment and Reemployment Rights Act (USERRA), will be reinstated on the date he/she resumes employment with the Employer provided that such resumption of employment is within the time period specified in USERRA.

The reinstatement procedures following a USERRA military leave are subject to the requirements of USERRA.

FAMILY AND MEDICAL LEAVE (FMLA)

All Employers employing at least fifty (50) workers within a seventy-five (75) mile radius of the work place must provide eligible Employees with up to twelve (12) weeks or twenty-six (26) weeks, in the case of #5 below, of job-protected Leave of Absence during a twelve (12) month period, as determined by the Employer, generally for any of the following situations:

1. The birth or adoption of a Child;

2. The serious Illness of the Employee's spouse, Child, or parent;

3. The Employee's own disabling serious Illness;

4. The qualifying exigency (as defined by the Secretary of Labor) of the Employee's spouse, Child or parent service member who is on active duty or has been notified of an impending call or order to active duty; or

5. The serious Illness or Injury of the Employee's spouse, Child, parent or next of kin service member whose Illness or Injury was incurred in the line of duty that may render the member unfit to perform the duties of the service member's office, grade, rank or rating.

ELIGIBLE EMPLOYEES: Employees who have been employed by the Employer for at least twelve (12) months and who have worked at least 1,250 hours for the Employer during the previous twelve (12) months are eligible for Family and Medical Leave.

BENEFIT REQUIREMENT: The Employer must provide the same group health plan during the leave under the same level of contribution required during active employment.

RETURN TO EMPLOYMENT: Although the leave is unpaid, the Employee must be guaranteed return to the same or equivalent position with equivalent Employee benefits, pay, and other terms of employment. (Note: An Employer may deny job restoration under the leave law to Employees who are in the highest paid 10% of Employees.)

Employee benefits may include:

- group life
- educational benefits
- sick leave
- medical
- annual leave
- disability
- dental
- pensions

If an Employee chooses not to retain Plan coverage during Family and Medical Leave, Plan coverage may be restored upon return to active service as an Eligible Employee. Employees must be treated as though no service interruption had occurred. Any period of coverage provided for disability may run concurrently with Family and Medical Leave.

The above listing of Employee benefits may or may not be applicable to every Employer's plan of benefits. This section is intended as a summary of the Family and Medical Leave Act of 1993 (FMLA), effective August 5, 1993, as amended, not as a complete interpretation of the law.

NOTE: An Eligible Employee must refer to the Employer's policy for complete information.

CONTINUATION OF GROUP HEALTH COVERAGE (COBRA)

CONTINUATION OF COVERAGE

(Applies to Medical, Prescription Drug and Dental Coverage)

When Plan coverage terminates due to a Qualifying Event, a Covered Employee or covered Dependent is a Qualified Beneficiary and eligible to elect continued group health coverage ("COBRA coverage"). COBRA coverage is the same health coverage that applies to Covered Employees and covered Dependents under the Plan. However, the individual electing COBRA coverage must pay the full cost of the coverage plus an administrative fee of 2%.

The length of time COBRA coverage can be continued is based upon the date of and the applicable Qualifying Event as described below:

Qualified Beneficiary	**Qualifying Event**	**Maximum Coverage Period**
Covered Employee and/or Covered Dependent	Loss of coverage due to termination of employment (other than for gross misconduct) or reduction in hours	18 months
Disabled Covered Employee and/or Disabled Covered Dependent and each Qualified Beneficiary who is not disabled*	Loss of coverage due to termination of employment (other than for gross misconduct) or reduction in hours	29 months*
Covered Dependent	Loss of coverage due to divorce, legal separation or death of Employee	36 months
Covered Dependent	Loss of coverage due to Dependent Child losing eligibility as a Dependent Child	36 months
Covered Dependent	Loss of coverage due to Covered Employee's entitlement to Medicare (See Special Medicare Entitlement Rule section.)	36 months

NOTE: “Qualified Beneficiary” is a term defined under IRS 1999 final regulations to mean a Covered Employee, the spouse of a Covered Employee, or the Dependent Child of a Covered Employee. Continuation coverage for Domestic Partners and their Dependents is offered voluntarily by the Employer and is not required by or subject to COBRA. As this is COBRA-equivalent coverage, a Domestic Partner will be treated as a Qualified Beneficiary to the same extent as if the Domestic Partner were the Employee's spouse and will have independent election rights, including in the event of the Covered Employee’s death. In addition, the Dependent Children of a covered Domestic Partner will be treated as “Qualified Beneficiaries” for these purposes to the same extent that Dependents of a spouse would be so treated and will have independent election rights, including in the event of the Covered Employee’s death. Although the Plan will treat a Domestic Partner as a “Qualified Beneficiary,” this treatment does not qualify a Domestic Partner as a “Qualified Beneficiary” under IRS 1999 final regulations.

QUALIFIED BENEFICIARY

A Qualified Beneficiary also includes a Child born to or placed for adoption with a former Covered Employee/Qualified Beneficiary during the period of COBRA coverage. Newborns and adopted Children of former Covered Employees/Qualified Beneficiaries have independent COBRA rights and can remain on the Plan even if the former Covered Employee/Qualified Beneficiary drops coverage.

***SOCIAL SECURITY DISABILITY**

If a Covered Employee or a covered Dependent is determined to be disabled, as defined in the Social Security Act, on the date of the termination of employment or reduction in hours, or at any time during the first sixty (60) days of COBRA Continuation Coverage, the disabled person may be entitled to continue COBRA coverage for up to twenty-nine (29) months from the date of termination of employment or reduction in hours, provided the Social Security Administration determines, during the initial eighteen (18) month coverage period, that the individual is disabled. To qualify for the eleven (11) month extension of the maximum coverage period, the disabled person must provide the Plan Administrator with a copy of the Social Security Administration determination letter within sixty (60) days of receipt of same, and not later than the expiration of the original eighteen (18) month initial coverage period.

The cost of COBRA coverage for an individual entitled to extended coverage due to Social Security Disability for the period after the end of the eighteen (18) month COBRA coverage period will increase to 150% of the full cost for active participants.

SECONDARY QUALIFYING EVENTS

If COBRA coverage is elected by a covered Dependent based on the Covered Employee's loss of coverage due to termination of employment or reduction in hours and a second Qualifying Event (divorce, legal separation, death or a Dependent Child losing eligibility as a Dependent Child) occurs during the eighteen (18) month COBRA coverage period, the covered Dependent's maximum COBRA coverage period will begin on the date of the first Qualifying Event and continue for a thirty-six (36) month period. For example: If a Covered Employee terminates employment on December 31, 2022 the Employee's covered Dependent elects COBRA coverage, and the former Employee dies before July 1, 2024 (that is prior to the end of the original eighteen (18) month COBRA coverage period), the maximum COBRA coverage period for the Dependent who elected COBRA coverage is extended until December 31, 2025.

SPECIAL MEDICARE ENTITLEMENT RULE

Entitlement to Medicare is not considered a traditional secondary Qualifying Event for a covered Dependent; however, Medicare entitlement does provide potentially longer periods of continuation coverage to certain Qualified Beneficiaries based on the sequence of events. If a Covered Employee becomes entitled to Medicare, but the Employee is still a full-time active Employee, this event is not a COBRA Qualifying Event since Medicare entitlement alone does not cause a loss of coverage. If the Covered Employee voluntarily terminates employment after the Medicare entitlement date, the loss of coverage triggers a potential eighteen (18) month COBRA continuation period for all Qualified Beneficiaries. While the Covered Employee is only entitled to eighteen (18) months of COBRA Continuation Coverage, the other Qualified Beneficiaries (spouse and/or Dependent Children) are entitled to eighteen (18) months or thirty-six (36) months, measured from the date of the Employee's Medicare entitlement, whichever is greater.

EMPLOYEE RESPONSIBILITIES

COBRA coverage <u>is not automatic</u> upon the occurrence of a Qualifying Event. COBRA coverage must be elected as described below. In addition, a Covered Employee or a covered Dependent is responsible for notifying the Plan Administrator within sixty (60) days after the date of the Qualifying Event if the Qualifying Event is the loss of coverage due to divorce, legal separation, or a Dependent Child losing eligibility as a Dependent Child. A change form may be obtained from the Employer. Failure to provide such notice will result in loss of eligibility to elect COBRA coverage.

A Qualified Beneficiary must elect COBRA coverage no later than sixty (60) days after the date the eligible individual is sent an election form describing his/her right to elect continuation coverage (COBRA Election Period). If a Qualified Beneficiary elects coverage during the sixty (60) day COBRA Election Period, coverage is continuous from the time coverage would otherwise have been lost. A properly completed

election form must be returned to the Plan Administrator, signed and dated, by the end of the COBRA Election Period.

If premium payment is not sent with the election form, initial premium payment for COBRA coverage must be received no later than forty-five (45) days after the date COBRA coverage was elected. Initial payment must cover the retroactive monthly coverage period beginning with the date of loss of coverage. **Coverage will not become effective until initial premium payment is received.**

Coverage will remain in effect if subsequent premiums are paid no later than thirty (30) days after the due dates of such payments. **Failure to pay premiums within the time periods specified will result in termination of COBRA coverage. Once continuation is terminated, the coverage cannot be reinstated.** If timely payments of the premium are made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid is deemed to satisfy the Plan's requirement for the amount that must be paid for continuation coverage, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time (30 days) for payment of the deficiency to be made. For purposes of this section an amount not significantly less than the amount the Plan requires to be paid shall be defined as not more than the lesser of $50 or 10% of the required payment amount.

TERMINATION OF COBRA CONTINUATION COVERAGE

COBRA coverage, for a Qualified Beneficiary who elects such coverage, will terminate prior to the completion of the eighteen (18) month, twenty-nine (29) month, or thirty-six (36) month period previously described upon one of the following occurrences:

1. The Qualified Beneficiary becomes covered by another group health plan **after** the date of COBRA election;
2. Required contributions are not paid by or on behalf of the Qualified Beneficiary in a timely manner;
3. The Qualified Beneficiary becomes entitled to benefits under Medicare **after** the date of COBRA election;
4. The Qualified Beneficiary makes a request, in writing, to terminate coverage; or
5. The Plan Sponsor ceases to provide any group health plan to any similarly situated Employee.

NEW DEPENDENTS

If during the eighteen (18) months, twenty-nine (29) months or thirty-six (36) months, if applicable, of COBRA coverage, a Qualified Beneficiary acquires new Dependents (such as through marriage), the new Dependent(s) may be added to the coverage according to the provisions of the Plan. However, the new Dependents do not gain the status of a Qualified Beneficiary and will lose coverage if the Qualified Beneficiary who added them to the Plan loses coverage.

An exception to this is a Child who is born to, or a Child who is placed for adoption with, the Covered Employee Qualified Beneficiary. If the newborn or adopted Child is added to the Covered Employee's COBRA Continuation Coverage, then, unlike a new spouse, the newborn or adopted Child will gain the rights of all other Qualified Beneficiaries. The addition of a newborn or adopted Child does not extend the eighteen (18) or twenty-nine (29) month coverage period. Plan procedures for adding new Dependents can be found in the Eligibility and Effective Date sections of this Plan. Premium rates will be adjusted at that time to the applicable rate.

OPEN ENROLLMENTS

Should an Open Enrollment Period occur during the COBRA continuation period, the Plan Administrator will notify the COBRA Participant of that right as well. If an Open Enrollment Period occurs, the Qualified Beneficiary will have the same rights to select the coverage and any of the options or plans that are available for similarly situated non-COBRA Participants.

TIMING OF THE ELECTION NOTICE

If a Qualifying Event is the Covered Employee's loss of coverage due to termination of employment, reduction in hours, death or Medicare entitlement, the Plan Administrator has forty-four (44) days to notify the Qualified Beneficiary of the right to elect COBRA coverage or, if applicable, the Plan Administrator must notify the COBRA Administrator within thirty (30) days of the Qualifying Event, and the COBRA Administrator has fourteen (14) days to notify the Qualified Beneficiary of the right to elect COBRA coverage.

CONTINUATION OF COVERAGE UNDER USERRA

This section summarizes continuation of coverage under this Plan for Employees absent from work due to military service. The Plan intends to provide benefits as a result of military Leave of Absence as mandated by USERRA, as it may be amended from time to time.

As an Employee you have a right to choose this continuation of coverage if you are absent from work due to service in one of the uniformed services of the United States. "Service" means: active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty and absence from work to determine the Employee's fitness for any of the designated types of duty.

Employees who are dishonorably discharged from the military are not eligible for continuation of coverage under USERRA.

Under the law, the Employee must give the Employer written or verbal advance notice of the military leave, if it is practical to do so, and failure to do so may result in the departing Employee's coverage being cancelled, unless the Employee is excused from giving advance notice of service under USERRA's provisions because it was impossible, unreasonable, or precluded by military necessity. A designated, authorized officer of the branch of the military in which the Employee will be serving may also provide such notice directly to the Employer.

Coverage also may be cancelled if a departing Employee leaves for a period of service that exceeds thirty (30) days and gives advance notice of service, but fails to elect continuation coverage. However, should the Employee pay all unpaid amounts due within sixty (60) days from the date the Employee left for such service, then the Employee will be retroactively reinstated with uninterrupted coverage to the Employee's date of departure.

If the Employee chooses Continuation of Coverage under USERRA, the Employer is required to offer coverage identical to that provided under the Plan prior to the Employee's military leave. If the Employee takes military leave on or after December 10, 2004, and the Employee lost coverage due to that military service, the Employee has the right to elect to extend coverage for the Employee, the Employee's spouse and the Employee's Dependents who are covered by the Plan for up to twenty-four (24) months while the Employee remains on active duty, or during the period that the Employee's reemployment rights are protected. During the first thirty (30) days of leave, the cost of the coverage the Employee elects is the same as the rate that the Employee paid as an Employee. After that time, the rate is the same rate that the Plan charges for COBRA Continuation Coverage. If the Employee or another member of the Employee's Family covered by the Plan becomes disabled during the first sixty (60) days of such coverage, and the Employee provides to the Plan a copy of the Social Security Administration determination of disability before the end of the twenty-four (24) months of coverage, the coverage by the Plan for the Employee, as well as the Employee's spouse and other Family members, can be extended to twenty-nine (29) months. The Employee will have to pay a higher rate for this additional five (5) months of coverage. In addition, if there is an event that would allow the Employee's spouse or Dependent to receive thirty-six (36) months of COBRA coverage, as described above under the COBRA Continuation Coverage provisions, then the Employee's spouse or Dependent will be entitled to elect such coverage if they notify the Plan within sixty (60) days after the event occurs.

If the Employee does not make timely premium payments, then the Plan will provide the Employee with thirty (30) days written notice to pay the premiums. If the Employee fails to pay the requested premium(s) within the thirty (30) days, the Plan has the right to cancel the Employee's continuation of coverage.

If an Employee's or a Dependent of an Employee's health plan coverage was terminated by reason of service in the uniformed services, that coverage must be reinstated upon reemployment, unless the Plan imposes an exclusion or Waiting Period as to illnesses or injuries determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of service.

If you feel you might have continuation rights under USERRA, please contact Human Resources as soon as possible.

DEFINITIONS

Terminology listed below, along with the definition or explanation of the manner in which the term is used, will be recognized for the purpose of this Plan, only if used in this Plan. Terms defined, but not used in this Plan, are to be considered general in nature and are in no way to be used to define or limit benefits or provisions of the Plan. Words or phrases used in this Plan that are capitalized or set forth in bold type but not defined in the Plan are contained in that form as section headings or for ease of review and are intended to have the general meanings associated with such words or phrases based on the context in which they are used.

Masculine pronouns used in this Plan Document shall include masculine or feminine gender unless the context indicates otherwise.

Wherever any words are used herein in the singular or plural, they shall be construed as though they were in the plural or singular, as the case may be, in all cases where they would so apply.

Accident: A sudden and unforeseen event, or a deliberate act resulting in unforeseen consequences.

Accidental Injury: See definition of "Injury".

Actively at Work: As applied to an Employee: the Employee will be considered “Actively at Work” on any day the Employee performs in the customary manner all of the regular duties of employment; an Employee will be deemed “Actively at Work” on each day of a regular paid vacation or on a regular non-working day on which the Covered Employee is not totally disabled, provided the Covered Employee was “Actively at Work” on the last preceding regular work day. An Employee shall be deemed Actively at Work if the Employee is absent from work due to a health factor, subject to the Plan’s Leave of Absence provisions.

ADA: The American Dental Association.

Administrative Period: A period of time selected by the Employer beginning immediately following the end of the Measurement Period and ending immediately before the start of the associated Stability Period. This period of time is used by the Employer to determine if Variable Hour Employees and/or Ongoing Employees are eligible for coverage and, if so, to make an offer of coverage.

Adverse Benefit Determination: Any denial, reduction or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, rescission of coverage, termination or failure to provide or make payment that is based on certain benefit coverage and eligibility determinations.

Adverse Benefit Determination on Appeal: The upholding or affirmation of an appealed Adverse Benefit Determination.

Allowable Claim Limits: The charges for services and supplies, listed and included as Covered Medical Expenses under the Plan, which are Medically Necessary for the care and treatment of Illness or Injury, but only to the extent that such fees are within the Allowable Claim Limits. See Claim Review and Audit Program section.

Allowable Expense: The Usual and Customary charge within Allowable Claim Limits for any Medically Necessary, Reasonable eligible item of expense, at least a portion of which is covered under this Plan. When some other plan provides benefits in the form of services rather than cash payments, the Reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any other plan include the benefits that would have been payable had Claim been duly made.

Alternate Recipient: Any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant’s Eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an Eligible Dependent, but for

purposes of the reporting and disclosure requirements an Alternate Recipient shall have the same status as a Participant.

Alternative Care Plan: In circumstances where there is a reasonable expectation of savings for standard of care medical treatment, medication, or other services and this alternative care can be substituted for more costly care while remaining the treatment of choice, an Alternative Care Plan will be developed to optimize the savings obtained by the services substituted. Example: Substituting Home Health Private Duty Nursing for care in an Inpatient Skilled Nursing Facility.

AMA: The American Medical Association.

Ambulatory Surgery Center: An institution or Facility, either free-standing or as a part of a Hospital with permanent Facilities, equipped and operated for the primary purpose of performing Surgical Procedures and to which a patient is admitted and from which a patient is discharged within a twenty-four (24) hour period. An office maintained by a Physician for the practice of medicine or dentistry, or for the primary purpose of performing terminations of Pregnancy, shall not be considered as an Ambulatory Surgery Center.

Ancillary Services: Incidental services that assist a medical procedure, but are not essential to the accomplishment of the medical procedure (i.e., laboratory testing).

Annual: Yearly; occurring once each Calendar Year.

Traditional Plan:
Annual Out-of-Pocket Maximum: The Maximum dollar amount a Covered Person will pay for Covered Medical Expenses, including the Calendar Year Deductible Medical Copays, but excluding any Covered Charges already paid at 100% in any one Calendar Year period, unless otherwise specified in the Schedule of Benefits. A separate Prescription Drug Annual Out-of-Pocket Maximum applies to Prescription Drug Copays and Expenses.

High Deductible Health Plan:
Annual Out-of-Pocket Maximum: The Maximum dollar amount a Covered Person will pay for Covered Medical and Prescription Drug Expenses including the Calendar Year Deductible, but excluding any Covered Charges already paid at 100% in any one Calendar Year period, unless otherwise specified in the Schedule of Benefits.

Applied Behavior Analysis (ABA) Therapy: Applied Behavior Analysis (ABA) Therapy is a scientific approach that applies the understanding of how behavior works to real situations with the goal of increasing behaviors that are helpful, and decreasing behaviors that are harmful or that affect learning. ABA Therapy involves many techniques for understanding and changing behavior. ABA Therapy programs can help to increase language and communication skills; improve attention, social skills, and academics; and decrease problem behaviors.

Approved Clinical Trial: A phase I, II, III or IV trial that is federally funded by specified Agencies (National Institutes of Health, CDCP, Agency for Health Care Research, CMS, Dept. of Defense or Veterans Affairs, or a non-governmental entity identified by NIH guidelines) or is conducted under an Investigational new Drug application reviewed by the FDA (if such application is required).

Assignment of Benefits: An arrangement whereby the Plan Participant assigns his/her right to seek and receive payment of eligible Plan benefits, in strict accordance with the terms of this Plan Document, to a Provider. If a Provider accepts said arrangement, Provider's rights to receive Plan benefits are equal to those of a Plan Participant, and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an "Assignment of Benefits" as consideration in full for services, supplies, and/or treatment rendered.

Authorized Representative: Person authorized to act on behalf of a Claimant for a benefit Claim or appeal of an Adverse Benefit Determination.

Autism Spectrum Disorder: A disorder that includes autism, Asperger's Syndrome or pervasive development disorder.

Benefit Determination: A determination by the Plan Administrator or Claims Administrator on a Claim for benefits, including an Adverse Benefit Determination.

Benefit Percentage: The portion of Covered Expenses to be paid by the Plan in accordance with the coverage provisions as shown on the Schedule of Benefits. It is the basis used to determine any out-of-pocket expenses including the Calendar Year Deductible, Medical Copays/Expenses and Prescription Drug Copays/Expenses including the Calendar Year Deductible which are to be paid by the Covered Person.

Birthing Center: A Facility, staffed by Physicians, which is licensed as a Birthing Center in the jurisdiction where it is located.

Breach: A Breach is, generally, an impermissible use or disclosure under the Privacy Rule that compromises the security or privacy of the protected health information such that the use or disclosure poses a significant risk of financial, reputational, or other harm to the affected individual.

Calendar Year: A period of time commencing on January 1 and ending on December 31 of the same given year.

Certified IDR Entity: An entity responsible for conducting determinations under the No Surprises Act and that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

Chemical Dependency: The abuse of, or psychological or physical dependency on, or addiction to, alcohol or a controlled substance. A "controlled substance" means a toxic inhalant or a substance designated as a controlled substance as declared by Federal and State law where applicable.

Chemical Dependency Treatment Center: A Facility which provides a program for the treatment of Chemical Dependency pursuant to a written treatment plan approved and monitored by a Physician and is also:

1. Accredited as such a Facility by the Council on Accreditation (COA) or Joint Commission on Accreditation of Health Care Organizations or sponsored by the A.M.A. or A.H.A.;
2. Affiliated with a Hospital under contractual agreement with an established system for patient referral;
3. Licensed as a Chemical Dependency treatment program by the applicable State Commission on Alcohol and Drug Abuse; and
4. Licensed, certified or approved as a Chemical Dependency treatment program or center by any other State agency having legal authority to so license, certify or approve.

Child(ren): In addition to the Employee's own blood descendant of the first degree or lawfully adopted Child, a Child placed with a Covered Employee in anticipation of adoption, a Covered Employee's Child who is an Alternate Recipient under a Qualified Medical Child Support Order as required by the Federal Omnibus Budget Reconciliation Act of 1993, any stepchild, or any other Child for whom the Employee has been legally appointed guardian or conservator. See definition of "Dependent" for any other eligibility provisions for a Child.

CHIP: Refers to the Children's Health Insurance Program or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

CHIPRA: Refers to the Children's Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

Chiropractic Services: The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column.

Claim: A request for a Plan benefit or benefits made by a Claimant in accordance with the Plan's reasonable procedure for filing benefit Claims.

Claim Determination Period: A Calendar Year, a Plan Year or that portion of a Calendar or Plan Year during which the Covered Person, for whom Claim is made, has been covered under this Plan.

Claimant: Individual for whom a Claim is filed.

Claims Administrator: The third party or parties with whom the Plan Administrator has contracted to process the Claims for the benefits under this Plan.

Clean Claim: A Clean Claim is one that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a Claim which has no defect or impropriety. A defect or impropriety shall include a lack of required substantiating documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include Claims under investigation for fraud and abuse or Claims under review for Medical Necessity and Reasonableness, or fees under review for Usual and Customariness, or any other matter that may prevent the charge(s) from being covered expenses in accordance with the terms of this document.

Filing a Clean Claim. A Provider submits a Clean Claim by providing the required data elements on the standard Claim forms, along with any attachments and additional elements or revisions to data elements of which the Provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to Claim submittal) to ensure charges constitute covered expenses as defined by and in accordance with the terms of this document. The paper Claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A Claim will not be considered to be a Clean Claim if the Plan Participant has failed to submit required forms or additional information to the Plan as well.

Close Relative: Includes the spouse, mother, father, sister, brother, Child, or in-laws of the Covered Person.

COBRA: Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COBRA Continuation Coverage: Coverage under this Plan that satisfies an applicable COBRA continuation provision.

COBRA Election Period: The sixty (60) day period during which a COBRA Qualified Beneficiary, who would lose coverage as a result of a Qualifying Event, may elect Continuation Coverage under COBRA. This sixty (60) day period begins the later of:

1. The date of termination of coverage as a result of a Qualifying Event; or
2. The date of the notice of the right to elect COBRA Continuation Coverage under this Plan.

COBRA Qualified Beneficiary: A former Employee or Dependent covered under this Plan on the day before the Qualifying Event who is eligible for continuing coverage under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and its amendments. A COBRA Qualified Beneficiary has independent election rights. A Domestic Partner does not qualify as a spouse under Federal law. If termination of employment occurs, the Plan will treat a Domestic Partner as a "Qualified Beneficiary"; however, this treatment does not qualify a Domestic Partner as a "Qualified Beneficiary" under IRS 1999 final regulations.

Coinsurance: The portion of Covered Expenses that is shared by the Plan and the Covered Person in a specific ratio (i.e., 80%/20%) after the Calendar Year Deductible has been satisfied. The amount of Coinsurance paid by or on behalf of the Covered Person is applied toward the Covered Person's or Family's Annual Out-of-Pocket Maximum.

Complications of Pregnancy: A Disease, disorder or condition which is diagnosed as distinct from normal Pregnancy but adversely affected by or caused by Pregnancy. This includes, but is not limited to:

1. Inter-abdominal Surgery, including cesarean section;
2. Excessive vomiting (hyperemesis gravidarum);
3. Toxemia with convulsions (eclampsia);
4. Extra-uterine Pregnancy (ectopic);
5. Postpartum hemorrhage;
6. Rupture or prolapse of the uterus;
7. Spontaneous termination of Pregnancy during a period of gestation in which a viable birth is not possible;
8. Similar medical and surgical condition of comparable severity.

Complications of Pregnancy will not include:

1. Elective abortion;
2. False labor;
3. Occasional spotting;
4. Physician prescribed rest;
5. Morning sickness; or
6. Similar conditions associated with the management of a difficult Pregnancy.

Concurrent Review: The Utilization Review department's review of a Hospital stay, periodically evaluating the need for continued hospitalization.

Congenital Anomaly: A Congenital Anomaly may be viewed as a physical, metabolic or anatomic deviation from the normal pattern of development that is apparent at birth or detected during the first year of life.

Copay: The portion of Covered Expenses which is payable by the Covered Person and which is not applicable to the Calendar Year Deductible unless otherwise stated in this Plan Document.

Corrective Shoes: Shoes with a prescription correction which is a permanent and integral part of the shoe.

Cosmetic Procedure/Cosmetic Surgery: A procedure performed solely for the improvement of a Covered Person's appearance rather than for the improvement or restoration of bodily function.

Covered Dental Expenses: The Usual and Customary fees incurred by the Covered Person for dental services which are provided or rendered by a Dentist and not listed as an exclusion in Dental Plan Limitations and Exclusions.

Covered Employee: An Employee meeting the eligibility requirements for coverage as specified in this Plan and who is properly enrolled in the Plan.

Covered Medical Expenses (Covered Expenses): The Reasonable and Usual and Customary charges, Allowable Claim Limit charges and/or contracted PPO charges incurred by or on behalf of a Covered Person for the Hospital or other medical services listed below which are:

1. Ordered by a Physician or licensed Practitioner;
2. Medically Necessary for the treatment of an Illness or Injury;
3. Not of a luxury or personal nature; and
4. Not excluded under the Major Medical Exclusions and Limitations section of this Plan.

Covered Person: An Employee, a Dependent, a COBRA Qualified Beneficiary or a COBRA Qualified Beneficiary's Dependent meeting the eligibility requirements for coverage as specified in this Plan, and who is properly enrolled in the Plan.

Custodial Care: That type of care or service, wherever furnished and by whatever name called, which is designed primarily to assist a Covered Person, whether or not totally disabled, in the activities of daily living. Such activities include, but are not limited to: bathing, dressing, feeding, preparation of special diets,

assistance in walking or in getting in and out of bed, and supervision over medication which can normally be self-administered.

Date of Hire: The Employee's first day of Full-time or Part-time Employment with the Employer.

Deductible: A specified dollar amount of Covered Expenses which must be incurred during a Calendar Year before any other Covered Expenses can be considered for payment according to the applicable Benefit Percentage. The Plan Administrator reserves the right to allocate and apportion the Deductible and benefits to any Covered Persons and assignees.

Dependent:

1. The Covered Employee's legal licensed spouse. Such spouse must have met all the requirements of a valid marriage contract in accordance with the laws of the State in which such parties were married. A common-law marriage recognized by the State in which the Covered Employee resides may be considered a legal marriage for this Plan. **NOTE:** Proof of legal status may be required by the Plan Administrator.

2. A Covered Employee's Domestic Partner who has a single, dedicated relationship with the Employee that contains the following elements:

   a. Both the Employee and Domestic Partner are at least eighteen (18) years of age and mentally competent to consent to contract; and
   b. The relationship is intended to last indefinitely.

   A "Statement of Domestic Partnership" must be completed, notarized and provided to the Plan Administrator to establish a Domestic Partner's spousal equivalency.

3. The Covered Employee's Child who meets all of the following conditions:

   a. Is less than **twenty-six (26) years of age**; and

   b. Is either a:

      i. Natural (biological) Child; or
      ii. Child who has been legally adopted or placed for adoption with the Covered Employee; or
      iii. Stepchild; or
      iv. Foster Child; or
      v. Child who has been placed under the legal guardianship or conservatorship of the Covered Employee or the Employee's covered Dependent spouse; or
      vi. Child of a Domestic Partner.

The age requirement above is waived for any unmarried Child who is Physically Handicapped or Intellectually Disabled and incapable of sustaining his/her own living, who has the same legal residence as the Employee for more than one-half of the Calendar Year, and who does not provide more than one-half of his/her own support for the Calendar Year in which the Child is enrolled for coverage under the Plan. Such Child must have been mentally or physically incapable of earning his/her own living prior to attaining the limiting age stated above. Proof of incapacity must be furnished to the Plan Administrator at the time of initial enrollment or within thirty (30) days of the date such Dependent's coverage would have otherwise terminated due to the age requirement. In addition, the Claims Administrator reserves the right to request proof of continued incapacity at any time.

NOTE: Proof of Dependent eligibility may be required.

Detoxification: The process whereby an alcohol-intoxicated person or person experiencing the symptoms of Substance Abuse is assisted, in a Facility licensed by the Department of Health, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol, alcohol dependency

factors or alcohol in combination with Drugs as determined by a licensed Physician, while keeping the physiological risk to the patient at a minimum.

Developmental Delay: A significant variation in normal development as measured by appropriate diagnostic instruments and procedures in one or more of the following: cognitive development, physical development, communication development, social or emotional development or adaptive development.

Direct Agreement: A complete agreement between a Directly Contracted Provider and Imagine360 or the Plan Sponsor which contains the terms and conditions under which the Covered Person may access discounted fees and/or negotiated or scheduled reimbursement rates which the Plan adopts as Allowable Claims Limits for Claims submitted by directly contracted Providers.

Directly Contracted Provider: A medical Provider, supplemental benefit provider, and/or supplemental network partner which has entered into a Direct Agreement with Imagine360, including any affiliates, or the Plan Sponsor to provide certain medical services to Covered Persons at agreed upon Allowable Claim Limits.

Disease: Any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the Plan is furnished showing that the individual concerned is covered as an Employee under any Workers' Compensation law, occupational Disease law or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the Plan, be regarded as a sickness, Illness or Disease.

Domestic Partners: Applies to two (2) individuals either of the same sex or opposite sex who live together in a long-term relationship of indefinite duration with an exclusive mutual commitment in which the Domestic Partners agree to be jointly responsible for each other's common welfare and share financial obligations.

Donor: One who furnishes blood, tissue, or an organ to be used in another person.

Drug: *"Drug" shall mean a Food and Drug Administration (FDA) approved Drug or medicine that is listed with approval in the United States Pharmacopeia, National Formulary or AMA Drug Evaluations published by the American Medical Association (AMA), that is prescribed for human consumption, and that is required by law to bear the legend: "Caution—Federal Law prohibits dispensing without prescription," or a State restricted drug (any medicinal substance which may be dispensed only by prescription, according to State law), legally obtained and dispensed by a licensed drug dispenser only, according to a written prescription given by a Physician and/or duly licensed Provider. "Drug" shall also mean insulin for purposes of injection. The Plan Administrator in its sole discretion may deem a medication which would otherwise not meet the definition of "Drug" a Covered Expense under the Plan, provided the safety and efficacy can be reasonably confirmed, for example, a foreign version of an FDA-approved Drug.*

Durable Medical Equipment: Equipment which is:

1. Able to withstand repeated use;
2. Primarily and customarily used to serve a medical purpose; and
3. Not generally useful to a person in the absence of Illness or Injury.

Elective Surgical Procedure/Elective Surgery: A non-Emergency Surgical Procedure which is scheduled at the Covered Person's convenience without endangering the Covered Person's life or without causing serious impairment to the Covered Person's bodily functions.

Electronic Protected Health Information (ePHI): "Electronic Protected Health Information (ePHI)" has the meaning set forth in 45 C.F.R. Section 160.103, as amended from time to time, and generally means Protected Health Information that is transmitted or maintained in any electronic media.

Eligible Dependent: An Employee's Dependent who meets the Plan's eligibility requirements to enroll for coverage while the Employee is covered under the Plan.

Eligible Employee: An Employee and who is employed by the Employer on a full-time or part-time basis for an average of at least thirty (30) hours per week.

Emergency/Medical Emergency: A situation where necessary treatment is required as the result of a sudden and severe medical event or acute condition. An Emergency includes poisoning, shock, and hemorrhage. Other Emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, that an Emergency did exist. The Plan may, at its own discretion, request satisfactory proof that an Emergency or acute condition did exist. Some examples of an Emergency are: apparent heart attack, severe bleeding, sudden loss of consciousness, severe or multiple Injuries, convulsions, respiratory distress including asthma attacks, apparent poisoning or severe pain from the sudden onset of an Illness. Some examples of conditions that are not generally considered an Emergency are: colds, influenza, ear infections, nausea or headaches.

Emergency Services: With respect to an Emergency/Medical Emergency:

1. An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the Emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including Ancillary Services routinely available to the Emergency department to evaluate such Emergency medical condition; and

2. Within the capabilities of the staff and Facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

When furnished with respect to an Emergency/Medical Emergency, Emergency Services shall also include an item or service provided by a Non-PPO Provider or Facility (regardless of the department of the Hospital or Facility in which items or services are furnished) after the Participant is stabilized and as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the Emergency Services are furnished, until such time as the Provider determines that the Participant is able to travel using non-medical transportation or non-emergency medical transportation, and the Participant is in a condition to, and in fact does, give informed consent to the Provider to be treated as a Non-PPO Provider.

Employee: A person who is determined by the Employer to either be employed for Full-time or Part-time Employment or employed as a Variable Hour Employee who has completed the most recent Measurement Period and entered a Stability Period.

Employer: The Employer and any affiliates adopting the Plan with the consent of the Employer by approval of the affiliate entity's governing body.

Enrollment Date: The Enrollment Date in the Plan for an Eligible Employee who enrolls in the Plan during his/her initial eligibility period is the Employee's Date of Hire. The Enrollment Date for a Special Enrollee or a Late Enrollee is the first day of coverage in the Plan.

Essential Health Benefits: "Essential Health Benefits" shall mean, under section 1302(b) of the Patient Protection and Affordable Care Act (PPACA), those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and Substance Abuse disorder services, including behavioral health treatment; Prescription Drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic Disease management; and pediatric services, including oral and vision care.

Experimental/Investigational: Services or treatments that are not widely used or accepted by most Practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments, and that are not the subject of, or in some manner related to, the conduct of an Approved

Clinical Trial, as such term is defined herein; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which:

1. Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or
2. Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

Non-approved Phase I and II clinical trials shall be considered Experimental. Non-approved clinical trials include anything that is not listed in the Approved Clinical Trial definition.

A Drug, device, or medical treatment or procedure is Experimental:

1. If the Drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the Drug or device is furnished;
2. If reliable evidence shows that the Drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials (unless identified as a covered service elsewhere) or under study to determine its:

    a. maximum tolerated dose;
    b. toxicity;
    c. safety;
    d. efficacy; and
    e. efficacy as compared with the standard means of treatment or diagnosis; or

3. Reliable evidence shows that the opinion among experts regarding the treatment, procedure, device, Drug, or medicine is that the preponderance of current evidence does not support its efficacy, safety, or its efficacy as compared with the standard means of treatment or with regard to medication, has not determined its maximum tolerated dose.

Reliable evidence shall mean:

1. Only published reports and articles in the authoritative medical and scientific literature;
2. The written protocol or protocols used by the treating Facility or the protocol(s) of another Facility studying substantially the same Drug, device, or medical treatment or procedure; or
3. The written informed consent used by the treating Facility or by another Facility studying substantially the same Drug, device, or medical treatment or procedure.

Subject to a medical opinion, if no other FDA approved treatment is feasible and as a result the Participant faces a life or death medical condition, the Plan Administrator retains discretionary authority to cover the services or treatment.

Medical care and treatment, including prescriptions/diagnostics/labs that are not related directly to a clinical trial are considered for coverage under the Plan for those patients participating in a clinical trial.

Facility/Free-standing Facility: A facility means a Hospital or treatment center that provides medical services on an Inpatient and/or Outpatient basis. A Free-standing Facility is an independent Facility which provides medical services on an Outpatient basis, which may or may not be affiliated with a Hospital (i.e., Ambulatory Surgery Center). See separate definition for "Independent Freestanding Emergency Department."

Family: A Covered Employee and his/her Eligible Dependents.

Family and Medical Leave: A Leave of Absence pursuant to the provisions of the Family and Medical Leave Act of 1993 (FMLA), as amended.

Fiduciary: The Plan Administrator, but only with respect to the specific responsibilities relating to the administration of the Plan.

Foster Child: A Child for whom an Employee has assumed a legal obligation to support and care, provided:

1. Such Child normally lives with the Employee in a parent-Child relationship; and
2. The Employee has a legal right to claim such Child as a Dependent on his federal income tax return if the Child resides with the Employee for a period of six (6) months or longer.

Full-time Employment: A basis whereby an Employee is regularly expected to be employed by the Employer for the minimum number of hours shown in the Employee Eligibility section of this Plan Document. Such work may occur either at the usual place of business of the Employer or at a location to which the business of the Employer requires the Employee to travel, and for which he/she receives regular earnings from the Employer.

Genetic Information: Information about genes, gene products and inherited characteristics that may derive from an individual or a Family member. This includes information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, Family histories and direct analyses of genes or chromosomes.

GINA: The Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies and Employers from discriminating on the basis of Genetic Information.

Habilitation Services: Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community based settings.

Hazardous Pursuit, Hobby or Activity: Services, supplies, care and/or treatment of an Injury or Illness that results from engaging in a Hazardous Pursuit, Hobby or Activity. A pursuit, hobby or activity is hazardous if it involves or exposes an individual to risk of a degree or nature not customarily undertaken in the course of the Covered Person's customary occupation or if it involves leisure time activities commonly considered as involving unusual or exceptional risks, characterized by a constant threat of danger or risk of bodily harm, including but not limited to: hang gliding; skydiving; bungee jumping; parasailing; use of all-terrain vehicles; rock climbing; use of explosives; automobile, motorcycle, aircraft, or speed boat racing; and travel to countries with advisory warnings.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): With regard to health care plans, it should be noted that this Act implemented the portability of health insurance and changed health status eligibility provisions for Employee health plans.

Health Maintenance Organization (HMO): An organized system of health care delivery available to individuals residing in a specific geographic area providing comprehensive medical care to enrollees for a predetermined periodic payment.

HIPAA Privacy Standards: The Privacy Standards of the Health Insurance Portability and Accountability Act of 1996, as they may be amended from time to time.

Home Health Care Agency: A public or private agency or organization that specializes in providing medical care and treatment in the patient's home. Such a Provider must meet all of the following conditions:

1. It is primarily engaged in and duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services;

2. It has policies established by a professional group associated with the agency or organization. This professional group must include at least one (1) Physician and at least one (1) Registered Nurse (RN) to govern the services provided and it must provide for full-time supervision of such services by a Physician or Registered Nurse (RN);

3. It maintains a complete medical record on each individual; and

4. It has a full-time administrator.

Home Health Care Plan: A program for care and treatment of a Homebound Covered Person, established and approved by the Covered Person's attending Physician, which is in lieu of confinement as an Inpatient in a Hospital or other Inpatient Facility in the absence of the services and supplies provided for under the Home Health Care Plan.

Home Infusion Therapy: The administration of fluids, nutrition or medication (including all additives and chemotherapy) by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the home setting. Home Infusion Therapy shall include:

1. Drugs and IV solutions;
2. Pharmacy compounding and dispensing services;
3. All equipment and ancillary supplies necessitated by the defined therapy;
4. Delivery services;
5. Patient and Family education; and
6. Nursing services.

Over-the-counter products which do not require a Physician's or other Provider's prescription, including but not limited to standard nutritional formulations used for enteral nutrition therapy, are not included within this definition.

Home Infusion Therapy Provider: An entity that is duly licensed by the appropriate State agency to provide Home Infusion Therapy.

Homebound: A patient's medical condition is such that it significantly restricts the ability to leave the home, and the patient is unable to drive a motor vehicle by himself/herself.

Hospice: A health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in institutional settings for Covered Persons suffering from a condition that has a terminal diagnosis. A Hospice must have an interdisciplinary group of personnel which includes at least one (1) Physician and one (1) Registered Nurse (RN), and it must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable State licensing requirements.

Hospice Benefit Period: A specified amount of time during which the Covered Person undergoes Hospice care. Such time period begins on the date the attending Physician of a Covered Person certifies a diagnosis of terminally ill, and the Covered Person is accepted into a Hospice program. The period shall end the earlier of six (6) months from this date or at the death of the Covered Person. A new benefit period may begin if the attending Physician certifies that the Covered Person is still terminally ill; however, additional proof may be required by the Claims Administrator before such a new benefit period can begin.

Hospital: An accredited institution which is approved as a Hospital by the Joint Commission on the Accreditation of Health Care Organizations or the American Osteopathic Association, and which meets all of the following criteria:

1. It is primarily engaged in providing, for compensation from its patients and on an Inpatient basis, diagnostic and therapeutic Facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons by or under the supervision of a staff of Physicians;

2. It continuously provides twenty-four (24) hours per day nursing services by registered professional nurses under the supervision of Physicians; and

3. It is not, other than incidentally, a place for rest, the aged, or a nursing home, a hotel or the like.

Hospital Expenses: Charges by a Hospital for Room and Board and/or for care in an Intensive Care Unit provided that such care is furnished at the direction of a Physician.

Hospital Miscellaneous Expenses: The actual charges made by a Hospital in its own behalf for services and supplies rendered to the Covered Person which are Medically Necessary for the treatment of such Covered Person. Hospital Miscellaneous Expenses do not include charges for Room and Board or for professional services (including intensive nursing care by whatever name called), regardless of whether the services are rendered under the direction of the Hospital or otherwise.

Hour of Service: Each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the Employer; and each hour for which an Employee is paid, or entitled to payment by the Employer for a period of time during which no duties are performed due to vacation, holiday, Illness, incapacity (including disability), layoff, jury duty, military duty or Leave of Absence.

Illness: A bodily disorder, Disease, physical sickness, mental infirmity, or functional nervous disorder of a Covered Person.

Immunization: The protection of individuals or groups from specific Diseases by vaccination or the injection of immune globulins.

Incurred Date: The date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered.

Independent Freestanding Emergency Department: A health care Facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable State law, and which provides any Emergency Services. Independent Freestanding Emergency Departments do not include Urgent Care Facilities (Minor Emergency Medical Clinics).

Individual Treatment Plan: A treatment plan with specific attainable goals and objectives appropriate to both the patient and the treatment modality of the program.

Injury: A condition caused by accidental means which results in damage to the Covered Person's body from an external force.

Inpatient: Refers to a patient admitted as a bed patient to a Hospital, Hospice, Rehabilitation Facility or Skilled Nursing Facility for treatment or observation; charges must be incurred for Room and Board or observation for a period of at least twenty-four (24) hours.

Intensive Care Unit (ICU): A separate, clearly designated service which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a “coronary care unit” or an “acute care unit.” It has Facilities for special nursing care not available in regular rooms and wards of the Hospital, special life-saving equipment which is immediately available at all times, at least two (2) beds for the accommodation of the critically ill and at least one (1) Registered Nurse (RN) in continuous and constant attendance twenty-four (24) hours a day.

Late Enrollee: An Employee or Dependent who gave up his/her initial opportunity to enroll in the Plan and who enrolls in the Plan more than thirty (30) days after the date of his/her initial eligibility and who is not eligible for a Special Enrollment, or who has failed to enroll by the end of a Special Enrollment Period. Late Enrollees can only enroll once a year during the Annual Open Enrollment Period for the Plan.

Leave of Absence: A Leave of Absence of an Employee that has been approved by his/her Participating Employer, as provided for in the Participating Employer’s rules, policies, procedures and practices.

Licensed Practical Nurse/Licensed Vocational Nurse: An individual who has received specialized nursing training and practical nursing experience, and is duly licensed to perform such nursing services by

the State or regulatory agency responsible for such licensing in the State in which that individual performs such services.

Material Reduction: Material Reduction in covered services or benefits is any modification to the Plan or change in the information required to be included in the Summary Plan Description (SPD) that, independently or in conjunction with other contemporaneous modifications or changes, would be considered by the average Plan Participant to be an important reduction in covered services or benefits.

Maximum Allowable Charge: The amount payable for a specific covered item under this Plan. For Claim determinations made in accordance with the Claim Review and Audit Program, the Maximum Allowable Charge will be limited to the Allowable Claim Limits. Please refer to the section, "Claim Review and Audit Program" for the definition of Allowable Claim Limits. For all other Claims, the Maximum Allowable Charge will be a negotiated rate, if one exists. For Claims subject to the No Surprises Act (see "No Surprises Act – Emergency Services and Surprise Bills" within the "Federal Laws" section), if no negotiated rate exists, the Maximum Allowable Charge will be an amount deemed payable by a Certified IDR Entity or a court of competent jurisdiction, if applicable.

If none of the above factors is applicable, the Maximum Allowable Charge will be determined and established by the Plan, at the Plan Administrator's discretion, using normative data and submitted information such as, but not limited to, any one or more of the following, in the Plan Administrator's discretion:

- Medicare reimbursement rates (presently utilized by the Centers for Medicare and Medicaid Services ["CMS"]).
- Prices established by CMS utilizing standard Medicare Payment methods and/or based upon supplemental Medicare pricing data for items Medicare does not cover based on data from CMS.
- Prices established by CMS utilizing standard Medicare payment methods and/or based upon prevailing Medicare rates in the community for non-Medicare Facilities for similar services and/or supplies provided by similarly skilled and trained Providers of care.
- Prices established by CMS utilizing standard Medicare payment methods for items in alternate settings based on Medicare rates provided for similar services and/or supplies paid to similarly skilled and trained Providers of care in traditional settings.
- Medicare cost data as reflected in the applicable individual Provider's cost report(s).
- The fee(s) which the Provider most frequently charges the majority of patients for the service or supply.
- Amounts the Provider specifically agrees to accept as payment in full either through direct negotiation or through a Preferred Provider Organization (PPO) network.
- Average wholesale price (AWP) and/or manufacturer's retail pricing (MRP).
- Medicare cost-to-charge ratios or other information regarding the actual cost to provide the service or supply.
- The allowable charge otherwise specified within the terms of this Plan.
- The prevailing range of fees charged in the same "area" (defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made) by Providers of similar training and experience for the service or supply.

The Plan Administrator may in its discretion, taking into consideration specific circumstances, deem a greater amount to be payable than the lesser of the aforementioned amounts. The Plan Administrator may take any or all such factors into account but has no obligation to consider any particular factor. The Plan Administrator may also account for unusual circumstances or complications requiring additional, or a lesser, amount of time, skill and experience in connection with a particular service or supply, industry standards and practices as they relate to similar scenarios, and the cause of Injury or Illness necessitating the service(s) and/or charge(s).

In all instances, the Maximum Allowable Charge will be limited to an amount which, in the Plan Administrator's discretion, is charged for services or supplies that are not unreasonably caused by the treating Provider, including errors in medical care that are clearly identifiable, preventable, and serious in

their consequence for patients. A finding of Provider negligence and/or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

The determination that fees for services are includable in the Maximum Allowable Charge will be made by the Plan Administrator, taking into consideration, but not limited to, the findings and assessments of the following entities: (a) The national medical associations, societies, and organizations; and (b) The Food and Drug Administration (FDA). To be includable in the Maximum Allowable Charge, services and fees must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The Plan Administrator has the discretionary authority to decide if a charge is covered under this Plan. The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Maximum Amount: Any limit on benefits that are payable under the Plan.

Maximum Benefit: The Maximum Amount that may be payable for each Covered Person for expenses incurred. The applicable Maximum Benefit is shown in the Schedule of Benefits. No further benefits are payable once the Maximum Benefit is reached.

Measurement Period: A period of time selected by the Employer during which Variable Hour Employees' and/or Ongoing Employees' Hours of Service are tracked to determine employment status for benefit purposes. The Initial Measurement Period applies to newly hired Variable Hour Employees. The Standard Measurement Period applies to Ongoing Employees.

Medical Care Benefits: Amounts paid for the diagnosis, cure, mitigation, treatment or prevention of Disease or amounts paid for the purpose of affecting any structure or function of the body.

Medical Child Support Order: Any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for Child support with respect to a Participant's Child or directs the Participant to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law); or
2. Enforces a law relating to Medical Child Support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

Medical Record Review: The process by which the Plan, based upon a review and audit of medical records, determines that a different treatment or different quantity of a Drug or supply was provided which is not supported in the billing. The Plan Administrator may determine the Maximum Allowable Charge according to the Medical Record Review and audit results.

Medical Review Specialist: An organization under contract to the Plan Administrator to provide the services required under the cost containment features of Utilization Review Notification/Concurrent Review/Coordination of Care/Case Management. The Plan Administrator will furnish the name, address and phone number of the Medical Review Specialist.

Medically or Dentally Necessary/Medical or Dental Necessity: Refers to health care services ordered by a Physician or Dentist exercising prudent clinical judgment provided to a Plan Participant for the purposes of evaluation, diagnosis or treatment of that Plan Participant's Illness or Injury. Such services, to be considered Medically/Dentally Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the diagnosis or treatment of the Plan Participant's Illness or Injury. The Medically/Dentally Necessary setting and level of service is that setting and level of service which, considering the Plan Participant's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically/Dentally Necessary must be no more costly than alternative interventions and are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Plan Participant's Illness or Injury without adversely affecting the Plan Participant's medical condition.

1. It must not be maintenance therapy or maintenance treatment;
2. Its purpose must be to restore health;
3. It must not be primarily custodial in nature;
4. It must not be a listed item or treatment not allowed for reimbursement by CMS (Medicare); and
5. The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical or Dental Necessity and/or an Allowable Expense.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Participant is receiving or the severity of the Participant's condition and that safe and adequate care cannot be received as an Outpatient or in a less intensive medical setting. The mere fact that the service is furnished, prescribed or approved by a Physician or Dentist does not mean that it is "Medically or Dentally Necessary." In addition, the fact that certain services are excluded from coverage under this Plan because they are not "Medically or Dentally Necessary" does not mean that any other services are deemed to be "Medically or Dentally Necessary."

To be Medically or Dentally Necessary, all of these criteria must be met. Merely because a Physician or Dentist recommends, approves, or orders certain care does not mean that it is Medically or Dentally Necessary. The determination of whether a service, supply, or treatment is or is not Medically or Dentally Necessary may include findings of the American Medical Association and the Plan Administrator's own medical advisors.

Medicare Benefits: All benefits under Parts A, B and/or D of Title XVIII of the Social Security Act of 1965, as amended from time to time.

Mental Disorder: Any Disease or condition, regardless of whether the cause is organic, that is classified as a Mental or Nervous Disorder in the current edition of *International Classification of Diseases*, published by the U.S. Department of Health and Human Services, or is listed in the current edition of *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association or other relevant State guideline or applicable sources.

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA): In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that:

1. The financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage) and that there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan); and

2. The treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage), and that there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage offered in connection with such a plan).

Midwife: A Practitioner who is certified as a Nurse Midwife (CNM) by the American College of Nurse-Midwives and who is authorized to practice as a Nurse Midwife under State regulations.

Morbid Obesity: A diagnosed condition in which the body weight of an individual is the greater of 100 pounds or 100% over the medically recommended weight for a person of the same height, age and mobility and by a BMI (body mass index) greater than 40 (in accordance with Utilization Review's criteria for morbid or severe Obesity).

National Medical Support Notice or NMSN: A notice that contains the following information:

1. Name of an issuing State agency;
2. Name and mailing address (if any) of an Employee who is a Participant under the Plan;
3. Name and mailing address of one or more Alternate Recipients (i.e., the Child or Children of the Participant or the name and address of an official or agency that has been substituted for the mailing address of the Alternate Recipients(s)); and
4. Identity of an underlying Child support order.

Newborns' and Mothers' Health Protection Act of 1996 (NMHPA): A regulation that added a new section restricting the extent to which group health plans may limit Hospital lengths of stays for mothers and newborn Children following delivery. NMHPA regulations apply as of the first day of the first Plan Year beginning on or after January 1, 1998.

No-Fault Automobile Insurance: Automobile insurance that pays for medical expenses for Injuries sustained during the operation of an automobile, regardless of who may have been responsible for causing the Accident.

Non-variable Hour Employee: An Employee reasonably expected at the time of hire to work thirty (30) or more hours per week.

Nurse: An individual who has received specialized nursing training and is authorized to use the designation Registered Nurse (RN), Licensed Vocational Nurse (LVN) or Licensed Practical Nurse (LPN), and who is duly licensed by the State or regulatory agency responsible for such license in the State in which the individual performs the nursing services.

Obesity: A diagnosed condition in which the BMI (body mass index) is at least 30 (ranging from 30-39).

OBRA: The coverage provided under the provisions of the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993), effective August 10, 1993.

Occupational Therapy: Treatment which is rendered for reasons other than restoration of bodily functions and the prevention of disability. Such treatment is usually rendered by the use of work-related skills and leisure tasks for the evaluation of an individual's behavior and/or abilities of self-care, work or play.

Ongoing Employee: An Employee who has been employed by the Employer for at least one (1) complete Measurement Period.

Oral Surgery: Maxillofacial Surgical Procedures include, but are not limited to:

1. Excision of non-dental related neoplasms, including benign tumors and cysts and all malignant and pre-malignant lesions and growths;
2. Incision and drainage of facial abscess;
3. Surgical Procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses; and
4. Surgical and diagnostic treatment of conditions affecting the temporomandibular joint (including the jaw and the craniomandibular joint) as a result of an Accident, a trauma, a congenital defect, a developmental defect or a pathology.

Orthopedic Shoes: Special shoes designed for support of the feet or the prevention or correction of deformities of the feet.

Orthotic Devices: External devices used to support, align, prevent or correct deformities or to improve the function of movable parts of the body. An orthotic insole is a foot supporting device prescribed by a Physician or licensed Practitioner.

Out-of-Area: "Out-of-Area" applies to a Covered Person living or traveling outside of the geographic zip code area serviced by the Preferred Provider Organization (PPO).

Outpatient: A patient who receives medical services at a Hospital but is not admitted as a registered overnight bed patient; this must be for a period of less than twenty-four (24) hours. This term can also be applicable to services rendered in a free-standing independent Facility, such as an Ambulatory Surgery Center.

Outpatient Chemical Dependency/Drug Treatment Facility: An institution which provides a program for a diagnosis, evaluation and effective treatment of Chemical Dependency, and/or Drug use or abuse; provides Detoxification services needed with its effective treatment program; provides infirmary level medical services or arranges at a Hospital in the area for any other medical services that may be required; is at all times supervised by a staff of Physicians; provides at all times skilled nursing care by licensed nurses who are directed by a full-time Registered Nurse (RN); prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs, which is supervised by a Physician; and meets applicable State and Federal, if any, licensing standards.

Outpatient Psychiatric Day Treatment Facility: An administratively distinct governmental, public, private or independent unit or part of such unit that provides for a psychiatrist who has regularly scheduled hours in the Facility, and who assumes the overall responsibility for coordinating the care of all patients.

Part-time Employee: An Employee who is not regularly scheduled to work for the Employer for at least the minimum number of hours shown in the Eligibility section of this Plan Document.

Physical Therapy: Management of the patient's movement system. This includes conducting an examination; alleviating impairments and functional limitation; preventing Injury, impairment, functional limitation and disability; and engaging in consultation, education and research. Direct interventions include the appropriate use of patient education, therapeutic exercise and physical agents such as massage, thermal modalities, hydrotherapy and electricity.

Physically Handicapped or Intellectually Disabled: The inability of a person to be self-sufficient as the result of a condition such as intellectual disability, cerebral palsy, epilepsy or another neurological disorder and diagnosed by a Physician as a permanent and continuing condition.

Physician: A person acting within the scope of his/her license and holding the degree of Doctor of Medicine (MD) or Doctor of Osteopathy (DO) and who is legally entitled to practice medicine in all its branches under the laws of the State or jurisdiction where the services are rendered.

Placement for Adoption: A Child placed with the Covered Employee for adoption, whether or not the adoption has become final, will be considered eligible and will be covered from the date of such adoption or Placement for Adoption. "Placement" means the assumption and retention by the Covered Employee of a legal obligation for total or partial support of such Child in anticipation of adoption of such Child.

Plan: Without qualification, this Plan Document/Summary Plan Description, including any Plan Amendments thereto.

Plan Administrator: Gunnison County, Colorado, who is responsible for the day-to-day functions and arrangements of the Plan. The Plan Administrator may employ persons or firms to process Claims and perform other Plan connected services.

Plan Amendment: A formal document that changes the provisions of the Plan Document, duly signed by the authorized person or persons as designated by the Plan Sponsor.

Plan Participant: Eligible Employee, Eligible Dependent, eligible COBRA Qualified Beneficiary or a COBRA Qualified Beneficiary's Dependent properly enrolled in the Plan.

Plan Sponsor: Gunnison County, Colorado.

Plan Year: The twelve (12) month period beginning on January 1 and ending December 31 of each Calendar Year. The Plan Year is the year on which Plan records are kept.

Practitioner: A Physician or person acting within the scope of applicable State licensure/certification requirements including the following:

1. Advanced Practice Nurse (APN)
2. Audiologist
3. Board Certified Behavior Analyst (BCBA)
4. Certified Diabetic Educator and Dietitian
5. Certified Nurse Midwife (CNM)
6. Certified Operating Room Technician (CORT)
7. Certified Registered Nurse Anesthetist (CRNA)
8. Certified Surgical Technician (CST)
9. Doctor of Chiropractic (DC)
10. Doctor of Dental Medicine (DMD)
11. Doctor of Dental Surgery (DDS)
12. Doctor of Medicine (MD)
13. Doctor of Optometry (OD)
14. Doctor of Osteopathy (DO)
15. Doctor of Podiatric Medicine (DPM)
16. Licensed Acupuncturist (LAC)
17. Licensed Clinical Social Worker (LCSW)
18. Licensed Marriage and Family Therapist (LMFT)
19. Licensed Occupational Therapist
20. Licensed or Registered Physical Therapist
21. Licensed Practical Nurse (LPN)
22. Licensed Professional Counselor (LPC)
23. Licensed Surgical Assistant (LSA)
24. Licensed Vocational Nurse (LVN)
25. Master of Social Work (MSW)
26. Physician Assistant (PA)
27. Psychologist (PhD, EdD, PsyD)
28. Registered Nurse (RN)
29. Registered Nurse First Assistant (RNFA)
30. Registered Nurse Practitioner (RN-NP)
31. Speech Language Pathologist

Preferred Provider Organization (PPO): An alternate health care delivery system with which Plan Administrators may contract to provide comprehensive medical care for Employees. A PPO is a network of individual Physicians and other Providers who accept pre-negotiated, discounted fees for services rendered. Employee participation is encouraged by plan design for improved benefits when network Providers are used. Employees have flexibility under PPO arrangements in which there is a choice of network or non-network Providers.

Pregnancy: The physical state which results in childbirth, life-threatening abortion, or miscarriage, and any medical complications arising out of, or resulting from, such state.

Prescription Drugs: Licensed medicine that is government regulated which must be prescribed by a Qualified Prescriber before it can be obtained.

Preventive Care: This Plan intends to comply with the Patient Protection and Affordable Care Act's (PPACA) requirement to offer in-network coverage for certain preventive services without cost-sharing. To comply with PPACA, and in accordance with the recommendations and guidelines, the Plan will provide in-network coverage for:

- Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations;
- Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention;

- Comprehensive guidelines for infants, Children, and adolescents supported by the Health Resources and Services Administration (HRSA); and
- Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines with services listed by group (all adults, women, children) may be found here: https://www.healthcare.gov/coverage/preventive-care-benefits/. For more information, you may contact the Plan Administrator / Employer at 1-970-641-7623.

Privacy Regulation: The regulations issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended.

Private Duty Nursing: Continuous skilled care or intermittent care by a Registered Nurse (RN), Licensed Practical Nurse (LPN) or Licensed Vocational Nurse (LVN) while a patient is not confined in a Hospital.

Protected Health Information (PHI): Individually identifiable health information that is created or received by a Covered Entity (the Plan) and relates to: (a) a person's past, present or future physical or mental health or condition; (b) provision of health care to that person; or (c) past, present or future payment for that person's health care. This term shall be construed in accordance with the Privacy Regulation.

Provider: A Physician, Practitioner, health care professional or health care Facility licensed, certified or accredited as required by state law.

Psychiatric Treatment Facility: A mental health Facility which:

1. Provides treatment for individuals who suffer from acute Mental Disorders;
2. Uses a structured psychiatric program with Individual Treatment Plans that have specified goals and appropriate objectives for the patient and treatment modality of the program; and
3. Is clinically supervised by a Physician of medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology.

Qualified Individual: Someone who is eligible to participate in an "Approved Clinical Trial" and either the individual's doctor has concluded that participation is appropriate or the participant provides medical and scientific information establishing that their participation is appropriate.

Qualified Medical Child Support Order (QMCSO): As originally enacted in OBRA 1993, as amended, a Medical Child Support Order that satisfies the following requirements to be a Qualified Medical Child Support Order:

1. The name and last known mailing address of the Plan Participant;
2. The name and address of each Alternate Recipient. "Alternate Recipient" means any Child of a Plan Participant who is recognized under a Medical Child Support Order as having a right to enrollment under a group health plan with respect to such Plan Participant;
3. A reasonable description of the type of coverage to be provided by the group health plan or the manner in which coverage will be determined;
4. The period for which coverage must be provided; and
5. Each plan to which the order applies.

Qualified Medical Child Support Orders include not only court orders, but also administrative processes established under State law.

Qualifying Payment Amount: The median of the contracted rates recognized by the Plan, or recognized by all plans serviced by the Plan's Third Party Administrator (if calculated by the Third Party Administrator), for the same or a similar item or service provided by a Provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning at least three) contracted rates available to determine a Qualifying Payment Amount, said amount will be determined by referencing a State all-payer claims database or any eligible third-party database in accordance with applicable law.

Reasonable: In the Plan Administrator's discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of Illness or Injury not caused by the treating Provider. Determination that fee(s) or services are Reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of Injury or Illness necessitating the service(s) and/or charge(s).

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be Reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, are not Reasonable. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Administrator. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

Charge(s) and/or services are not considered to be Reasonable, and as such are not eligible for payment (exceed the Maximum Allowable Charge), when they result from Provider error(s) and/or Facility-acquired conditions deemed "reasonably preventable" through the use of evidence-based guidelines, taking into consideration, but not limited to, CMS guidelines.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and, therefore, not eligible for payment by the Plan.

Recognized Amount: Except for Out-of-Network air ambulance services, an amount determined under an applicable all-payer model agreement or, if unavailable, an amount determined by applicable State law. If no such amounts are available or applicable and for Out-of-Network air ambulance services generally, the Recognized Amount shall mean the lesser of a Provider's billed charge or the Qualifying Payment Amount.

Reconstructive Surgery: A procedure performed to restore the anatomy and/or functions of the body which were lost or impaired due to an Injury or Illness.

Registered Nurse (RN): An individual who has received specialized nursing training and is authorized to use the designation of "RN," and who is duly licensed by the State or regulatory agency responsible for such licensing in the State in which the individual performs such nursing services.

Rehabilitation Facility: A legally operating institution or distinct part of an institution which has a transfer agreement with one or more Hospitals, and which is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post-acute Hospital and rehabilitative Inpatient care, and is duly licensed by the appropriate government agency to provide such services. It does not include institutions which provide only minimal care, Custodial Care, ambulatory, or part-time care services, or an institution which primarily provides treatment of Mental Disorders or Chemical Dependency, except if such Facility is licensed, certified or approved as a Rehabilitation Facility for the treatment of mental conditions or Drug addiction or Chemical Dependency in the jurisdiction where it is located, or it is accredited as such a Facility by the Joint Commission on the Accreditation of Health Care Organizations, or the Commission on the Accreditation of Rehabilitation Facilities.

Residential Treatment Center: Facility that provides twenty-four (24) hour treatment for Chemical Dependency, Drug and Substance Abuse or mental health problems on an Inpatient basis. It must provide at least the following: Room and Board; medical services; nursing and dietary services; patient diagnosis, assessment and treatment; individual, Family and group counseling; and educational and support services. A Residential Treatment Center is recognized if it is accredited for its stated purpose by the Joint Commission on Accreditation of Hospitals and carries out its stated purpose in compliance with all relevant State and local laws.

Retrospective Review: A determination by Utilization Review that medical services performed either Inpatient or Outpatient met criteria for Medical Necessity.

Room and Board: All charges, by whatever name called, which are made by a Hospital, Hospice, Skilled Nursing Facility, Rehabilitation Facility or other covered Facilities as a condition of Inpatient confinement as a bed patient. Such charges do not include the professional services of Physicians nor intensive nursing care, by whatever name called.

Routine Newborn Care: Inpatient charges for a well newborn Child for nursery Room and Board, related expenses following birth, including newborn hearing exams and Physician's pediatric services including circumcision. This term does not apply to a newborn Child's diagnosed Illness.

Routine Patient Cost(s): All items and services consistent with the coverage provided in the Plan that is typically covered for a Qualified Individual who is not enrolled in a clinical trial. Routine Patient Costs do not include: 1) the Investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the Plan's network area unless out-of-network benefits are otherwise provided under the Plan.

Seasonal Employee: An Employee who is hired into a position for which the customary annual employment is six (6) months or less.

Security Incidents: "Security Incidents" has the meaning set forth in 45 C.F.R. Section 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

Series of Treatments: A Series of Treatments is a planned, structured program which may include Inpatient or Outpatient treatment and is complete when the Covered Person is discharged on medical advice from Inpatient care, Day Treatment or Outpatient Treatment without a lapse in treatment or when a person fails to materially comply with the treatment program for a period of thirty (30) days.

Serious Mental Illness: Defined as any one of the following eight (8) categories:

1. Schizophrenia
2. Paranoid and other psychotic disorders
3. Bipolar disorders (mixed, manic and depressive);
4. Major depressive disorders (single episode or recurrent);
5. Schizo-affective disorders (bipolar or depressive);
6. Pervasive developmental disorders;
7. Obsessive compulsive disorder; and
8. Depression in childhood and adolescence.

Skilled Nursing Facility/Extended Care Facility: An institution that:

1. Primarily provides skilled, as opposed to custodial, nursing services to patients; and
2. Is approved by the Joint Commission on the Accreditation of Health Care Organizations and/or Medicare.

Sleep Disorder: Medical/psychological condition that disrupts the patient's sleep on a chronic basis.

Special Enrollee: An Eligible Employee and his/her Eligible Dependents who have Special Enrollment rights and who enroll in the Plan during a Special Enrollment Period.

Special Enrollment Period: The period of thirty (30) days in which an Eligible Employee or Dependent who previously declined enrollment in the Plan by signing a waiver of coverage can enroll in the Plan. The Special Enrollment Period for both Employees and Dependents can be activated by:

1. Loss of eligibility for other coverage (except for cause or non-payment of premium);
2. A new Dependent acquired by an Employee through marriage, birth, adoption or Placement for Adoption;
3. Loss of eligibility under Medicaid or a State Children's Health Insurance Program (CHIP) (in which case the Special Enrollment Period is sixty (60) days); or
4. Gain of eligibility for a premium assistance subsidy under Medicaid or CHIP (in which case the Special Enrollment Period is sixty (60) days).

Speech Therapy: A program which evaluates the patient's motor-speech skills, expressive and receptive language skills, writing and reading skills, and determines if the patient requires an extensive hearing evaluation by an audiologist. The therapist also evaluates the patient's cognitive functioning, as well as his/her social interaction skills, such as the ability to maintain eye contact and initiate conversation. Therapy may also involve developing the patient's speech, listening and conversational skills and higher-level cognitive skills, such as understanding abstract thought, making decisions, sequencing, etc. Therapy must be considered medically appropriate even for patients who do not have apparent speech problems, but who do have deficits in higher-level language functioning as a result of trauma or identifiable organic Disease process.

Stability Period: A period selected by the Employer that immediately follows, and is associated with, a Standard Measurement Period or an Initial Measurement Period and, if elected by the Employer, the Administrative Period associated with that Standard Measurement Period or Initial Measurement Period, and is used by the Employer as part of the look back Measurement Method. The Stability Period is a period of time in which the Variable Hour Employee's and/or Ongoing Employee's eligibility status is fixed.

Status Change: Cafeteria plans (under Section 125 of the Internal Revenue Code) permit coverage changes during a Plan Year when a change in status occurs that affects gain or loss of eligibility for coverage for the Employee, the Employee's spouse or Dependent. Some examples of a Status Change are: change in Employee's legal marital status, change in number of Employee's Dependents, change in employment status of Employee, spouse or Dependent and loss of other coverage.

Substance Abuse: The excessive use of a substance, especially alcohol or a Drug. The current edition of *Diagnostic and Statistical Manual* definition is applied as follows:

1. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a twelve (12) month period:

    a. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (i.e., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of Children or household);
    b. Recurrent substance use in situations in which it is physically hazardous (i.e., driving an automobile or operating a machine when impaired by substance use);
    c. Recurrent substance-related legal problems (i.e., arrests for substance-related disorderly conduct); and
    d. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (i.e., arguments with spouse about consequences of intoxication, physical fights).

2. The symptoms have never met the criteria for Substance Dependence for this class of substance.

Substance Abuse Treatment Center: An Institution which provides a program for the treatment of Substance Abuse by means of a written treatment plan approved and monitored by a Physician. This Institution must be:

1. Affiliated with a Hospital under a contractual agreement with an established system for patient referral;

2. Accredited as such a Facility by the Joint Commission on Accreditation of Hospitals; or
3. Licensed, certified or approved as an alcohol or Substance Abuse treatment program or center by a State agency having legal authority to do so.

Substance Dependence: Substance use history which includes the following:

1. Substance abuse (see above);
2. Continuation of use despite related problems;
3. Development of tolerance (more of the Drug is needed to achieve the same effect); and
4. Withdrawal symptoms.

Surgery: Any of the following:

1. The incision, excision, debridement or cauterization of any organ or part of the body, and the suturing of a wound;
2. The manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;
3. The removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body;
4. The induction of artificial pneumothorax and the injection of sclerosing solutions;
5. Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;
6. Obstetrical delivery and dilatation and curettage; or
7. Biopsy.

Surgical Procedure: Surgical Procedures will include all CPT (Current Procedural Terminology) codes from 10000 to 69999.

TEFRA: Tax Equity and Fiscal Responsibility Act of 1982, as amended from time to time.

Temporomandibular Joint (TMJ) Disorders: Disorders that affect the temporomandibular joints at either side of the jaw also known as myofascial pain-dysfunction syndrome.

Total Disability (Totally Disabled): A physical state of a Covered Person resulting from an Illness or Injury which wholly prevents:
1. An Employee from engaging in any and every business or occupation and from performing any and all work for compensation or profit; or
2. A Dependent or a COBRA Qualified Beneficiary from performing the normal activities of a person of that age and sex in good health.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA): A Federal law which applies to persons who have been absent from work because of "service in the uniformed services." "Uniformed services" consists of the United States Army, Navy, Marine Corps, Air Force or Coast Guard; Army Reserve, Naval Reserve, Marine Corps Reserve, Air Force Reserve or Coast Guard Reserve; Army National Guard or Air National Guard; Commissioned Corps of the Public Health Service; any other category of persons designated by the President in time of war or Emergency. "Service" in the uniformed services means: active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty and absence from work for an examination to determine a person's fitness for any of the designated types of duty.

UR Notification: A Plan requirement for a Covered Person to advise Utilization Review of a Hospital admission, health care service, treatment plan, Prescription Drug or Durable Medical Equipment that results in a decision by the Plan that such service is Medically Necessary. The Plan may require notification for certain services as they are received, except in an Emergency. UR Notification is not a guarantee the Plan will cover the cost of such services.

Urgent Care Facility (Minor Emergency Medical Clinic): A Free-standing Facility which is engaged primarily in providing minor Emergency and episodic medical care to a Covered Person. A board-certified Physician, a Registered Nurse (RN), and a registered x-ray technician must be in attendance at all times

that the clinic is open. The clinic's Facilities must include x-ray and laboratory equipment and a life support system. For the purposes of this Plan, a clinic meeting these requirements will be considered to be an Urgent Care Facility (Minor Emergency Medical Clinic), by whatever actual name it may be called; however, a clinic located on the premises of, or in conjunction with, or in any way made a part of, a regular Hospital shall be excluded from the terms of this definition.

Usual and Customary: Covered expenses which are identified by the Plan Administrator, taking into consideration the fee(s) which the Provider most frequently charges the majority of patients for the service or supply, the cost to the Provider for providing the services, the prevailing range of fees charged in the same "area" by Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care Facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was incurred.

The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of an individual of the same sex, comparable age and who has received such services or supplies within the same geographic locale.

The term "Usual and Customary" does not necessarily mean the actual charge made nor the specific service or supply furnished to a Plan Participant by a Provider of services or supplies, such as a Physician, therapist, Nurse, Hospital, or pharmacist. The Plan Administrator will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service or supply is customary.

Usual and Customary charges may, at the Plan Administrator's discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.
For Claim determinations made in accordance with the Claim Review and Audit Program, the Usual and Customary fee will be the Allowable Claim Limits. Please refer to the section, "Claim Review and Audit Program," for the definition of Allowable Claim Limits.

Utilization Review (UR): Process by which consistent and measurable standards are applied in which to evaluate and control health care utilization by determining appropriateness of care, setting and Medical Necessity.

Utilization Review Department: The Utilization Review Department provides consistent and measurable standards in which to evaluate and control health care utilization by determining appropriateness of care, setting and Medical Necessity. The department's role is to ensure the best use of health care services, eliminating unnecessary costs while maintaining consideration for the patient's best interests.

Variable Hour Employee: An Employee, based on the facts and circumstances at the Employee's start date, whose reasonable expectation of average hours per week cannot be determined. **This also includes Part-time, Temporary and Seasonal Employees.**

Waiting Period: The period of time that must pass before Plan coverage can become effective for an otherwise Eligible Employee or Dependent. An Employee shall be deemed Actively at Work if the Employee is absent from work due to a health factor.

Well Baby Care or Well Child Care: Medical treatment, services or supplies rendered to a Child, solely for the purpose of health maintenance and not for the treatment of an Illness or Injury, to include medical screenings for vision and hearing.

AMENDMENT #4

To Plan Document Dated September 1, 2017
and Restated January 1, 2020

GUNNISON COUNTY, COLORADO
EMPLOYEE MEDICAL BENEFIT PLAN

COST PLUS PLAN

The following changes to the Plan Document are effective January 1, 2023:

1. All references to "Group & Pension Administrators, Inc.," "Group & Pension Administrators, Inc. (GPA)," and "Group & Pension Administrators, LLC dba GPA" are deleted and replaced as follows:

   Imagine360 Administrators, LLC

2. All references to "ELAP Services, LLC and/or ELAP are deleted and replaced with:

   Imagine360

3. General Information and Purpose, page 4, Utilization Review is deleted and replaced as follows:

   Utilization Review Department
   Imagine360 Administrators, LLC
   Park Central 8
   12770 Merit Drive, Suite 200
   Dallas, Texas 75251
   972-744-2486 ◆ 866-206-3224

4. General Information and Purpose, page 4, GPA Group Number is deleted and replaced as follows:

   Group Number
   H880141

5. Schedule of Benefits – Traditional Plan, page 20, Level I Benefits - Colonoscopy, is deleted and replaced as follows:

Colonoscopy (including polyp removal) (Routine or Diagnostic)	100% of Allowable Claim Limits Deductible waived	Benefit applies beginning at age 45 or Family history of colon cancer with or without diagnosis.

6. Schedule of Benefits – Traditional Plan, page 26, UCM Digital Health, is deleted and replaced as follows:

Telehealth/Telemedicine Consultation (telephone or online – 24/7 unlimited access • Virtual Emergent and Urgent Care • Virtual Primary Care • Virtual Mental Health Services	100%; no Copay or Consultation fee 100% after $20 Copay Deductible waived 100% after $20 Copay Deductible waived	

7. Schedule of Benefits – Traditional Plan, page 27, item #13, Routine Colonoscopy, is deleted and replaced as follows:

13. *Routine/Diagnostic Colonoscopy (including polyp removal - beginning at age 45 with or without a diagnosis or Family history of colon cancer)

8. Schedule of Benefits – High Deductible Health Plan, page 30, Level I Benefits - Colonoscopy, is deleted and relaced as follows:

Colonoscopy (including polyp removal) (Routine or Diagnostic)	100% of Allowable Claim Limits Deductible waived	Benefit applies beginning at age 45 or Family history of colon cancer with or without diagnosis.

9. Schedule of Benefits – High Deductible Health Plan, page 35, UCM Digital Health, is deleted and replaced as follows:

Telehealth/Telemedicine Consultation (telephone or online – 24/7 unlimited access • Virtual Emergent and Urgent Care • Virtual Primary Care • Virtual Mental Health Services	$10 Consultation Fee Fee applies to satisfy PPO Deductible and PPO Annual Out-of-Pocket Maximum. 100% after PPO Deductible 100% after PPO Deductible	

10. Schedule of Benefits – High Deductible Health Plan, page 36, item #13, Routine Colonoscopy, is deleted and replaced as follows:

13. *Routine/Diagnostic Colonoscopy (including polyp removal - beginning at age 45 with or without a diagnosis or Family history of colon cancer)

11. All references to “GPA HW Cancer Care Program,” “HW Cancer Care Program” and “GPA’s HealthWatch department’s Cancer Care Program” are deleted and replaced as follows:

    Cancer Care Program

12. All references to “GPA’s HealthWatch department’s Cancer Care nurse” and “HW Cancer Care Program Nurse” are deleted and replaced as follows:

    Cancer Care Program nurse

13. All references to “memberservices@gpatpa.com” are deleted and replaced as follows:

    memberservices@imagine360.com

14. Coordination of Care, page 45, Coordination of Care Requirements, the first paragraph is deleted and replaced as follows:

    Contact the Utilization Review Department for Coordination of Care prior to receiving the following services:

15. The section entitled “GPA Nurse Navigator℠,” page 47, is deleted from the Plan Document in its entirety.

16. All remaining references to GPA Nurse Navigator℠ are deleted and replaced as follows:

    Imagine360 Member Services

17. All references to the phone number for GPA Nurse Navigator℠, 800-843-6705, are deleted and replaced as follows:

    the number shown on your ID card

18. Major Medical Expense Benefits, page 55, Genetic Testing, is added as follows:

    Genetic Testing. The charges for genetic testing, if Medically Necessary and indicated under nationally accepted guidelines, and genetic testing as required under Preventive Services.

19. Major Medical Expense Benefits, page 59, Telehealth/Telemedicine Consultations, is added as follows:

    Telehealth/Telemedicine Consultations. The charges for a consultation (telephone or online) with a Physician and/or other Providers through the Plan’s telehealth/telemedicine vendor(s), to include Virtual Emergent and Urgent Care and Virtual Primary Care/Virtual Mental Health Services.

20. Major Medical Plan Exclusions and Limitations, page 60, Consultations Online/Telephone, is deleted and replaced as follows:

    Consultations (Online/Telephone). Charges for telephone or online consultations with a Physician and/or other Providers except for consultations through the Plan’s telehealth/telemedicine vendor(s).

21. Major Medical Expense Benefits, page 61, Genetic Testing, is deleted from the Plan Document.

22. Claim Review and Audit Program, page 75, item #2a, is deleted and replaced as follows:

    2. **Guidelines.** The following guidelines will be used when determining Allowable Claim Limits:

        a. Facilities. The Allowable Claim Limit for Claims by a Facility, including but not limited to, Hospitals, emergency and urgent care centers, rehabilitation and skilled nursing centers, and any other health care Facility, shall be the greater of (I) 112% of the Facility's most recent departmental cost ratio, reported to the Centers for Medicare and Medicaid Services ("CMS") and published in the American Hospital Directory as the "Medicare Cost Report" (the "CMS Cost Ratio"), or (II) the Medicare allowed amount for the services in the geographic area plus an additional 20%. The Allowable Claim Limit for (I) shall not exceed 250% of the federal non-commercial Medicare allowed amount, except for children's hospitals, which shall not exceed 350% of the federal non-commercial Medicare allowed amount. If insufficient information is available to identify either the Facility's most recent departmental cost ratio or the Medicare allowed amount, the Allowable Claim Limit shall be either (I) or (II) herein that can be identified.

23. Definitions, page 115, Directly Contracted Provider, is deleted and replaced as follows:

    A medical Provider, supplemental benefit provider, and/or supplemental network partner which has entered into a Direct Agreement with Imagine360, including any affiliates, or the Plan Sponsor to provide certain medical services to Covered Persons at agreed upon Allowable Claim Limits.

24. Definitions, page 132, Utilization Review (UR) Department is deleted and replaced as follows:

    Utilization Review Department: The Utilization Review Department provides consistent and measurable standards in which to evaluate and control health care utilization by determining appropriateness of care, setting and Medical Necessity. The department's role is to ensure the best use of health care services, eliminating unnecessary costs while maintaining consideration for the patient's best interests.

25. Definitions, new definitions are added to the Plan Document as follows:

    Virtual Emergent and Urgent Care: 24/7 on-demand care from a dedicated team of board-certified Providers, including emergency medicine trained Providers, Physician Assistants, and Nurse Practitioners, to treat common, yet urgent, conditions and to assist patients with healthcare needs delivered via virtual platform. Such services shall include, but shall not be limited to, taking of medical histories, examination of patients, development of care plans, prescription writing, and referrals. Examples of conditions treated include any non-life threatening emergency, Illness or Injury, an emergency related to acute or chronic conditions, upper respiratory infection, urinary tract infection, cough, sore throat, COVID-19, the flu, nausea, vomiting, diarrhea and dermatology.

    Virtual Mental Health Services: Virtual mental health services shall include evaluation, counseling, therapy, treatment, care management, triage, guidance, education and training services provide by mental health professionals to patients. Such services shall include, but not be limited to, taking mental health histories, triage and assessment of patients, counseling and care management, development of care plans and referrals and they may be either scheduled or unscheduled and delivered via virtual platform. Virtual mental health and substance abuse counseling will be confidential and provided either on-demand or scheduled with Masters and PhD level counselors. Virtual psychiatry evaluations by psychiatric Providers shall include, but not be limited to, diagnosis and treatment of mental health conditions, new prescriptions and maintenance medication refills.

    Virtual Primary Care: Scheduled appointments, including same day appointment availability, for wellness, preventative, routine and ongoing care from a team of primary care Providers. Virtual Primary Care services shall include, but not be limited to, taking of medical histories, examination of patients, development of care plans, performing annual physicals, ordering and interpretation of medical diagnostic tests and imaging, prescription writing, and referrals.

26. All remaining references to “GPA’s HealthWatch department” and to “HealthWatch” are deleted and replaced as follows:

    medical management

In all other respects, the Plan Document remains unchanged.

Acknowledged by:

Gunnison County, Colorado:

By: _____

Printed Name: Jonathan Houck

Title: Chair, Board of County Commissioners

Date: 6-6-2023

AMENDMENT #3

To Plan Document Dated September 1, 2017
and Restated January 1, 2020

GUNNISON COUNTY, COLORADO
EMPLOYEE MEDICAL BENEFIT PLAN

COST PLUS PLAN

The following changes to the Plan Document are effective January 1, 2022:

Schedule of Benefits – Traditional Plan, pages 19 and 22, are deleted in their entirety and replaced with attached revised pages 19 and 22.

In all other respects, the Plan Document remains unchanged.

Acknowledged by:

Gunnison County, Colorado

By: Docusigned by: Lauren Trautz 195D4D36AD284A4...

Printed Name: Lauren Trautz

Title: HR Director

Date: 11/2/2022

SCHEDULE OF BENEFITS – TRADITIONAL PLAN (Cont'd.)

LEVEL I BENEFITS – Payment Levels and Limits:
This section applies to covered services rendered by Hospitals and other Facilities shown in the preceding Level I Providers list and to charges for services rendered by Providers billing "as a Facility." The benefits shown apply to all such covered, licensed, accredited Providers of service **without regard to participation in a Preferred Provider Organization (PPO) network**.

NO SURPRISES ACT - Emergency Services and Surprise Bills
For Out-of-Network Claims subject to the No Surprises Act ("NSA") (part of the Consolidated Appropriations Act of 2021), a Participant's cost-sharing will be the same amount as would be applied if the Claim was provided by an Imagine Provider and will be calculated as if the Plan's Allowable Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Charge. The NSA prohibits Providers from pursuing Participants for the difference between the Maximum Allowable Charge and the Provider's billed charge for applicable services. Cost-sharing amounts will accrue toward In-Network Deductibles and Out-of-Pocket Maximums.

Benefits for Claims subject to the NSA will be denied or paid within thirty (30) days of receipt of an initial Claim and, if approved, will be paid directly to the Provider.

Claims subject to the NSA are those which are submitted for:

- Emergency Services; and
- Covered Out-of-Network air ambulance services.

Coordination of Care Requirements	
Coordination of Care required for the following services: • Inpatient Hospital/Facility Admissions • Inpatient Hospice • Home Health Care • Other Specified Level I and Level II Services	See Coordination of Care section for additional information.
Utilization Review (UR) Notification Requirements	
Utilization Review required for: • Products included on the Select Drugs and Products List (check Select Drugs and Products List for additional information) **NOTE:** Products must be ordered through Noble Health Services Specialty Pharmacy at 888-843-2040.	Non-compliance Penalty: 100% reduction in benefits payable Non-compliance penalty applies for failure to notify Utilization Review and enroll in the Specialty Drugs Program. See Coordination of Care section and "Specialty Drugs Program" under the Prescription Drug Plan Benefits section for additional information.

Benefit Percentage For:	**Level I Benefit**	**Maximum Benefits, Limits & Provisions**
Gunnison Valley Health Systems Inpatient/Outpatient Services		
Gunnison Valley Health Systems Inpatient / Outpatient Services	80% of negotiated rate Deductible applies	
Hospital/Facility Inpatient Services		
Inpatient Hospital Services	80% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Contact Utilization Review for Coordination of Care.
Maternity Inpatient Hospital Services	80% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Contact Utilization Review for Coordination of Care.

LEVEL II BENEFITS – Payment Levels and Limits:
This section applies to covered services rendered by Physicians and all other Providers not listed in Level I. Benefits shown are payable **based upon the Provider's participation in the Preferred Provider Organization (PPO) network.** Non-PPO Covered Charges are subject to Allowable Claim Limits.

The "Level II PPO Benefit" applies to services rendered by Preferred Providers in the designated PPO Network (In-Network); the "Level II Non-PPO Benefit" applies to services rendered by Providers other than Preferred Providers (Out-of-Network).

NO SURPRISES ACT - Emergency Services and Surprise Bills
For Out-of-Network Claims subject to the No Surprises Act ("NSA") (part of the Consolidated Appropriations Act of 2021), a Participant's cost-sharing will be the same amount as would be applied if the Claim was provided by an Imagine Provider and will be calculated as if the Plan's Allowable Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Charge. The NSA prohibits Providers from pursuing Participants for the difference between the Maximum Allowable Charge and the Provider's billed charge for applicable services. Cost-sharing amounts will accrue toward In-Network Deductibles and Out-of-Pocket Maximums.

Benefits for Claims subject to the NSA will be denied or paid within thirty (30) days of receipt of an initial Claim and, if approved, will be paid directly to the Provider.

Claims subject to the NSA are those which are submitted for:

- Emergency Services; and
- Covered Out-of-Network air ambulance services.

Maximum Benefits, Limits and Provisions are subject to all other Plan exclusions, limitations and provisions set forth in this Plan.

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
Physician Services			
Gunnison Valley Health Systems Inpatient/ Outpatient Physician Services	80% of negotiated rate Deductible applies		
Physician Hospital Visits/Surgeon	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
Physician Hospital Visit for Mental Disorders/ Chemical Dependency, Drug and Substance Abuse	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
Emergency Room Physician	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
Maternity (Including prenatal care, delivery and postnatal care, except initial visit) Lab and X-ray Benefit applies. Initial Visit	80% of PPO rate Deductible applies 100% of PPO rate Deductible waived	80% of Allowable Claim Limits Deductible applies 100% of Allowable Claim Limits Deductible waived	Contact Utilization Review for Coordination of Care.

AMENDMENT #2

To Plan Document Dated September 1, 2017
and Restated January 1, 2020

GUNNISON COUNTY, COLORADO
EMPLOYEE MEDICAL BENEFIT PLAN

COST PLUS PLAN

The following changes to the Plan Document are effective January 1, 2020:

1. Schedule of Benefits – Traditional Plan, page 22, is deleted in its entirety and replaced with the attached revised page 22.

2. Schedule of Benefits – High Deductible Health Plan, page 32, is deleted in its entirety and replaced with the attached revised page 32.

The following changes to the Plan Document are effective January 1, 2022:

1. All references in the Plan Document to "Free-standing Emergency Room Facility" are deleted and replaced as follows:

   Independent Freestanding Emergency Department

2. Introduction, page 7 is deleted in its entirety and replaced with attached revised page 7.

3. Schedule of Benefits – Traditional Plan, pages 18, 19,19a, 20, 22, 25, 25a, 26 and 27 are deleted in their entirety and replaced with attached revised pages 18, 19, 19a, 20, 22, new page 22a, 25, 25a, 26 and 27.

4. Schedule of Benefits – High Deductible Health Plan, pages 28, 29, 29a, 30, 32, 34, 34a, 35 and 36 are deleted in their entirety and replaced with attached revised pages 28, 29, 29a, 30, 32, new page 32a, 34, 34a, 35 and 36.

5. Prescription Drug Plan Benefits, pages 41, 42, 43 and 44 are deleted in their entirety and replaced with the attached revised pages 41, 42, 43, 44 and new page 44a.

6. Case Management, pages 45 and 45a are deleted in their entirety and replaced with the attached revised page 45. Page 45a is deleted in its entirety.

7. Comprehensive Medical Benefits, pages 49, 49a, 50 and 51 are deleted in their entirety and replaced with the attached revised page 49, 50 and 51. Page 49a is deleted in its entirety.

8. Major Medical Expense Benefits, page 52, Autism Spectrum Disorder is deleted and replaced as follows:

   Autism Spectrum Disorder. The charges for treatment of Autism Spectrum Disorder, not subject to the Plan's internal Therapy Maximums. Treatment includes all generally recognized services prescribed in relation to Autism Spectrum Disorder by the patient's Physician. "Generally recognized services" may include services such as evaluation and assessment, Applied Behavior Analysis (ABA) Therapy, behavior training and management, Speech Therapy, Occupational Therapy, Physical Therapy and medications or nutritional supplements used to address symptoms of Autism Spectrum Disorder.

9. Major Medical Expense Benefits, page 55, Drugs is deleted and replaced as follows:

   Drugs. The charges for Drugs requiring the written prescription of a licensed Physician; such Drugs must be Medically Necessary for the treatment of an Illness or Injury. See Prescription Drug Plan section. Prescription Drugs are covered by the Prescription Drug Card, Mail Order Service, or Specialty Pharmacy and not payable under Major Medical Expense Benefits. However, Specialty Drugs that are not listed on the Plan's Select Drugs and Products List (SDL) which are excluded from the Prescription Drug Plan and are determined to be Medically Necessary are payable under Major Medical Expense Benefits. Regarding Specialty Drugs that are listed on the Select Drugs and Products List (SDL) which are excluded from the Prescription Drug Plan and are determined to be Medically Necessary, see "Specialty Drugs Program" in the Prescription Drug Plan Benefits section.

10. Major Medical Expense Benefits, page 56, Hospital is deleted and replaced as follows:

    Hospital. The charges for:

    1. The actual Room and Board expenses incurred for confinement in a regular Hospital room;
    2. The actual expense incurred for confinement in an Intensive Care Unit, a Cardiac Care Unit or Burn Unit;
    3. Miscellaneous Hospital services and supplies during Hospital confinement;
    4. Inpatient Charges for nursery Room and Board;
    5. Outpatient Hospital services and supplies; and
    6. Hospital Emergency Room services and supplies.

11. Major Medical Expense Benefits, page 58, Skilled Nursing Facility/Extended Care Facility is deleted and replaced as follows:

    Skilled Nursing Facility/Extended Care Facility. The charges incurred for confinement in a Skilled Nursing Facility/Extended Care Facility; however, the attending Physician must certify that confinement is Medically Necessary and only charges incurred in connection with care related to the Injury or Illness for which the Covered Person was Hospital confined will be eligible.

12. Major Medical Expense Benefits, page 59, UCM Digital Health is added to the Plan Document as follows:

    UCM Digital Health. The charges for a **UCM Digital Health** consultation (telephone or online) with a Physician.

13. Major Medical Plan Exclusions and Limitations, page 60, Consultations (Online/Telephone) is deleted and replaced as follows:

    Consultations (Online/Telephone). Charges for telephone or online consultations with a Physician and/or other Providers except for UCM Digital Health consultations.

14. Major Medical Plan Exclusions and Limitations, page 61, Hypnotherapy, Behavior Training and Biofeedback is deleted and replaced as follows:

    Hypnotherapy, Behavior Training and Biofeedback. Charges for hypnotherapy, Applied Behavior Analysis (ABA) Therapy and/or behavior training (except ABA Therapy and/or behavior training for treatment of Autism Spectrum Disorder) and biofeedback.

15. Claim Review and Audit Program, page 75 is deleted in its entirety and replaced with the attached revised page 75.

16. Procedures for Claims and Appeals, page 80, Appeal Process, new language is added before the last paragraph after item #11 as follows:

NOTE: When the dispute of a Claim payment or denial only involves payment amounts due from the Plan to the Out-of-Network Provider, and the Provider has no recourse against the Plan Participant under the No Surprises Act (NSA), the payment dispute may only be resolved through open negotiation, or the Independent Dispute Resolution (IDR) process as outlined in the NSA. There may be instances when a Plan Participant may appeal a Claim through this section concurrently with an Out-of-Network Provider's payment dispute through the IDR process.

17. Procedures for Claims and Appeals, page 84, External Review of Adverse Benefit Determination is deleted in its entirety and replaced as follows:

EXTERNAL REVIEW OF ADVERSE BENEFIT DETERMINATION

When the internal appeals procedures have been exhausted, the Claimant may elect to have an additional and final opportunity for a review of an Adverse Benefit Determination (including a final internal Adverse Benefit Determination) by an independent review organization (IRO). The IRO will be accredited by URAC or a similar nationally recognized accrediting organization for the purpose of conducting an independent and unbiased review.

The request for an external review must be filed by the Claimant within four (4) months following the Claimant's receipt of the notice of Adverse Benefit Determination or final internal Adverse Benefit Determination. However, if the Plan fails to strictly adhere to all the requirements of the internal claims and appeals process with respect to a Claim, the Claimant will be deemed to have exhausted the internal claims and appeals process, and the Claimant may initiate an external review and pursue any available remedies under applicable law, such as judicial review.

The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Claimant or beneficiary failed to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process, in accordance with the current Affordable Care Act regulations and other applicable law, applies only to:

1. Any eligible Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; its determination that a treatment is Experimental or Investigational; its determination whether a Claimant or beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program; its determination whether a plan or issuer is complying with the nonquantitative treatment limitation provisions of Code section 9812 and § 54.9812-1, which generally require, among other things, parity in the application of medical management techniques), as determined by the external reviewer.

2. An Adverse Benefit Determination that involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in the No Surprises Act.

3. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

There are two (2) types of external reviews; standard and expedited. An external review is a standard external review unless the timing required to perform a standard external review involves circumstances that would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the final internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency services but has not yet been discharged from the Facility. In such cases, the Plan will consider the external review to be an expedited review.

18. General Provisions, page 89, Fraud is deleted and replaced as follows:

FRAUD
The following actions by a Covered Person or a Covered Person's knowledge of such actions being taken by another, constitute fraud and will result in immediate, indefinite and permanent termination of all coverage under this Plan for the entire Family unit of which the Covered Person is a member:

1. Attempting to submit a Claim for benefits (which includes attempting to fill a prescription) for a person who is not a Covered Person in the Plan;
2. Attempting to file a Claim for a Covered Person for services that were not rendered or Drugs or other items that were not provided;
3. Providing false or misleading information in connection with enrollment in the Plan;
4. Providing any false or misleading information to the Plan; or
5. Providing any false or misleading information to the Specialty Drugs Program or those alternate funding programs that it identifies.

19. Definitions, page 115, Emergency Services is deleted and replaced as follows:

Emergency Services: With respect to an Emergency/Medical Emergency:

1. An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the Emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including Ancillary Services routinely available to the Emergency department to evaluate such Emergency medical condition; and

2. Within the capabilities of the staff and Facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

When furnished with respect to an Emergency/Medical Emergency, Emergency Services shall also include an item or service provided by a Non-PPO Provider or Facility (regardless of the department of the Hospital or Facility in which items or services are furnished) after the Participant is stabilized and as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the Emergency Services are furnished, until such time as the Provider determines that the Participant is able to travel using non-medical transportation or non-emergency medical transportation, and the Participant is in a condition to, and in fact does, give informed consent to the Provider to be treated as a Non-PPO Provider.

20. Definitions, page 119, Hospital Expenses is deleted and replaced as follows:

Hospital Expenses: Charges by a Hospital for Room and Board and/or for care in an Intensive Care Unit provided that such care is furnished at the direction of a Physician.

21. Definitions, page 120, Maximum Allowable Charge is deleted and replaced as follows:

Maximum Allowable Charge: The amount payable for a specific covered item under this Plan. For Claim determinations made in accordance with the Claim Review and Audit Program, the Maximum Allowable Charge will be limited to the Allowable Claim Limits. Please refer to the section, "Claim Review and Audit Program" for the definition of Allowable Claim Limits. For all other Claims, the Maximum Allowable Charge will be a negotiated rate, if one exists. For Claims subject to the No Surprises Act (see "No Surprises Act – Emergency Services and Surprise Bills" within the "Federal Laws" section), if no negotiated rate exists, the Maximum Allowable Charge will be an amount deemed payable by a Certified IDR Entity or a court of competent jurisdiction, if applicable.

If none of the above factors is applicable, the Maximum Allowable Charge will be determined and established by the Plan, at the Plan Administrator's discretion, using normative data and submitted information such as, but not limited to, any one or more of the following, in the Plan Administrator's discretion:

- Medicare reimbursement rates (presently utilized by the Centers for Medicare and Medicaid Services ["CMS"]).
- Prices established by CMS utilizing standard Medicare Payment methods and/or based upon supplemental Medicare pricing data for items Medicare does not cover based on data from CMS.
- Prices established by CMS utilizing standard Medicare payment methods and/or based upon prevailing Medicare rates in the community for non-Medicare Facilities for similar services and/or supplies provided by similarly skilled and trained Providers of care.
- Prices established by CMS utilizing standard Medicare payment methods for items in alternate settings based on Medicare rates provided for similar services and/or supplies paid to similarly skilled and trained Providers of care in traditional settings.
- Medicare cost data as reflected in the applicable individual Provider's cost report(s).
- The fee(s) which the Provider most frequently charges the majority of patients for the service or supply.
- Amounts the Provider specifically agrees to accept as payment in full either through direct negotiation or through a Preferred Provider Organization (PPO) network.
- Average wholesale price (AWP) and/or manufacturer's retail pricing (MRP).
- Medicare cost-to-charge ratios or other information regarding the actual cost to provide the service or supply.
- The allowable charge otherwise specified within the terms of this Plan.
- The prevailing range of fees charged in the same "area" (defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made) by Providers of similar training and experience for the service or supply.

The Plan Administrator may in its discretion, taking into consideration specific circumstances, deem a greater amount to be payable than the lesser of the aforementioned amounts. The Plan Administrator may take any or all such factors into account but has no obligation to consider any particular factor. The Plan Administrator may also account for unusual circumstances or complications requiring additional, or a lesser, amount of time, skill and experience in connection with a particular service or supply, industry standards and practices as they relate to similar scenarios, and the cause of Injury or Illness necessitating the service(s) and/or charge(s).

In all instances, the Maximum Allowable Charge will be limited to an amount which, in the Plan Administrator's discretion, is charged for services or supplies that are not unreasonably caused by the treating Provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of Provider negligence and/or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

The determination that fees for services are includable in the Maximum Allowable Charge will be made by the Plan Administrator, taking into consideration, but not limited to, the findings and assessments of the following entities: (a) The national medical associations, societies, and organizations; and (b) The Food and Drug Administration (FDA). To be includable in the Maximum Allowable Charge, services and fees must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The Plan Administrator has the discretionary authority to decide if a charge is covered under this Plan. The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

22. Definitions, page 126, Private is deleted in its entirety.

23. Definitions, page 128, Semi-Private is deleted in its entirety.

24. Definitions, the following new definitions are added to the Plan Document:

Certified IDR Entity: An entity responsible for conducting determinations under the No Surprises Act and that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

Gene and Cellular Therapy Products: Products included on the Select Drugs and Products List, as defined by the Office of Tissues and Advanced Therapies (OTAT) of the U.S. Food and Drug Administration, under either the Medical benefits or the Prescription Drug benefits.

Independent Freestanding Emergency Department: A health care Facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable State law, and which provides any Emergency Services. Independent Freestanding Emergency Departments do not include Urgent Care Facilities (Minor Emergency Medical Clinics).

Qualifying Payment Amount: The median of the contracted rates recognized by the Plan, or recognized by all plans serviced by the Plan's Third Party Administrator (if calculated by the Third Party Administrator), for the same or a similar item or service provided by a Provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning at least three) contracted rates available to determine a Qualifying Payment Amount, said amount will be determined by referencing a State all-payer claims database or any eligible third-party database in accordance with applicable law.

Recognized Amount: Except for Out-of-Network air ambulance services, an amount determined under an applicable all-payer model agreement or, if unavailable, an amount determined by applicable State law. If no such amounts are available or applicable and for Out-of-Network air ambulance services generally, the Recognized Amount shall mean the lesser of a Provider's billed charge or the Qualifying Payment Amount.

Select Drugs and Products List: A list of Specialty Drugs or Gene and Cellular Therapy Products that are subject to step-therapy, prior authorization and administrative review and may only be acquired after enrollment in the Plan's Specialty Drugs Program for coverage.

Specialty Drugs: Prescription Drug or biologic products that have ANY of the following features associated with their use or acquisition: 1) difficult or unusual process of administration to the patient when self-administered or healthcare Practitioner-administered, 2) require enrollment in an FDA mandated Risk Evaluation and Mitigation Strategy (REMS), 3) require enhanced data collection efforts, 4) require patient management services that are enhanced to the normal practice of pharmacy, 5) are products used in the treatment of rare disease, 6) require patient training or side effect management, and 7) cost greater than $680 per thirty (30) day supply as defined by the Plan.

Specialty Drugs Program: A mandatory Plan-sponsored program, as defined in the Prescription Drug Plan Benefits section, offered to Plan Participants that utilizes a specialty healthcare advocate for products listed on the Plan's Select Drugs and Products list.

In all other respects, the Plan Document remains unchanged.

Acknowledged by:

Gunnison County, Colorado:

By: _____

Printed Name: _____

Title: _____

Date: _____

SCHEDULE OF BENEFITS – TRADITIONAL PLAN (Cont'd.)

LEVEL II BENEFITS – Payment Levels and Limits:
This section applies to covered services rendered by Physicians and all other Providers not listed in Level I. Benefits shown are payable **based upon the Provider's participation in the Preferred Provider Organization (PPO) network.** Non-PPO Covered Charges are subject to Allowable Claim Limits.

The "Level II PPO Benefit" applies to services rendered by Preferred Providers in the designated PPO Network (In-Network); the "Level II Non-PPO Benefit" applies to services rendered by Providers other than Preferred Providers (Out-of-Network).

Maximum Benefits, Limits and Provisions are subject to all other Plan exclusions, limitations and provisions set forth in this Plan.

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
Physician Services			
Gunnison Valley Health Systems Inpatient/ Outpatient Physician Services	80% of negotiated rate Deductible applies		
Physician Hospital Visits/Surgeon	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
Physician Hospital Visit for Mental Disorders/ Chemical Dependency, Drug and Substance Abuse	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
Emergency Room Physician	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
Maternity (Including prenatal care, delivery and postnatal care, except initial visit) Lab and X-ray Benefit applies. Initial Visit	80% of PPO rate Deductible applies 100% of PPO rate Deductible waived	80% of Allowable Claim Limits Deductible applies 100% of Allowable Claim Limits Deductible waived	Contact Utilization Review for Coordination of Care.
Routine Newborn Care (Inpatient routine pediatric care to date of mother's discharge)	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
***Lab and X-ray Benefits** **Select Diagnostic Medical Procedures** (MRI, CT scan, etc.; see list in Comprehensive Medical Benefits section)			
• Outpatient Hospital Interpretation	80% of PPO rate Deductible applies	80% of Allowable Claim Limits	
• Free-standing or Independent Facility (includes interpretation)	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	

SCHEDULE OF BENEFITS – HIGH DEDUCTIBLE HEALTH PLAN (Cont'd.)

LEVEL II BENEFITS – Payment Levels and Limits:
This section applies to covered services rendered by Physicians and all other Providers not listed in Level I. Benefits shown are payable **based upon the Provider's participation in the Preferred Provider Organization (PPO) network.** Non-PPO Covered Charges are subject to Allowable Claim Limits.

The "Level II PPO Benefit" applies to services rendered by Preferred Providers in the designated PPO Network (In-Network); the "Level II Non-PPO Benefit" applies to services rendered by Providers other than Preferred Providers (Out-of-Network).

Maximum Benefits, Limits and Provisions are subject to all other Plan exclusions, limitations and provisions set forth in this Plan.

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
Physician Services			
Gunnison Valley Health Systems Inpatient / Outpatient Physician Services	100% of negotiated rate Deductible applies		
Physician Hospital Visits/Surgeon	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
Physician Hospital Visit for Mental Disorders/ Chemical Dependency, Drug and Substance Abuse	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
Emergency Room Physician	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
Maternity (Including prenatal care, delivery and postnatal care, except initial visit)	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	Contact Utilization Review for Coordination of Care.
Initial Visit	100% of PPO rate Deductible waived	100% of Allowable Claim Limits Deductible waived	
Routine Newborn Care (Inpatient routine pediatric care to date of mother's discharge)	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
***Lab and X-ray Benefits Select Diagnostic Medical Procedures** (MRI, CT scan, etc.; see list in Comprehensive Medical Benefits section)			
• Outpatient Hospital Interpretation	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
• Free-standing or Independent Facility (includes interpretation)	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	

recommended that a Plan Participant verify with the Provider that the Provider is still a Preferred Provider before receiving services.

The Preferred Provider Network (PPO) does **not** include services and supplies provided by Facilities such as Hospital Facilities, Ambulatory Surgery Center Facilities, Ambulatory Infusion Centers and dialysis clinics or Facilities. You may contact the Claims Administrator or the Plan Administrator with any questions regarding which Facilities may be included under the Claim Review and Audit Program, and which may be included under the PPO Network agreement.

For all Facility Providers and those Physicians and professional Providers not participating in the PPO, the Plan will identify the Reasonable cost for the services and supplies through its Claim Review and Audit Program. There is a section in this Summary Plan Description that fully describes the Claim Review and Audit Program. The benefits for Facility Providers are described in the Schedule of Benefits under Level I and the benefits for those Physicians and professional Providers not participating in the PPO (Non-PPO) are described in Level II.

This plan may use Allowable Claim Limits to determine Covered Charges in lieu of a PPO discount.

If a Participant receives information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative, indicating that a particular Provider is an In-Network Provider and the Participant receives such item or service in reliance on that information, the Participant's Coinsurance, Copayment, Deductible, and Out-of-Pocket Maximum will be calculated as if the Provider had been In-Network despite that information proving to be inaccurate.

EFFECTIVE DATE

Effective Date of the Plan: **September 1, 2017**; Amended and restated effective: **January 1, 2020**

CLAIMS ADMINISTRATOR

The Claims Administrator of the Plan is shown in the General Information and Purpose section.

NAMED FIDUCIARY

The named Fiduciary to the Plan is **Gunnison County, Colorado**, who, as Plan Administrator, shall have the authority to control and manage the operation and administration of the Plan. The Employer may delegate responsibilities for the operation and administration of the Plan. The Employer or Board of Directors of the Employer, if applicable, shall have the authority to amend or terminate the Plan, to determine its policies, to appoint and remove service Providers, adjust their compensation (if any), and exercise general administrative authority over them. The Employer has the sole authority and responsibility to review and make final decisions on all Claims to benefits hereunder.

CONTRIBUTIONS TO THE PLAN

Contributions to the Plan are to be made on the following basis:

The Employer shall from time to time evaluate the costs of the Plan and determine the amount to be contributed by the Employer and the amount to be contributed by each Covered Employee.

Notwithstanding any other provision of the Plan, the Employer's obligation to pay Claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraph. Payment of said Claims in accordance with these procedures shall discharge completely the Employer's obligation with respect to such payments.

In the event that the Employer, if applicable, terminates the Plan, then as of the effective date of termination, the Employer and Covered Employees shall have no further obligation to make additional contributions to the Plan and the Plan shall have no obligation to pay Claims incurred after the termination date of the Plan.

SCHEDULE OF BENEFITS – TRADITIONAL PLAN

MAJOR MEDICAL BENEFITS FOR COVERED PERSONS

NOTE: All Claims are subject to review and/or audit to ensure that charges are payable in accordance with the terms and limitations of this Plan.

LEVEL I PROVIDERS – Facilities and Providers billing as a Facility to include, but not limited to:

- Hospitals (Inpatient and Outpatient treatment)
- Inpatient Facilities (such as Rehabilitation Facilities, Skilled Nursing Facilities and Hospice)
- Inpatient and Outpatient Facilities for treatment of Mental Disorders, Chemical Dependency, Drug and Substance Abuse
- Ambulatory Surgery Centers
- Dialysis Clinics
- Ambulance (air and ground)

LEVEL II PROVIDERS – Physicians and all other Providers of service

Maximum Benefits	
Lifetime Maximum Dollar Benefit (All Covered Essential Health Benefits)	Unlimited
Annual Maximum Dollar Benefit (All Covered Essential Health Benefits)	Unlimited

Deductible and Annual Out-of-Pocket Maximum	Level I Benefit Level II PPO / Non-PPO Benefit
Calendar Year Deductible • Per Covered Person • Family Limit*	 $800 $1,600
Benefit Percentage (unless otherwise noted)	80%
Annual Out-of-Pocket Maximum (Includes Deductible and Medical Copays; excludes Prescription Drug Copays** and products included on the Select Drugs and Products List) • Per Covered Person • Family Limit*	 $3,200 $6,400

NOTE: The Calendar Year Deductibles and Annual Out-of-Pocket Maximums are determined by combining both Level I and Level II (PPO and Non-PPO) Covered Charges, excluding charges for Drugs listed on the Plan's Select Drugs and Products List. See Comprehensive Medical Benefits section. Upon reaching the Annual Out-of-Pocket Maximum, Covered Medical Expenses are payable at 100% for the remainder of the Calendar Year (excluding non-compliance penalties for Specialty Drugs included on the Select Drugs and Products List which do not contribute to meeting the Annual Out-of-Pocket Maximum or Deductible under this Major Medical Plan). Any applicable Maximums or Limitations for specified services are also determined by combining Level I and Level II (PPO and Non-PPO) Covered Charges. The Covered Person's Coinsurance is determined by the Plan's Benefit Percentage reflected in this Schedule of Benefits. The Covered Person is responsible for the difference between the Plan's Benefit Percentage and 100%.

*Applies collectively to all Covered Persons in the same Family.

** Prescription Drug Copays apply to satisfy a separate Prescription Drug Out-of-Pocket Maximum.

LEVEL I BENEFITS – Payment Levels and Limits:
This section applies to covered services rendered by Hospitals and other Facilities shown in the preceding Level I Providers list and to charges for services rendered by Providers billing "as a Facility." The benefits shown apply to all such covered, licensed, accredited Providers of service **without regard to participation in a Preferred Provider Organization (PPO) network**.

NO SURPRISES ACT - Emergency Services and Surprise Bills
For Out-of-Network Claims subject to the No Surprises Act ("NSA") (part of the Consolidated Appropriations Act of 2021), a Participant's cost-sharing will be the same amount as would be applied if the Claim was provided by an Imagine Provider and will be calculated as if the Plan's Allowable Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Charge. The NSA prohibits Providers from pursuing Participants for the difference between the Maximum Allowable Charge and the Provider's billed charge for applicable services. Cost-sharing amounts will accrue toward In-Network Deductibles and Out-of-Pocket Maximums.

Benefits for Claims subject to the NSA will be denied or paid within thirty (30) days of receipt of an initial Claim and, if approved, will be paid directly to the Provider.

Claims subject to the NSA are those which are submitted for:

- Emergency Services; and
- Covered Out-of-Network air ambulance services.

Coordination of Care Requirements	
Coordination of Care required for the following services: • Inpatient Hospital/Facility Admissions • Inpatient Hospice • Home Health Care • Other Specified Level I and Level II Services	See Coordination of Care section for additional information.
Utilization Review (UR) Notification Requirements	
Utilization Review required for: • Products included on the Select Drugs and Products List (check Select Drugs and Products List for additional information) **NOTE:** Products must be ordered through Noble Health Services Specialty Pharmacy at 888-843-2040.	Non-compliance Penalty: 100% reduction in benefits payable Non-compliance penalty applies for failure to notify Utilization Review and enroll in the Specialty Drugs Program. See Coordination of Care section and "Specialty Drugs Program" under the Prescription Drug Plan Benefits section for additional information.

Benefit Percentage For:	**Level I Benefit**	**Maximum Benefits, Limits & Provisions**
Gunnison Valley Health Systems Inpatient/Outpatient Services		
Gunnison Valley Health Systems Inpatient / Outpatient Services	70% of negotiated rate Deductible applies	
Hospital/Facility Inpatient Services		
Inpatient Hospital Services	80% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Contact Utilization Review for Coordination of Care.
Maternity Inpatient Hospital Services	80% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Contact Utilization Review for Coordination of Care.

SCHEDULE OF BENEFITS – TRADITIONAL PLAN (Cont'd.)

Benefit Percentage For:	Level I Benefit	Maximum Benefits, Limits & Provisions
Hospital/Facility Inpatient Services		
Routine Newborn Care Inpatient Hospital Services (to date of mother's discharge)	80% of Allowable Claim Limits for nursery Room and Board/ancillary charges Deductible applies	
Skilled Nursing Facility	80% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Limited to 120 days per Calendar Year. Contact Utilization Review for Coordination of Care.
Rehabilitation Facility	80% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Contact Utilization Review for Coordination of Care.
Mental Disorders/Chemical Dependency, Drug and Substance Abuse Inpatient Hospital Services/ Residential Treatment Center	80% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Contact Utilization Review for Coordination of Care.
Emergency Room (Hospital Emergency Room Services/ Free-standing Emergency Room Facility Services)		
Emergency Room	80% of Allowable Claim Limits Deductible applies	If admitted Inpatient, contact Utilization Review for Coordination of Care.
Hospital/Facility Outpatient Diagnostic/Preventive Screening Services		
Select Diagnostic Medical Procedures (MRI, CT scan, etc.; see list in Comprehensive Medical Benefits section)	80% of Allowable Claim Limits Deductible applies	
All Other Diagnostic Lab and X-ray	80% of Allowable Claim Limits Deductible applies	

SCHEDULE OF BENEFITS – TRADITIONAL PLAN (Cont'd.)

Benefit Percentage For:	Level I Benefit	Maximum Benefits, Limits & Provisions
Hospital/Facility Outpatient Diagnostic/Preventive Screening Services		
Routine Bone Density Test, Other Routine Diagnostic Lab and X-ray	100% of Allowable Claim Limits Deductible waived	Age and/or frequency limitations may apply.
Annual Mammogram (Routine screening) Additional Mammogram (Diagnostic)	100% of Allowable Claim Limits Deductible waived 80% of Allowable Claim Limits Deductible applies	
Colonoscopy (including polyp removal) (Routine or Diagnostic)	100% of Allowable Claim Limits Deductible waived	Routine Limited to beginning at age 50 or Family history of colon cancer with or without diagnosis.
Women's Elective Sterilization Procedures		
All Covered Expenses	100% of Allowable Claim Limits Deductible waived	All FDA approved
Outpatient Surgery/Ambulatory Surgery Centers Covered Services and Supplies		
All Covered Expenses	80% of Allowable Claim Limits Deductible applies	
Outpatient Psychiatric Day Treatment Facility and Outpatient Chemical Dependency Drug Treatment Facility		
Day Treatment Facility/ Psychological Testing/ Outpatient Therapy (including group therapy)	80% of Allowable Claim Limits Deductible applies	
Physical, Occupational and Speech Therapy Services		
All Covered Expenses	80% of Allowable Claim Limits Deductible applies	Limited to 60 visits per therapy per Calendar Year.
Cardiac Rehabilitation		
All Covered Expenses	80% of Allowable Claim Limits Deductible applies	
Chemotherapy, Radiation Therapy, Infusion Therapy, Dialysis Facilities Covered Services and Supplies		
All Covered Expenses	80% of Allowable Claim Limits Deductible applies	Contact Utilization Review for Coordination of Care. UR Notification required or penalty applies for products included on the Select Drugs and Products List.
Diabetic Self-Management Training		
All Covered Expenses	80% of Allowable Claim Limits Deductible applies	
Hospice		
All Covered Expenses	80% of Allowable Claim Limits Deductible applies	Contact Utilization Review for Coordination of Care for Inpatient and Homebound Hospice.

LEVEL II BENEFITS – Payment Levels and Limits:
This section applies to covered services rendered by Physicians and all other Providers not listed in Level I. Benefits shown are payable **based upon the Provider's participation in the Preferred Provider Organization (PPO) network.** Non-PPO Covered Charges are subject to Allowable Claim Limits.

The "Level II PPO Benefit" applies to services rendered by Preferred Providers in the designated PPO Network (In-Network); the "Level II Non-PPO Benefit" applies to services rendered by Providers other than Preferred Providers (Out-of-Network).

NO SURPRISES ACT - Emergency Services and Surprise Bills
For Out-of-Network Claims subject to the No Surprises Act ("NSA") (part of the Consolidated Appropriations Act of 2021), a Participant's cost-sharing will be the same amount as would be applied if the Claim was provided by an Imagine Provider and will be calculated as if the Plan's Allowable Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Charge. The NSA prohibits Providers from pursuing Participants for the difference between the Maximum Allowable Charge and the Provider's billed charge for applicable services. Cost-sharing amounts will accrue toward In-Network Deductibles and Out-of-Pocket Maximums.

Benefits for Claims subject to the NSA will be denied or paid within thirty (30) days of receipt of an initial Claim and, if approved, will be paid directly to the Provider.

Claims subject to the NSA are those which are submitted for:

- Emergency Services; and
- Covered Out-of-Network air ambulance services.

Maximum Benefits, Limits and Provisions are subject to all other Plan exclusions, limitations and provisions set forth in this Plan.

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
Physician Services			
Gunnison Valley Health Systems Inpatient/ Outpatient Physician Services	70% of negotiated rate Deductible applies		
Physician Hospital Visits/Surgeon	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
Physician Hospital Visit for Mental Disorders/ Chemical Dependency, Drug and Substance Abuse	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
Emergency Room Physician	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
Maternity (Including prenatal care, delivery and postnatal care, except initial visit) Lab and X-ray Benefit applies.	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	Contact Utilization Review for Coordination of Care.
Initial Visit	100% of PPO rate Deductible waived	100% of Allowable Claim Limits Deductible waived	

SCHEDULE OF BENEFITS – TRADITIONAL PLAN (Cont'd.)

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
Physician Services			
Routine Newborn Care (Inpatient routine pediatric care to date of mother's discharge)	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
***Lab and X-ray Benefits** **Select Diagnostic Medical Procedures** (MRI, CT scan, etc.; see list in Comprehensive Medical Benefits section)			
• Outpatient Hospital Interpretation	80% of PPO rate Deductible applies	80% of Allowable Claim Limits	
• Free-standing or Independent Facility (includes interpretation)	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	

SCHEDULE OF BENEFITS – TRADITIONAL PLAN (Cont'd.)

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
Other Covered Services			
***Therapy Services** • Physical • Occupational • Speech	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	Limited to 60 visits per therapy per Calendar Year.
***Cardiac Rehabilitation**	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
***Chemotherapy/ Radiation Therapy/ Infusion Therapy/ Dialysis**	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	Contact Utilization Review for Coordination of Care. UR Notification required or penalty applies for products included on the Select Drugs and Products List.
***Durable Medical Equipment**	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
***Orthotic Devices**	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
***Prosthetics**	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
Hearing Exams / Hearing Aids	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	Hearing aids are limited to $4,500 Calendar Year Maximum Benefit every five (5) years. Maximum Benefit does not apply to initial purchase of hearing aid/device if Medically Necessary due to Illness, Accidental Injury, Congenital Anomaly or Surgical Procedure.

SCHEDULE OF BENEFITS – TRADITIONAL PLAN (Cont'd.)

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
Other Covered Services			
***Home Health Care Services**	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	Limited to 120 visits per Calendar Year. Contact Utilization Review for Coordination of Care.
***Home Infusion Therapy**	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	Contact Utilization Review for Coordination of Care. UR Notification required or penalty applies for medications or biologics listed on the Select Drugs and Products List.

SCHEDULE OF BENEFITS – TRADITIONAL PLAN (Cont'd.)

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
Other Covered Services			
***Hospice**	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	Contact Utilization Review GPA Nurse Navigator℠ for Coordination of Care for Inpatient and Homebound Hospice.
Bereavement Counseling	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
Diabetic Self-Management Training	100% of PPO rate after $40 Copay PCP $60 Copay Specialist Deductible waived	100% of Allowable Claim Limits $40 Copay PCP $60 Copay Specialist Deductible waived	
***Temporomandibular Joint (TMJ) Disorders and Orthognathic Disorders (including Surgical and Non-Surgical Treatment)**	Related services will be considered at the applicable benefit level (Surgery, devices, diagnostic services, etc.)		
***Morbid Obesity**	Related services will be considered at the applicable benefit level (Surgery, devices, diagnostic services, etc.)		
***Ambulance — Air or Ground Transportation**	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
UCM Digital Health Consultation (telephone or online – unlimited access)	100%; no Copay or Consultation fee		Call 844-4-VIP DOC (844-484-7362).
***All Other Covered Expenses**	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	

*** If these services are rendered by Providers billing as a Facility, please refer to the appropriate category under Level I for the benefit.**

Organ Transplant Services
Organ and Tissue Transplants, Donor Expenses Contact Utilization Review upon transplant evaluation for Coordination of Care. Refer to Employer's Organ Transplant Policy as Primary payer. See Major Medical Expense Benefits for additional information.

SCHEDULE OF BENEFITS – TRADITIONAL PLAN (Cont'd.)

Preventive and Wellness Care Benefits This benefit is payable for Covered Procedures incurred as part of a Preventive and Wellness Care Program and is not payable for treatment of a diagnosed Illness or Injury. Services must be identified and billed as routine or part of a routine physical exam or as specified below.			
Benefit Percentage For:	**Level II PPO Benefit**	**Level II Non-PPO Benefit**	**Limits & Provisions**
All Covered Wellness Benefits	100% of PPO rate Copay and Deductible waived	100% of Allowable Claim Limits Deductible applies	See age and frequency limits and other special provisions below

Examples of Covered Wellness Procedures to include but are not limited to:

1. Routine Physical Exam
2. Annual Well Woman Exam
3. *Annual Pap smear and other routine lab
4. *Annual Mammogram (routine)
5. *Bone Density test (routine)
6. *Annual PSA test (routine)
7. Well Baby Care Exam/Well Child Care Exam
8. Routine Immunizations
9. Flu vaccine/pneumonia vaccine
10. *Routine lab, x-ray, diagnostic testing and other medical screenings
11. Routine Vision Screening for Covered Dependent Children
12. Routine Hearing Screening for Covered Dependent Children
13. *Routine/Diagnostic Colonoscopy (including polyp removal – routine beginning at age 50 or Family history of colon cancer)
14. Tobacco Use Screening/Cessation Intervention (limited to two attempts per Calendar Year with four tobacco cessation counseling sessions per attempt)
15. *All FDA approved Women's Contraceptive methods and Women's elective Sterilization procedures

NOTE: Refer to the definition of "Preventive Care" for a link to a website that lists additional services that may be covered for preventive treatment.

*** If these services are rendered by Providers billing as a Facility, please refer to the appropriate category under Level I for the benefit.**

SCHEDULE OF BENEFITS – HIGH DEDUCTIBLE HEALTH PLAN

MAJOR MEDICAL BENEFITS FOR COVERED PERSONS

NOTE: All Claims are subject to review and/or audit to ensure that charges are payable in accordance with the terms and limitations of this Plan.

LEVEL I PROVIDERS – Facilities and Providers billing as a Facility to include, but not limited to:

- Hospitals (Inpatient and Outpatient treatment)
- Inpatient Facilities (such as Rehabilitation Facilities, Skilled Nursing Facilities and Hospice)
- Inpatient and Outpatient Facilities for treatment of Mental Disorders, Chemical Dependency, Drug and Substance Abuse
- Ambulatory Surgery Centers
- Dialysis Clinics
- Ambulance (air and ground)

LEVEL II PROVIDERS – Physicians and all other Providers of service

Maximum Benefits	
Lifetime Maximum Dollar Benefit (All Covered Essential Health Benefits)	Unlimited
Annual Maximum Dollar Benefit (All Covered Essential Health Benefits)	Unlimited

Deductible and Annual Out-of-Pocket Maximum	Level I Benefit Level II PPO / Non-PPO Benefit
Calendar Year Deductible (Includes Covered Medical and Prescription Drug Expenses) • Per Covered Person • Family Limit*	 $4,000 $8,000
Benefit Percentage (unless otherwise noted)	100%
Annual Out-of-Pocket Maximum (Includes Calendar Year Deductible, Covered Medical and Prescription Drug Expenses; excludes products included on the Select Drugs and Products List) • Per Covered Person • Family Limit*	 $4,000 $8,000

NOTE: The Calendar Year Deductibles and Annual Out-of-Pocket Maximums are determined by combining both Level I and Level II (PPO and Non-PPO) Covered Charges, excluding charges for Drugs listed on the Plan's Select Drugs and Products List. See Comprehensive Medical Benefits section. Upon reaching the Annual Out-of-Pocket Maximum, Covered Medical Expenses and Prescription Drug Expenses are payable at 100% for the remainder of the Calendar Year (excluding non-compliance penalties for Specialty Drugs included on the Select Drugs and Products List which do not contribute to meeting the Annual Out-of-Pocket Maximum or Deductible under this Major Medical Plan). Any applicable Maximums or Limitations for specified services are also determined by combining Level I and Level II (PPO and Non-PPO) Covered Charges.

* The Calendar Year Deductible per Covered Person (individual Deductible) is embedded in the Deductible Family Limit and the Annual Out-of-Pocket Maximum per Covered Person (individual Annual Out-of-Pocket) is embedded in the Annual Out-of-Pocket Maximum Family Limit. Each covered Family member is only required to satisfy his/her own individual Deductible and individual Annual Out-of-Pocket, not the entire Family Limit, in order to receive Plan benefits. The Deductible Family Limit and Annual Out-of-Pocket Maximum Family Limit are satisfied by two (2) or more Family members collectively; however, each Family member cannot contribute more than his/her own individual Deductible or individual Annual Out-of-Pocket Maximum.

LEVEL I BENEFITS – Payment Levels and Limits:
This section applies to covered services rendered by Hospitals and other Facilities shown in the preceding Level I Providers list and to charges for services rendered by Providers billing "as a Facility." The benefits shown apply to all such covered, licensed, accredited Providers of service **without regard to participation in a Preferred Provider Organization (PPO) network**.

NO SURPRISES ACT - Emergency Services and Surprise Bills
For Out-of-Network Claims subject to the No Surprises Act ("NSA") (part of the Consolidated Appropriations Act of 2021), a Participant's cost-sharing will be the same amount as would be applied if the Claim was provided by an Imagine Provider and will be calculated as if the Plan's Allowable Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Charge. The NSA prohibits Providers from pursuing Participants for the difference between the Maximum Allowable Charge and the Provider's billed charge for applicable services. Cost-sharing amounts will accrue toward In-Network Deductibles and Out-of-Pocket Maximums.

Benefits for Claims subject to the NSA will be denied or paid within thirty (30) days of receipt of an initial Claim and, if approved, will be paid directly to the Provider.

Claims subject to the NSA are those which are submitted for:

- Emergency Services; and
- Covered Out-of-Network air ambulance services.

Coordination of Care Requirements	
Coordination of Care required for the following services: • Inpatient Hospital/Facility Admissions • Inpatient Hospice • Home Health Care • Other Specified Level I and Level II Services	See Coordination of Care section for additional information.
Utilization Review (UR) Notification Requirements	
Utilization Review required for: • Products included on the Select Drugs and Products List (check Select Drugs and Products List for additional information) **NOTE:** Products must be ordered through Noble Health Services Specialty Pharmacy at 888-843-2040.	Non-compliance Penalty: 100% reduction in benefits payable Non-compliance penalty applies for failure to notify Utilization Review and enroll in the Specialty Drugs Program. See Coordination of Care section and "Specialty Drugs Program" under the Prescription Drug Plan Benefits section for additional information.

Benefit Percentage For:	**Level I Benefit**	**Maximum Benefits, Limits & Provisions**
Gunnison Valley Health Systems Inpatient / Outpatient Services		
Gunnison Valley Health Systems Inpatient / Outpatient Services	100% of negotiated rate Deductible applies	
Hospital/Facility Inpatient Services		
Inpatient Hospital Services	100% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Contact Utilization Review for Coordination of Care.
Maternity Inpatient Hospital Services	100% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Contact Utilization Review for Coordination of Care.

SCHEDULE OF BENEFITS – HIGH DEDUCTIBLE HEALTH PLAN (Cont'd.)

Benefit Percentage For:	Level I Benefit	Maximum Benefits, Limits & Provisions
Hospital/Facility Inpatient Services		
Routine Newborn Care Inpatient Hospital Services (to date of mother's discharge)	100% of Allowable Claim Limits for nursery Room and Board/ancillary charges Deductible applies	
Skilled Nursing Facility	100% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Limited to 120 days per Calendar Year. Contact Utilization Review for Coordination of Care.
Rehabilitation Facility	100% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Contact Utilization Review for Coordination of Care.
Mental Disorders/Chemical Dependency, Drug and Substance Abuse Inpatient Hospital Services/ Residential Treatment Center	100% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Contact Utilization Review for Coordination of Care.
Emergency Room (Hospital Emergency Room Services/ Free-standing Emergency Room Facility Services)		
Emergency Room	100% of Allowable Claim Limits Deductible applies	If admitted Inpatient, contact Utilization Review for Coordination of Care.
Hospital/Facility Outpatient Diagnostic/Preventive Screening Services		
Select Diagnostic Medical Procedures (MRI, CT scan, etc.; see list in Comprehensive Medical Benefits section)	100% of Allowable Claim Limits Deductible applies	
All Other Diagnostic Lab and X-ray	100% of Allowable Claim Limits Deductible applies	

SCHEDULE OF BENEFITS – HIGH DEDUCTIBLE HEALTH PLAN (Cont'd.)

Benefit Percentage For:	Level I Benefit	Maximum Benefits, Limits & Provisions
Hospital/Facility Outpatient Diagnostic/Preventive Screening Services		
Routine Bone Density Test, Other Routine Diagnostic Lab and X-ray	100% of Allowable Claim Limits Deductible waived	Age and/or frequency limitations may apply.
Annual Mammogram (Routine screening) Additional Mammogram (Diagnostic)	100% of Allowable Claim Limits Deductible waived 100% of Allowable Claim Limits Deductible applies	
Colonoscopy (including polyp removal) (Routine or Diagnostic)	100% of Allowable Claim Limits Deductible waived	Routine Limited to beginning at age 50 or Family history of colon cancer with or without diagnosis.
Women's Elective Sterilization Procedures		
All Covered Expenses	100% of Allowable Claim Limits Deductible waived	All FDA approved
Outpatient Surgery/Ambulatory Surgery Centers Covered Services and Supplies		
All Covered Expenses	100% of Allowable Claim Limits Deductible applies	
Outpatient Psychiatric Day Treatment Facility and Outpatient Chemical Dependency Drug Treatment Facility		
Day Treatment Facility/ Psychological Testing/ Outpatient Therapy (including group therapy)	100% of Allowable Claim Limits Deductible applies	
Physical, Occupational and Speech Therapy Services		
All Covered Expenses	100% of Allowable Claim Limits Deductible applies	Limited to 60 visits per therapy per Calendar Year.
Cardiac Rehabilitation		
All Covered Expenses	100% of Allowable Claim Limits Deductible applies	
Chemotherapy, Radiation Therapy, Infusion Therapy, Dialysis Facilities Covered Services and Supplies		
All Covered Expenses	100% of Allowable Claim Limits Deductible applies	Contact Utilization Review for Coordination of Care. UR Notification required or penalty applies for products included on the Select Drugs and Products List.
Diabetic Self-Management Training		
All Covered Expenses	100% of Allowable Claim Limits Deductible applies	
Hospice		
All Covered Expenses	100% of Allowable Claim Limits Deductible applies	Contact Utilization Review for Coordination of Care for Inpatient and Homebound Hospice.

LEVEL II BENEFITS – Payment Levels and Limits:
This section applies to covered services rendered by Physicians and all other Providers not listed in Level I. Benefits shown are payable **based upon the Provider's participation in the Preferred Provider Organization (PPO) network.** Non-PPO Covered Charges are subject to Allowable Claim Limits.

The "Level II PPO Benefit" applies to services rendered by Preferred Providers in the designated PPO Network (In-Network); the "Level II Non-PPO Benefit" applies to services rendered by Providers other than Preferred Providers (Out-of-Network).

NO SURPRISES ACT - Emergency Services and Surprise Bills
For Out-of-Network Claims subject to the No Surprises Act ("NSA") (part of the Consolidated Appropriations Act of 2021), a Participant's cost-sharing will be the same amount as would be applied if the Claim was provided by an Imagine Provider and will be calculated as if the Plan's Allowable Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Charge. The NSA prohibits Providers from pursuing Participants for the difference between the Maximum Allowable Charge and the Provider's billed charge for applicable services. Cost-sharing amounts will accrue toward In-Network Deductibles and Out-of-Pocket Maximums.

Benefits for Claims subject to the NSA will be denied or paid within thirty (30) days of receipt of an initial Claim and, if approved, will be paid directly to the Provider.

Claims subject to the NSA are those which are submitted for:

- Emergency Services; and
- Covered Out-of-Network air ambulance services.

Maximum Benefits, Limits and Provisions are subject to all other Plan exclusions, limitations and provisions set forth in this Plan.

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
Physician Services			
Gunnison Valley Health Systems Inpatient / Outpatient Physician Services	100% of negotiated rate Deductible applies		
Physician Hospital Visits/Surgeon	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
Physician Hospital Visit for Mental Disorders/ Chemical Dependency, Drug and Substance Abuse	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
Emergency Room Physician	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
Maternity (Including prenatal care, delivery and postnatal care, except initial visit) Initial Visit	100% of PPO rate Deductible applies 100% of PPO rate Deductible waived	100% of Allowable Claim Limits Deductible applies 100% of Allowable Claim Limits Deductible waived	Contact Utilization Review for Coordination of Care.

SCHEDULE OF BENEFITS – HIGH DEDUCTIBLE HEALTH PLAN (Cont'd.)

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
Physician Services			
Routine Newborn Care (Inpatient routine pediatric care to date of mother's discharge)	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
***Lab and X-ray Benefits** **Select Diagnostic Medical Procedures** (MRI, CT scan, etc.; see list in Comprehensive Medical Benefits section)			
• Outpatient Hospital Interpretation	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
• Free-standing or Independent Facility (includes interpretation)	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	

SCHEDULE OF BENEFITS – HIGH DEDUCTIBLE HEALTH PLAN (Cont'd.)

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
Other Covered Services			
***Therapy Services** • Physical • Occupational • Speech	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	Limited to 60 visits per therapy per Calendar Year.
***Cardiac Rehabilitation**	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
***Chemotherapy/ Radiation Therapy/ Infusion Therapy/ Dialysis**	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	Contact Utilization Review for Coordination of Care. UR Notification required or penalty applies for products included on the Select Drugs and Products List.
***Durable Medical Equipment**	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
***Orthotic Devices**	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
***Prosthetics**	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
Hearing Exams/Hearing Aids	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	Hearing aids are limited to $4,500 Calendar Year Maximum Benefit every five (5) years. Maximum Benefit does not apply to initial purchase of hearing aid/device if Medically Necessary due to Illness, Accidental Injury, Congenital Anomaly or Surgical Procedure.

SCHEDULE OF BENEFITS – HIGH DEDUCTIBLE HEALTH PLAN (Cont'd.)

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
Other Covered Services			
***Home Health Care Services**	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	Limited to 120 visits per Calendar Year. Contact Utilization Review for Coordination of Care.
***Home Infusion Therapy**	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	Contact Utilization Review for Coordination of Care. UR Notification required or penalty applies for medications or biologics listed on the Select Drugs and Products List.

SCHEDULE OF BENEFITS – HIGH DEDUCTIBLE HEALTH PLAN (Cont'd.)

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
Other Covered Services			
***Hospice**	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	Contact Utilization Review for Coordination of Care for Inpatient and Homebound Hospice.
Bereavement Counseling	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
Diabetic Self-Management Training	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
***Temporomandibular Joint (TMJ) Disorders and Orthognathic Disorders (including Surgical and Non-Surgical Treatment)**	Related services will be considered at the applicable benefit level (Surgery, devices, diagnostic services, etc.)		
***Morbid Obesity**	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
***Ambulance — Air or Ground Transportation**	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
UCM Digital Health Consultation (telephone or online – unlimited access)	$10 Consultation Fee Fee applies to satisfy PPO Deductible and PPO Annual Out-of-Pocket Maximum.		Call 844-4-VIP DOC (844-484-7362).
***All Other Covered Expenses**	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	

*** If these services are rendered by Providers billing as a Facility, please refer to the appropriate category under Level I for the benefit.**

Organ Transplant Services
Organ and Tissue Transplants, Donor Expenses Contact Utilization Review upon transplant evaluation for Coordination of Care. Refer to Employer's Organ Transplant Policy as Primary payer. See Major Medical Expense Benefits for additional information.

SCHEDULE OF BENEFITS – HIGH DEDUCTIBLE HEALTH PLAN (Cont'd.)

Preventive and Wellness Care Benefits This benefit is payable for Covered Procedures incurred as part of a Preventive and Wellness Care Program and is not payable for treatment of a diagnosed Illness or Injury. Services must be identified and billed as routine or part of a routine physical exam or as specified below.			
Benefit Percentage For:	**Level II PPO Benefit**	**Level II Non-PPO Benefit**	**Limits & Provisions**
All Covered Wellness Benefits	100% of PPO rate Deductible waived	100% of Allowable Claim Limits Deductible applies	See age and frequency limits and other special provisions below

Examples of Covered Wellness Procedures to include but are not limited to:

1. Routine Physical Exam
2. Annual Well Woman Exam
3. *Annual Pap smear and other routine lab
4. *Annual Mammogram (routine)
5. *Bone Density test (routine)
6. *Annual PSA test (routine)
7. Well Baby Care Exam/Well Child Care Exam
8. Routine Immunizations
9. Flu vaccine/pneumonia vaccine
10. *Routine lab, x-ray, diagnostic testing and other medical screenings
11. Routine Vision Screening for Covered Dependent Children
12. Routine Hearing Screening for Covered Dependent Children
13. *Routine/Diagnostic Colonoscopy (including polyp removal – routine beginning at age 50 or Family history of colon cancer)
14. Tobacco Use Screening/Cessation Intervention (limited to two attempts per Calendar Year with four tobacco cessation counseling sessions per attempt)
15. *All FDA approved Women's Contraceptive methods and Women's elective Sterilization procedures

NOTE: Refer to the definition of "Preventive Care" for a link to a website that lists additional services that may be covered for preventive treatment.

*** If these services are rendered by Providers billing as a Facility, please refer to the appropriate category under Level I for the benefit.**

PRESCRIPTION DRUG PLAN BENEFITS

High Deductible Health Plan		
Prescription Drug Expenses apply to satisfy the Medical Plan's Level I/Level II Calendar Year Deductible. The Plan requires the Covered Person to pay the entire cost of Prescription Drug Expenses until the Deductible has been met. After the Calendar Year Deductible and Annual Out-of-Pocket Maximum have been met, covered Prescription Drugs will be payable at 100% for the remainder of the Calendar Year. Out-of-Pocket non-compliance penalties for Specialty Drugs included on the Select Drugs and Products List do not contribute to meeting the Annual Out-of-Pocket Maximum or Deductibles.		
	Supply Limit	**Benefit**
Prescription Card Service Generic and Brand Name Drugs	30 – 90 days	100% after Deductible
Mail Order Service Generic and Brand Name Drugs	90 days	100% after Deductible
Specialty Drugs* Supply Limit: 30 days 100% Copay* All Drugs or products included on the Select Drugs and Products List require enrollment in the Specialty Drugs Program** for coverage limits to apply.		
Optional Mail Order Service (CanaRx) Supply Limit Certain Brand Name Preventive Care Drugs may be available to you free of charge through CanaRx's voluntary international Prescription Drug program. Please contact CanaRx at 866-893-6337 for more information.		**100%; $0 Copay** 3 months

Traditional Plan	
Prescription Drug Copays apply to satisfy a separate Prescription Drug Annual Out-of-Pocket Maximum. After the separate Prescription Drug Annual Out-of-Pocket Maximum has been met, covered Prescription Drugs will be payable at 100% for the remainder of the Calendar Year. Out-of-Pocket non-compliance penalties for Specialty Drugs included on the Select Drugs and Products List do not contribute to meeting the separate Prescription Drug Annual Out-of-Pocket Maximum or Deductibles.	
Calendar Year Prescription Drug Deductible Per Covered Person	 $100
The Prescription Drug Deductible must be satisfied each Calendar Year before Copays apply.	
Prescription Drug Annual Out-of-Pocket Maximum Per Covered Person Family Limit*	 $3,000 $6,000
*Applies collectively to all Covered Persons in the same Family.	
Prescription Card Service <u>Supply Limit</u> Generic (Tier 1) Preferred Brand Name Drugs (Tier 2) Non-Preferred Brand Name Drugs (Tier 3)	**100% after applicable Copay** <u>30 days</u> $5 Copay 75% Copay with a minimum $35 Copay and up to a maximum $150 Copay 75% Copay with a minimum $70 Copay and up to a maximum $150 Copay
Prescription Card Service – Generic Drugs Only <u>Supply Limit</u> Generic Drugs (Tier 1)	 <u>90 days</u> $15 Copay
Mail Order Service <u>Supply Limit</u> Generic (Tier 1) Preferred Brand Name Drugs (Tier 2) Non-Preferred Brand Name Drugs (Tier 3)	**100% after applicable Copay** <u>90 days</u> $10 Copay 75% Copay with a minimum $80 Copay 75% Copay with a minimum $80 Copay

Traditional Plan (Continued)	
Specialty Drugs* Supply Limit All Drugs or products included on the Select Drugs and Products List require enrollment in the Specialty Drugs Program** for coverage limits to apply.	**100% Copay*** 30 days
Optional Mail Order Service (CanaRx) **Supply Limit** **Certain Brand Name Drugs may be available to you free of charge through CanaRx's voluntary international Prescription Drug program. Please contact CanaRx at 866-893-6337 for more information.**	**100%; $0 Copay** **3 months**

*** The Calendar Year Deductible and Annual Out-of-Pocket Maximum are exclusive of charges for Drugs listed on the Plan's Select Drugs and Products List. Upon reaching the Annual Out-of-Pocket Maximum, Covered Medical Expenses are payable at 100%, excluding products on the Select Drugs and Products List, for the remainder of the Calendar Year. Specialty Drugs must be ordered through Noble Health Services Specialty Pharmacy at 888-843-2040, and all Plan Participants using Specialty Drugs must enroll in the Plan-sponsored Specialty Drugs Program**.**

NOTE: Medications required for Preventive Care services may be covered at 100%, Copay and/or Deductible waived.

For Coordination of Benefits when this Plan is secondary, file the prescription receipt with the Drug Plan. Call the Prescription Claims Help Desk for a Claim form. See Plan Participant identification card for the phone number.

(Traditional Plan only) If the pharmacy charge is less than the Generic or Brand Copay, then the actual charge will become the Copay. Generic and Brand Name copayments apply separately to each prescription and refill and do not apply to the Calendar Year Deductible.

To be covered, Prescription Drugs must be:

1. Purchased from a participating licensed pharmacist;
2. Dispensed to the Covered Person for whom they are prescribed; and
3. Legally prescribed by a Qualified Prescriber.

Specialty Drugs Program**

The Plan requires Plan Participants to enroll in a Specialty Healthcare Advocacy Program to receive coverage under the Program for medications or biologics listed on the Plan's Select Drugs and Products List (SDL). All Plan Participants seeking Plan coverage for listed Specialty Drugs are required to meet prior authorization and administrative review criteria, which includes enrollment in the Specialty Healthcare Advocacy Program.

The Specialty Healthcare Advocacy Program will help Plan Participants obtain their SDL listed Drugs by identifying alternative forms of funding for their eligible prescriptions. The Plan is sponsoring this Program and Plan Participants will not be responsible for any fees to participate in the Program. If a Plan Participant chooses not to enroll in the Specialty Healthcare Advocacy Program, the non-compliance penalty of 100% member payment will apply and this non-compliance penalty will not accumulate toward the Deductible or the Out-of-Pocket Maximum.

Advocates from the Specialty Healthcare Advocacy Program will contact Plan Participants to complete the enrollment process and gather any additional information required to help the Plan Participant maximize his/her benefit for Specialty Drugs under the Program. Some alternate funding programs require verification of income as a condition of meeting alternate funding program criteria. In such cases, the Plan Participant will be asked to provide this information directly to the alternate funding program, and such information will not be provided to the Plan.

Plan Participants who have completed prior authorization and administrative review are eligible for benefit reconsideration under the First Appeal Level process in the event that alternate funding is not available. Such cases that meet Plan First Appeal Level criteria will be eligible for Prescription Drug benefits as defined in the Plan, where Out-of-Pocket Maximums and Deductibles will accumulate.

All Specialty Drugs paid for by the Plan, after meeting First Appeal Level criteria, must be dispensed/coordinated by Noble Pharmacy. Noble Pharmacy will collect a Plan Participant's Coinsurance as outlined in the Plan Participant's selected plan. Questions related to the Specialty Drugs Program may be made directly to the Specialty Healthcare Advocacy Program contact center by calling 877-869-7772.

DEFINITIONS

Brand Name Drugs (Tier 2 and Tier 3)
Trademark Drugs or substances marketed by the original manufacturer. Tier 2 Drugs are commonly used Preferred Brand Name Drugs shown on the Formulary Drug List as "Formulary Alternative(s)." Tier 3 Drugs are Non-Preferred Brand Name Drugs listed as "Non-Formulary" or not listed.

Generic Drugs (Tier 1)
Drugs or substances which:

1. Are not trademark Drugs or substances; and
2. May be legally substituted for trademark Drugs or substances.

Over the Counter (OTC) Drugs
Drugs which do not require a prescription from a Qualified Prescriber, unless otherwise specified.

Prescription Drugs
Legend Drugs or medicines which are prescribed by a Qualified Prescriber for the treatment of Illness, Injury or Pregnancy.

Qualified Prescriber
A licensed Physician, Dentist, or other health care Practitioner who may, in the legal scope of his/her practice, prescribe Drugs or medicines.

Select Drugs and Product List (SDL)
A list of Specialty Drugs or Gene and Cellular Therapy Products that are subject to step-therapy, prior authorization and administrative review, and that may only be acquired after enrollment in the Plan's Specialty Drugs Program for coverage.

Specialty Drugs
Prescription Drug or biologic products that have ANY of the following features associated with their use or acquisition: 1) difficult or unusual process of administration to the patient when self-administered or healthcare-Practitioner administered, 2) require enrollment in an FDA mandated Risk Evaluation and Mitigation Strategy (REMS), 3) require enhanced data collection efforts, 4) require patient management services that are enhanced to the normal practice of pharmacy, 5) are products used in the treatment of rare disease, 6) require patient training or side effect management, and 7) cost greater than $680 per thirty (30) day supply as defined by the Plan.

Specialty Drug List
A list of Prescription Drugs, typically prescribed by a Specialist, that may require special handling, storage, transportation services, or enhanced clinical monitoring by a Specialist or Specialty Pharmacy Provider. The Specialty Drug List is updated periodically by the Plan to address changes in prescription labelling, new market entrants, and safety and efficacy considerations, and each Drug listed requires Plan prior authorization, step-therapy, and administrative review for coverage.

Product Selection
The pharmacist substitutes more economically priced Generic equivalent Drugs whenever possible unless there is a specific request for a Brand Name by the prescribing Physician or when State law requires no substitution for the Brand Name Drug. **Under this program if the prescribing Physician does not specify the Brand Name, but the Covered Person requests the Brand product when there is a Generic substitute available, the Covered Person is required to pay the difference in cost between the Brand and Generic product in addition to the usual Brand Copay (applies to Prescription Card and Mail Order).**

Most pharmacists, as a courtesy to the patient, will ask whether a Generic Drug is acceptable to the Covered Person if the Physician has specified "product selection permitted" on the prescription. If the Physician has specified "dispense as written," no choice is given to the patient, and only the applicable Copay will be charged.

Miscellaneous Provisions
The following provisions may be included in your Prescription Drug Plan. Please contact the Prescription Card Service Customer Service phone number listed on the Plan Participant identification card for more information.

Step Therapy: The practice of starting Drug therapy for a medical condition with the most cost-effective and safest Drug available, then progressing to other more costly alternatives if necessary.

Therapeutic Substitution: A Physician-oriented service designed to increase the utilization of more cost-effective products. Substitutes are made for Non-Preferred Brand Name Drugs with either Generic or similar Preferred Brand Name Drugs in the same therapeutic class.

Drug Review
The Plan includes a Drug Review program which is automatically administered by the pharmacist through a nationwide computer network that verifies the eligibility of each Covered Person's card and protects the Covered Person from conflicting prescriptions which might prove harmful if taken at the same time. This program also guards against duplication of medications and incorrect dosage levels.

Covered and Excluded Drugs
The following Covered and Excluded Drug listings are not all inclusive. To find out if a particular Drug is covered, please contact the Prescription Card Service Customer Service phone number listed on the Plan Participant identification card.

NOTE: Some Drugs (including all Specialty Drugs, as listed on the current Specialty Drug List) may require prior authorization and may only be covered, and/or covered for certain ages, if Medically Necessary.

Prescription Drug Plan – Covered Drugs
1. Legend Drugs (Drugs requiring a prescription either by Federal or State law) (there are certain Legend Drugs that may be excluded);
2. Insulin on prescription;
3. Disposable insulin needles/syringes, test strips and lancets on prescription;
4. Compounded medications of which at least one ingredient is a prescription legend Drug;
5. All FDA approved women's contraceptive Drugs and methods (Generic covered at 100%, Copay and/or Deductible waived; if no Generic available, Brand covered at 100%, Copay and/or Deductible waived);
6. Tobacco deterrent medications or any other tobacco use OTC cessation aids, all dosage forms limited to a 168-day supply per Plan Calendar Year (Generic covered at 100%, Copay and/or Deductible waived); if no Generic available, Brand covered at 100%, Copay and/or Deductible waived); and
7. Specialty Drugs (includes injectables). See Specialty Drugs Program.

NOTE: Quantity limitations may apply to some Covered Drugs in addition to those shown above.

NOTE: Refer to the definition of "Preventive Care" for a link to a website that lists additional Drugs that may be covered for preventive treatment.

Prescription Drug Plan – Excluded Drugs
1. Abortifacients;
2. Drugs for Cosmetic purposes;

3. Weight loss medications;
4. Immunization agents (except immunizations and vaccines as required for Preventive Care services; Generic covered at 100%, Copay and/or Deductible waived; if no Generic available, Brand covered at 100%, Copay and/or Deductible waived), biological sera, blood or blood plasma;
5. Therapeutic devices or appliances, including needles, syringes, support garments and other non-medical substances, regardless of intended use, except those listed above;
6. Charges for the administration or injection of any Drug;
7. Prescriptions which a Covered Person is entitled to receive without charge from any Workers' Compensation laws;
8. Drugs labeled "Caution-limited by Federal law to Investigational use," or Experimental Drugs, even though a charge is made to the individual;
9. Medication which is to be taken by or administered to an individual, in whole or in part, while he/she is a patient in a licensed Hospital, Extended Care Facility, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a Facility for dispensing pharmaceuticals; and
10. Any prescription refilled in excess of the number specified by the Physician, or any refill dispensed after one (1) year from the Physician's original order.

NOTE: Drugs excluded from the Prescription Drug Plan are not payable under Major Medical Expense Benefits. However, Specialty Drugs that are <u>not</u> listed on the Plan's Select Drugs and Products List (SDL) which are excluded from the Prescription Drug Plan and are determined to be Medically Necessary are payable under Major Medical Expense Benefits. Regarding Specialty Drugs that are listed on the Select Drugs and Products List (SDL) which are excluded from the Prescription Drug Plan and are determined to be Medically Necessary, see "Specialty Drugs Program" in this Prescription Drug Plan Benefits section.

(Traditional Plan only) A Prescription Drug dispensed by a retail pharmacy, Mail Order Service or Specialty Pharmacy for which a Copay applies is not considered a Claim for benefits under this Plan and, therefore, is not subject to the Plan's Claim Filing Procedures.

When Alternative Care and treatment are identified by Case Management as Medically Necessary and approved by the Plan Administrator, and where there is a reasonable expectation of savings to the Plan without sacrificing the quality of care to the Plan Participant (patient), the Plan may approve and pay for all or part of the charges or fees not shown as a Covered Prescription Drug in this Plan Document.

PRESCRIPTION DRUG UTILIZATION AND ADMINISTRATIVE REVIEW

The Prescription Drug benefit does not have unlimited coverage. As with all medical and Hospital services, Prescription Drug utilization is subject to determinations of Medical Necessity, appropriate use and may be subject to administrative review as in the case of Specialty Drugs included on the Select Drugs and Products List. Drug Utilization Review may be concurrent, retrospective or prospective.

Concurrent Drug Utilization Review generally occurs at the time of service and may include electronic Claim audits which may help to protect patients from potential Drug interactions or Drug-therapy conflicts or overuse/under use of medications.

Retrospective Drug Utilization Review generally involves Claim review and may include communication by the Prescription Drug Plan and/or Utilization Review with the prescribing Physician to coordinate care and verify diagnoses and Medical Necessity. It may include a peer review by a Physician of like specialty to the prescribing Physician reviewing the medical and pharmacy records to determine Medical Necessity.

Should Medical Necessity not be determined by the peer review Physician, the treating Physician and Plan Participant will be notified and provided with the peer review results. The Plan Participant and Physician will be forwarded information on the appeal process as outlined in this Plan.

Prospective Drug Utilization Review may include, among other things, Physician or pharmacy assignment in which one Physician and/or one pharmacy is selected to serve as the coordinator of prescription Drug services and benefits for the eligible Plan Participant. The Plan Participant will be notified in writing of this and will be required to designate a Physician and pharmacy as his/her Providers.

COORDINATION OF CARE

Coordination of Care may be indicated for medical treatment that is Medically Necessary and not Experimental. Coordination of Care is provided by a Registered Nurse (RN) to assist the Plan Participant with coordination of medical care, prevent duplicate diagnostic testing and/or treatment, and identify and refer patients with diagnoses that would benefit from further Plan programs such as Case Management, Disease Management and/or Maternity Support.

COORDINATION OF CARE REQUIREMENTS

Contact GPA's HealthWatch department for Coordination of Care prior to receiving the following services:

- **Inpatient Hospital/Facility admissions (including admissions for Mental Disorders, Chemical Dependency, Drug and Substance Abuse);**
- **Inpatient and Home Hospice;**
- **Maternity;**
- **Radiation therapy, chemotherapy, dialysis or infusion therapy;**
- **Home Health Care;**
- **Transplant evaluation.**

Notification is required and must be provided prior to administration of the following products listed below:

- **Inpatient Hospital/Facility administered products included on the Select Drugs and Products List, as designated by the site of service (see Specialty Drugs Program**);**
- **Outpatient/Facility administered products included on the Select Drugs and Products List, as designated by the site of service (see Specialty Drugs Program**).**

CASE MANAGEMENT

During the Utilization Review process, catastrophic cases such as transplants, burns, spinal cord Injuries, cancer and other large cases will be identified and Case Management may be initiated. Case Management is provided by Nurses with specialized training and/or advanced national certification. The Nurse may monitor the medical care, consult with the Physicians, coordinate with the health care Providers and Facilities, and communicate with the patient and Family to promote receipt of appropriate, cost effective care to expedite the recovery process.

When Out-of-Network fees are negotiated by Case Management and/or Utilization Review on behalf of the Plan, Out-of-Network Covered Charges may be considered at the PPO Benefit level.

ALTERNATIVE CARE

Through alternative care, Case Management may help the patient and the Plan Administrator obtain care/treatment for a serious Illness or Injury that is Medically Necessary and appropriate for the diagnosis. When alternative care and treatment are identified by Case Management as Medically Necessary and approved by the Plan Administrator, and where there is a reasonable expectation of savings to the Plan without sacrificing the quality of care to the patient, the Plan may approve and pay for all or part of the charges not shown as a Covered Expense or as a Covered Prescription Drug in this Plan Document. These expenses will be considered on the same basis as the care and treatment for which they are substituted. Benefits provided under this section are subject to all other limitations and provisions within the Plan. In exercising its authority, this Plan will act in a way so as not to discriminate against any Plan Participant. If the care is not being substituted for other Covered Expenses, it will be considered on the same basis as a same or similar Covered Expense or Covered Prescription Drug shown in this Plan Document, as determined by the Claims Administrator.

All benefits provided in this section are subject to Medical Necessity, Reasonableness, and Usual and Customary charges, the Allowable Claim Limits under the Claim Review and Audit Program.

SELECT DIAGNOSTIC MEDICAL PROCEDURES
The following is a list of Select Diagnostic Medical Procedures that may be performed in a Physician's office, the Outpatient department of a Hospital, free-standing center or an independent Facility. Benefits are available under the Plan as specified in the Schedule of Benefits:

1. Bone scan – Specialized x-ray of bone tissues using radioactive injection if more sensitive to bone irregularities than usual x-rays:
   a. Limited area;
   b. Multiple areas;
   c. Whole body;
   d. With vascular flow only;
   e. Three phase technique; or
   f. Tomographic (SPECT).
2. Cardiac stress test:
   a. Thallium – Use of radioactive dye to define areas of decreased blood flow in vessels of the heart while the patient exercises.
   b. Treadmill – Reading of the electrical patterns of the heart (EKG) while the patient exercises on a treadmill.
3. CT Scan – Computerized x-ray picture of a part of the body.
4. MRI (Magnetic Resonance Imaging) – Diagnostic imaging modality that uses magnetic and radio frequency fields to image body tissue non-invasively.
5. PET Scan (Positron Emission Tomography) – A three-dimensional imaging technique that allows visual examination of the internal organs and illustrates organ function.
6. Ultrasound, Echography and Sonography – The use of inaudible sound waves to outline the shape of organs and tissues in the body. A sonogram during Pregnancy is not considered a Select Diagnostic Medical Procedure and is payable under the Plan's Lab/X-ray Benefit.
7. Myelogram – x-ray of the spine after injection of a contrast medium (dye) into a space in the spinal canal.
8. Aortography, Angiography, Lymphangiography, Venography, Transcatheter, Transluminal Atherectomy and Diskography.
9. Nuclear medicine scans.

CALENDAR YEAR MAXIMUM BENEFIT
The Maximum Amount payable for Covered Expenses during a Calendar Year Benefit Period for each Covered Person is limited to a specific dollar amount, number of days or visits as specified in the Schedule of Benefits. The Calendar Year is from January 1 through December 31 of the same year. The initial Calendar Year Benefit Period is from a Covered Person's effective date through December 31 of the same year. Level I and Level II (PPO and Non-PPO) Covered Charges are combined to determine is a Lifetime Maximum Benefit has been met.

CONTINUITY OF CARE
In the event a Participant is a continuing care patient receiving a course of treatment from a Provider which is In-Network or otherwise has a contractual relationship with the Plan governing such care and that contractual relationship is terminated, not renewed, or otherwise ends for any reason other than the Provider's failure to meet applicable quality standards or for fraud, the Participant shall have the following rights to continuation of care.

The Plan shall notify the Participant in a timely manner after termination that the Provider's contractual relationship with the Plan has terminated, and that the Participant has rights to elect continued transitional care from the Provider. If the Participant elects in writing to receive continued transitional care, Plan benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the Plan's notice of termination is provided and ending ninety (90) days later or when the Participant ceases to be a continuing care patient, whichever is sooner.

For purposes of this provision, "continuing care patient" means an individual who is:

- Undergoing a course of treatment for a serious and complex condition from a specific Provider;
- Undergoing a course of institutional or Inpatient care from a specific Provider;
- Scheduled to undergo non-elective surgery from a specific Provider, including receipt of postoperative care with respect to the surgery;

- Pregnant and undergoing a course of treatment for the Pregnancy from a specific Provider; or
- Determined (or was determined) to be terminally ill and is receiving treatment for such Illness from a specific Provider.

Note that during continuation, Plan benefits will be processed as if the termination had not occurred; however, the Provider may be free to pursue the Participant for any amounts above the Plan's benefit amount.

CHARGES RELATED TO ACCIDENTAL INJURIES
Prior to obtaining Accident details, the Maximum Benefit payable on charges arising from an Accidental Injury is $500. Once charges for the same related Claim equal or exceed $500, charges will be denied until expenses are determined to be an eligible benefit under this Plan.

TRADITIONAL PLAN

DEDUCTIBLE AMOUNT (LEVEL I and LEVEL II)
The Deductible amount for each Covered Person is the amount of Covered Expenses which must be incurred each Calendar Year before benefits are payable for Covered Medical Expenses incurred during the remainder of that year. It is the amount shown in the Schedule of Benefits as the Calendar Year Deductible. There is no Deductible carryover from one Calendar Year to the next for Covered Charges incurred and applied to the Deductible in the last three (3) months of a Calendar Year. Level I Covered Charges and Level II PPO and Non-PPO Covered Charges are combined to satisfy the Plan Calendar Year Deductible.

DEDUCTIBLE FAMILY LIMIT (LEVEL I and LEVEL II)
The Maximum Deductible amounts to be applied each Calendar Year to a Covered Employee and his/her covered Dependents will not be more than the Family Limit shown in the Schedule of Benefits. As soon as that limit is met (collectively) three (3) Family members have each satisfied their Deductible in the same Calendar Year, no further Deductibles will be applied to Covered Medical Expenses for any covered Family member during the remainder of that Calendar Year. To satisfy the Deductible Family Limit, each covered Family member can contribute no more than his/her own individual Deductible.

COINSURANCE
Coinsurance is the portion of Covered Medical Expenses shared by the Plan and the Covered Person in a specific ratio (i.e., 80%/20%) after the Calendar Year Deductible has been satisfied. The amount of Coinsurance paid by the Covered Person is applied to satisfy the Covered Person's Annual Out-of-Pocket Maximum.

ANNUAL OUT-OF-POCKET MAXIMUM (LEVEL I and LEVEL II)
The Annual Out-of-Pocket Maximum does not include expenses which are in excess of the Allowable Claim Limits (please refer to the Claim Review and Audit Program section for additional information regarding Allowable Claim Limits). The Annual Out-of-Pocket Maximum is the maximum dollar amount a Covered Person will pay for Covered Medical Expenses each Calendar Year including the Deductible and Medical Copays. Level I Covered Charges and Level II PPO and Non-PPO Covered Charges are combined to satisfy the Annual Out-of-Pocket Maximum. Upon reaching the Annual Out-of-Pocket Maximum, Covered Medical Expenses are payable at 100% for the remainder of the Calendar Year, excluding:

- Prescription Copays (subject to separate Prescription Drug Annual Out-of-Pocket Maximum);
- Expenses for Drugs listed on the Prescription Drug Plan Select Drugs and Products List;
- Any Covered Charges already paid at 100% in any one (1) Calendar Year period, unless otherwise specified in the Schedule of Benefits; and
- Charges in excess of Usual and Customary, Allowable Claim Limits,or charges for services that do not meet the Plan's definition of Reasonable.

ANNUAL OUT-OF-POCKET MAXIMUM FAMILY LIMIT (LEVEL I and LEVEL II)
The Annual Out-of-Pocket Maximum Family Limit is met when all covered Family members (collectively) incur the amount shown in the Schedule of Benefits as the Annual Out-of-Pocket Maximum Family Limit. To satisfy the Family Limit, each Covered Family member can contribute no more than his/her own individual Annual Out-of-Pocket Maximum.

OFFICE VISIT COPAY (PER VISIT)

The Office Visit Copay is the portion of Covered Medical Expenses, a flat dollar amount, payable by the Covered Person for Covered Charges provided by and billed by the Physician at the time of each Physician Office Visit. Whenever an Office Visit Copay applies, the Calendar Year Deductible is waived for that visit except for office procedures listed in the Schedule of Benefits which are not subject to the Office Visit Copay. The Office Visit Copay cannot be used to satisfy the Calendar Year Deductible but will apply to satisfy the Annual Out-of-Pocket Maximum.

Office Visit Copays for a Primary Care Physician and a Specialist are specified in the Schedule of Benefits. A referral from a Primary Care Physician to a Specialist is not required.

HIGH DEDUCTIBLE HEALTH PLAN

DEDUCTIBLE AMOUNT (LEVEL I and LEVEL II)
The Deductible amount for each Covered Person is the amount of Covered Medical and Prescription Drug Expenses which must be incurred each Calendar Year before benefits are payable for Covered Medical and Prescription Drug Expenses incurred during the remainder of that Calendar Year. It is the amount shown in the Schedule of Benefits as the Calendar Year Deductible. There is no Deductible carryover from one Calendar Year to the next for Covered Charges incurred and applied to the Deductible in the last three (3) months of a Calendar Year. Level I Covered Charges, Level II PPO/Non-PPO Covered Charges and Covered Prescription Drug Expenses are combined to satisfy the Calendar Year Deductible.

DEDUCTIBLE FAMILY LIMIT (LEVEL I and LEVEL II)
The Maximum Deductible amounts to be applied each Calendar Year to a Covered Employee and his/her covered Dependents will not be more than the Deductible Family Limit shown in the Schedule of Benefits. As soon as that limit is met (collectively), no further Deductibles will be applied to Covered Medical Expenses for any covered Family member during the remainder of that Calendar Year. To satisfy the Deductible Family Limit, each covered Family member can contribute no more than his/her own individual Deductible.

ANNUAL OUT-OF-POCKET MAXIMUM (LEVEL I and LEVEL II)
The Annual Out-of-Pocket Maximum does not include expenses which are in excess of the Allowable Claim Limits (please refer to the Claim Review and Audit Program section for additional information regarding Allowable Claim Limits). The Annual Out-of-Pocket Maximum is the maximum dollar amount a Covered Person will pay for Covered Medical and Prescription Drug Expenses each Calendar Year including the Deductible.

Level I Covered Charges, Level II PPO/Non-PPO Covered Charges and Covered Prescription Drug Expenses are combined to satisfy the Level I/Level II PPO/Non-PPO Annual Out-of-Pocket Maximum. Upon reaching the Annual Out-of-Pocket Maximum, Covered Medical and Prescription Drug Expenses are payable at 100% for the remainder of the Calendar Year, excluding:

- Expenses for Drugs listed on the Prescription Drug Plan Select Drugs and Products List;
- Any Covered Charges already paid at 100% in any one (1) Calendar Year period, unless otherwise specified in the Schedule of Benefits; and
- Charges in excess of Usual and Customary, Allowable Claim Limits or charges for services that do not meet the Plan's definition of Reasonable.

ANNUAL OUT-OF-POCKET MAXIMUM FAMILY LIMIT (LEVEL I and LEVEL II)
The maximum Annual Out-of-Pocket amounts to be applied each Calendar Year to a Covered Employee and his/her covered Dependents will not be more than the Annual Out-of-Pocket Maximum Family Limit shown in the Schedule of Benefits. As soon as that limit is met (collectively) no further Out-of-Pocket amounts will be applied to Covered Medical and Prescription Drug Expenses during the remainder of that Calendar Year. To satisfy the Family Limit, each Covered Family member can contribute no more than his/her own individual Annual Out-of-Pocket Maximum.

c. Charges that cannot be identified or understood; and
d. Charges that cannot be verified from audits of medical records.

2. **Guidelines.** The following guidelines will be used when determining Allowable Claim Limits:

a. Facilities. The Allowable Claim Limit for Claims by a Facility, including but not limited to, Hospitals, emergency and urgent care centers, rehabilitation and skilled nursing centers, and any other health care Facility, shall be the greater of (I) 112% of the Facility's most recent departmental cost ratio, reported to the Centers for Medicare and Medicaid Services ("CMS") and published in the American Hospital Directory as the "Medicare Cost Report" (the "CMS Cost Ratio"), or (II) the Medicare allowed amount for the services in the geographic area plus an additional 20%. If insufficient information is available to identify either the Facility's most recent departmental cost ratio or the Medicare allowed amount, the Allowable Claim Limit shall be either (I) or (II) herein that can be identified.

b. Ambulatory Health Care Centers. The Allowable Claim Limit for ambulatory health care centers, including Ambulatory Surgery Centers, which are independent Facilities shall be the Medicare allowed amount for the services in the geographic area plus an additional 20%. In the event that insufficient information is available to identify the Medicare allowed amount, the Allowable Claim Limit for such services shall be to the extent available either the Outpatient or Inpatient Medicare allowed amount for the service, plus an additional 20%.

c. Out-of-Network Professional Providers. The Allowable Claim Limits for Out-of-Network professional Providers shall be determined using the following:

i. For general medical and primary care Claims, the Medicare allowed amount in the geographic area plus an additional 40%;
ii. For Specialist medical and surgical care Claims, the Medicare allowed amount in the geographic area plus an additional 55%;
iii. For anesthesiologist Claims, the Medicare allowed amount in the geographic area plus an additional 100%; or
iv. For ambulance and air ambulance Claims, the Medicare allowed amount in the geographic area plus an additional 20%; or
v. For other non-Facility Claims and supplies (such as, but not limited to, Durable Medical Equipment, laboratory services and supplies, and mid-level Providers, etc.), the Medicare allowed amount in the geographic area.

For purposes of determining the proper Allowable Claim Limits for professional Providers in categories (i), (ii), (iii), (iv) or (v) above, the Plan Administrator shall determine the applicable category for each Claim based on the taxonomy code used by the professional Provider for that Claim. The Plan Administrator determines, in its sole discretion, the type of Provider for determining Allowable Claim Limits, as detailed above.

While this Plan typically pays professional Providers based on the Medicare allowed amounts above, certain services may be reimbursed at 110% of the Medicare allowed amount for the service. These services may include, but are not limited to, routine diagnostic tests, evaluation services, telehealth and services for ongoing therapy. A full list of services subject to this rule can be found here: www.planlimit.com/prof1. This list will be updated at least annually to reflect the Plan's current plan design.

d. Directly Contracted Providers. The Allowable Claim Limits for Directly Contracted Providers shall be the negotiated rate as agreed under the Direct Agreement.

e. Insufficient Information to Determine Allowable Claim Limit. In the event that insufficient information is available to determine Allowable Claim Limits for specific services or supplies using the guidelines listed in Section 2 above as may be applicable, ELAP may apply the following guidelines:

i. General Medical and/or Surgical Services. The Allowable Claim Limit for any covered services may be calculated based upon industry-standard resources including, but not limited to, published and publicly available fee and cost lists and comparisons, or any combination of such resources that, in the opinion of the Plan Administrator, results in the determination of a Reasonable expense under the Plan.
ii. Medical and Surgical Supplies, Implants, Devices. The Allowable Claim Limit for charges for medical and surgical supplies made by a Provider may be based upon the invoice price (cost)

AMENDMENT #1

To Plan Document Dated September 1, 2017
and Restated January 1, 2020

GUNNISON COUNTY, COLORADO
EMPLOYEE MEDICAL BENEFIT PLAN
COST PLUS PLAN

The following changes to the Plan Document are effective January 1, 2021:

1. General Information and Purpose, page 4, is deleted in its entirety and replaced with the attached revised page 4.

2. Introduction, pages 5, 6, and 7, are deleted in their entirety and replaced with the attached revised pages 5, 6, 7 and 7a.

3. Schedule of Benefits—Traditional Plan, pages 19, 20, 25 and 27are deleted in their entirety and replaced with the attached revised pages 19, 19a, 20, 25, 25a and 27.

4. Schedule of Benefits---High Deductible Health Plan, pages 29, 30, 34 and 36 are deleted in their entirety and replaced with the attached revised pages 29, 29a, 30, 34, 34a and 36.

5. Case Management, page 45, is deleted in its entirety and replaced with the attached revised page 45 and 45a.

6. Comprehensive Medical Benefits, page 49, is deleted in its entirety and replaced with the attached revised page 49 and 49a.

7. Major Medical Expense Benefits, Autism Spectrum Disorder, page 52, is deleted and replaced as follows:

   Autism Spectrum Disorder. The charges for treatment of Autism Spectrum Disorder provided to a Dependent Child. Treatment includes all generally recognized services prescribed in relation to Autism Spectrum Disorder by the patient's primary care Physician. "Generally recognized services" may include services such as evaluation and assessment, Applied Behavior Analysis (ABA) Therapy, behavior training and management, Speech Therapy, Occupational Therapy, Physical Therapy and medications or nutritional supplements used to address symptoms of Autism Spectrum Disorder.

8. Major Medical Plan Exclusions and Limitations, Education, page 61, is deleted and replaced as follows:

   Education. Charges for education or training of any type including those for learning disabilities, except diabetic self-management medical training for diagnosed cases of diabetes and Applied Behavior Analysis (ABA) Therapy and/or behavior training for treatment of Autism Spectrum Disorder.

9. Claim Review and Audit Program, pages 74 and 75, are deleted in their entirety and replaced with the attached revised pages 74 and 75.

10. Procedures for Claims and Appeals, pages 80 and 81, are deleted in their entirety and replaced with the attached revised pages 80 and 81.

11. Definitions, Direct Agreement, page 114, is deleted and replaced as follows:

    Direct Agreement: A complete agreement between a Directly Contracted Provider and ELAP or the Plan Sponsor which contains the terms and conditions under which the Covered Person may access discounted fees and/or negotiated or scheduled reimbursement rates which the Plan adopts as Allowable Claims Limits for Claims submitted by directly contracted Providers.

12. Definitions, Directly Contracted Provider, page 115, is deleted and replaced as follows:

    Directly Contracted Provider: A medical Provider which has entered into a Direct Agreement with ELAP or the Plan Sponsor to provide certain medical services to Covered Persons at agreed upon Allowable Claim Limits.

13. Definitions, the following new definition is added to the Plan Document as follows:

    Applied Behavior Analysis (ABA) Therapy: Applied Behavior Analysis (ABA) Therapy is a scientific approach that applies the understanding of how behavior works to real situations with the goal of increasing behaviors that are helpful, and decreasing behaviors that are harmful or that affect learning. ABA Therapy involves many techniques for understanding and changing behavior. ABA Therapy programs can help to increase language and communication skills; improve attention, social skills, and academics; and decrease problem behaviors.

In all other respects, the Plan Document remains unchanged.

Acknowledged by:

Gunnison County, Colorado:

By: _____

Printed Name: Jonathan Houck

Title: Chairperson of the Board

Date: 3-16-2021

Claims Administrator
Group & Pension Administrators, LLC dba GPA
Park Central 8
12770 Merit Drive, Suite 200
Dallas, Texas 75251
972-238-7900 ♦ 800-827-7223
The Plan Administrator has retained the services of the Claims Administrator to administer Claims under the Plan.

Utilization Review
GPA's HealthWatch Department
Group & Pension Administrators, LLC dba GPA
Park Central 8
12770 Merit Drive, Suite 200
Dallas, Texas 75251
972-744-2486 ♦ 866-206-3224

Plan Year
The twelve (12) month period beginning January 1 and ending December 31 of each Calendar Year

Employer Tax ID Number
84-6000770

GPA Group Number
H880141

Legal Entity; Service of Process
The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

INTRODUCTION

Gunnison County, Colorado, hereafter referred to as "Employer" hereby amends and restates the Gunnison County, Colorado Employee Medical Benefit Plan, a self-funded Employee Welfare Benefit Plan, hereafter referred to as the "Plan." The Plan's benefits and administration expenses are paid directly from the Employer's general assets, and the rights and privileges of which shall pertain to Employees and their Dependents with respect to such Plan. The Plan is not insured. Contributions received from Covered Persons are used to cover Plan costs and are expended immediately. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

PLAN ADMINISTRATOR AND ELAP

The Plan is administered by the Plan Administrator. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

Notwithstanding any provisions of this Plan Document and Summary Plan Description to the contrary, the Plan Sponsor has the authority to, and hereby does, allocate certain Fiduciary responsibility to ELAP Services LLC (*"ELAP"*). The Fiduciary responsibility allocated to ELAP is limited to discretionary authority and decision-making authority with respect to any appeals of denied Claims, which shall be referred to ELAP by the Plan Administrator (the "Referred Appeals"). The Plan Sponsor has allocated additional Fiduciary responsibility to ELAP, limited to discretionary authority and decision-making authority with respect to the review and audit of certain Claims in accordance with the applicable Plan provisions under the section, "Claim Review and Audit Program". Such Claims selected as eligible for review and audit shall be identified by ELAP under guidelines to which the Plan Sponsor has agreed, and shall be referred to ELAP by the Plan Administrator. ELAP shall have no authority, responsibility or liability other than with respect to the Referred Appeals and its duties under the Claim Review and Audit Program.

The Plan Administrator shall establish the policies, practices and procedures of this Plan. The Plan Administrator and ELAP shall administer this Plan in accordance with its terms. It is the express intent of this Plan that the Plan Administrator and ELAP shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of which services, supplies, care and treatment are Experimental/Investigational), to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator and/or ELAP as to the facts related to any Claim for benefits and the meaning and intent of any provision of the Plan, or its application to any Claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator or ELAP decides, in its discretion, that the Covered Person is entitled to them.

DUTIES OF THE PLAN ADMINISTRATOR

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a Plan Participant's rights;
6. To prescribe procedures for filing a Claim for benefits, to review Claim denials and appeals relating to them and to uphold or reverse such denials;

7. To keep and maintain the Plan documents and all other records pertaining to the Plan;
8. To appoint and supervise a third party administrator to pay Claims;
9. To perform all necessary reporting as required by applicable law;
10. To ensure that the Plan is administered in accordance with applicable law;
11. To establish and communicate procedures to determine whether a Medical Child Support Order or national medical support notice is a QMCSO;
12. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
13. To perform each and every function necessary for or related to the Plan's administration.

DUTIES OF ELAP

ELAP shall have the following duties with respect to the Referred Appeals and the Claim Review and Audit Program:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to benefits payable under the Plan and negotiating settlements, if appropriate;
6. To review Referred Appeals and to uphold or reverse any denials;
7. To keep and maintain records pertaining to the Referred Appeals;
8. To perform the duties in conjunction with the provisions of the Claim Review and Audit Program; and
9. To keep and maintain records pertaining to the Claim Review and Audit Program.

The duties of ELAP shall be limited to those set forth above.

PHYSICIAN-PATIENT RELATIONSHIP

The Plan is not intended to disturb the Physician-Patient relationship. Physicians and other healthcare Providers are not agents or delegates of the Plan Sponsor, Plan Administrator, Employer or Claims Administrator. The delivery of medical and other healthcare services on behalf of any Covered Person remains the sole prerogative and responsibility of the attending Physician or other healthcare Provider.

FREE CHOICE OF HOSPITAL AND PHYSICIAN

Nothing contained in this Plan shall in any way or manner restrict or interfere with the right of any person entitled to benefits hereunder to select a Hospital or to make a free choice of the attending Physician or professional Provider. However, benefits will be paid in accordance with the provisions of this Plan, and the Covered Person may have higher out-of-pocket expenses if the Covered Person uses the services of a Non-Preferred Provider Physician.

PREFERRED PROVIDER INFORMATION

The Preferred Provider Network (PPO) includes Physicians and other professional Providers who have contracted with the medical Provider Networks. For Physicians and all other professional Providers of service, this Plan contains provisions under which a Plan Participant may receive more benefits by using certain Providers. There is a section in the Schedule of Benefits which describes the benefits for PPO Providers (Level II). PPO Providers are individuals and entities that have contracted with the Plan to provide services to Plan Participants at pre-negotiated rates. A list of these Preferred Providers can be accessed on the PPO website free of charge. In addition, a Plan Participant may request a Preferred Provider list by contacting the Plan Administrator. The Preferred Provider list changes frequently; therefore, it is

recommended that a Plan Participant verify with the Provider that the Provider is still a Preferred Provider before receiving services.

The Preferred Provider Network (PPO) does **not** include services and supplies provided by Facilities such as Hospital Facilities, Ambulatory Surgery Center Facilities and dialysis clinics or Facilities. You may contact the Claims Administrator or the Plan Administrator with any questions regarding which Facilities may be included under the Claim Review and Audit Program, and which may be included under the PPO Network agreement.

For all Facility Providers and those Physicians and professional Providers not participating in the PPO, the Plan will identify the Reasonable cost for the services and supplies through its Claim Review and Audit Program. There is a section in this Summary Plan Description that fully describes the Claim Review and Audit Program. The benefits for Facility Providers are described in the Schedule of Benefits under Level I and the benefits for those Physicians and professional Providers not participating in the PPO (Non-PPO) are described in Level II.

This plan may use Allowable Claim Limits to determine Covered Charges in lieu of a PPO discount.

EFFECTIVE DATE

Effective Date of the Plan: **September 1, 2017**; Amended and restated effective: **January 1, 2020**

CLAIMS ADMINISTRATOR

The Claims Administrator of the Plan is shown in the General Information and Purpose section.

NAMED FIDUCIARY

The named Fiduciary to the Plan is **Gunnison County, Colorado**, who, as Plan Administrator, shall have the authority to control and manage the operation and administration of the Plan. The Employer may delegate responsibilities for the operation and administration of the Plan. The Employer or Board of Directors of the Employer, if applicable, shall have the authority to amend or terminate the Plan, to determine its policies, to appoint and remove service Providers, adjust their compensation (if any), and exercise general administrative authority over them. The Employer has the sole authority and responsibility to review and make final decisions on all Claims to benefits hereunder.

CONTRIBUTIONS TO THE PLAN

Contributions to the Plan are to be made on the following basis:

The Employer shall from time to time evaluate the costs of the Plan and determine the amount to be contributed by the Employer and the amount to be contributed by each Covered Employee.

Notwithstanding any other provision of the Plan, the Employer's obligation to pay Claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraph. Payment of said Claims in accordance with these procedures shall discharge completely the Employer's obligation with respect to such payments.

In the event that the Employer, if applicable, terminates the Plan, then as of the effective date of termination, the Employer and Covered Employees shall have no further obligation to make additional contributions to the Plan and the Plan shall have no obligation to pay Claims incurred after the termination date of the Plan.

the Plan Administrator shall provide adequate notice in writing to any covered Plan Participant whose Claim for benefits under this Plan has been denied, setting forth the specific reasons for such denial and written in a manner calculated to be understood by the Plan Participant. Further, the Plan Administrator shall afford a reasonable opportunity to any Plan Participant, whose Claim for benefits has been denied, for a fair review of the decision denying the Claim by the person designated by the Plan Administrator for that purpose.

SCHEDULE OF BENEFITS – TRADITIONAL PLAN (Cont'd.)

LEVEL I BENEFITS – Payment Levels and Limits:
This section applies to covered services rendered by Hospitals and other Facilities shown in the preceding Level I Providers list and to charges for services rendered by Providers billing "as a Facility." The benefits shown apply to all such covered, licensed, accredited Providers of service **without regard to participation in a Preferred Provider Organization (PPO) network**.

Coordination of Care Requirements	
Coordination of Care required for the following services: • Inpatient Hospital/Facility Admissions • Inpatient Hospice • Home Health Care • Other Specified Level I and Level II Services	See Coordination of Care section for additional information.

Utilization Review (UR) Notification Requirements	
Utilization Review required for: • Drugs in the Self-injectable, Physician Administered and Infusion Drug Specialty Program (https://www.gpatpa.com/docs/list.pdf) Physician Administered or Infusion Therapy Drugs Not in Program	Non-compliance Penalties: Drugs in Program: 50% reduction in benefits (for failure to enroll in Program and/or notify UR) Drugs Not in Program: $250 (for failure to notify UR) See Self-injectable, Physician Administered and Infusion Drug Specialty Program in Comprehensive Medical Benefits section for more information.

Benefit Percentage For:	**Level I Benefit**	**Maximum Benefits, Limits & Provisions**
Gunnison Valley Health Systems Inpatient / Outpatient Services		
Gunnison Valley Health Systems Inpatient / Outpatient Services	80% of negotiated rate Deductible applies	
Hospital/Facility Inpatient Services		
Inpatient Hospital Services	80% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Contact Utilization Review for Coordination of Care.
Maternity Inpatient Hospital Services	80% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Contact Utilization Review for Coordination of Care.
Routine Newborn Care Inpatient Hospital Services (to date of mother's discharge)	80% of Allowable Claim Limits for nursery Room and Board/ancillary charges Deductible applies	
Skilled Nursing Facility	80% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Limited to 120 days per Calendar Year. Contact Utilization Review for Coordination of Care.
Rehabilitation Facility	80% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Contact Utilization Review for Coordination of Care.
Mental Disorders/Chemical Dependency, Drug and Substance Abuse Inpatient Hospital Services/ Residential Treatment Center	80% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Contact Utilization Review for Coordination of Care.

Emergency Room (Hospital Emergency Room Services/ Free-standing Emergency Room Facility Services)		
Emergency Room	80% of Allowable Claim Limits Deductible applies	If admitted Inpatient, contact Utilization Review for Coordination of Care.
Hospital/Facility Outpatient Diagnostic/Preventive Screening Services		
Select Diagnostic Medical Procedures (MRI, CT scan, etc.; see list in Comprehensive Medical Benefits section)	80% of Allowable Claim Limits Deductible applies	
All Other Diagnostic Lab and X-ray	80% of Allowable Claim Limits Deductible applies	

SCHEDULE OF BENEFITS – TRADITIONAL PLAN (Cont'd.)

Benefit Percentage For:	Level I Benefit	Maximum Benefits, Limits & Provisions
Hospital/Facility Outpatient Diagnostic/Preventive Screening Services		
Routine Bone Density Test, Other Routine Diagnostic Lab and X-ray	100% of Allowable Claim Limits Deductible waived	Age and/or frequency limitations may apply.
Annual Mammogram (Routine screening) Additional Mammogram (Diagnostic)	100% of Allowable Claim Limits Deductible waived 80% of Allowable Claim Limits Deductible applies	
Colonoscopy (including polyp removal) (Routine or Diagnostic)	100% of Allowable Claim Limits Deductible waived	Benefit applies beginning at age 50 or Family history of colon cancer with or without diagnosis.
Women's Elective Sterilization Procedures		
All Covered Expenses	100% of Allowable Claim Limits Deductible waived	All FDA approved
Outpatient Surgery/Ambulatory Surgery Centers Covered Services and Supplies		
All Covered Expenses	80% of Allowable Claim Limits Deductible applies	
Outpatient Psychiatric Day Treatment Facility and Outpatient Chemical Dependency Drug Treatment Facility		
Day Treatment Facility/ Psychological Testing/ Outpatient Therapy (including group therapy)	80% of Allowable Claim Limits Deductible applies	
Physical, Occupational and Speech Therapy Services		
All Covered Expenses	80% of Allowable Claim Limits Deductible applies	Limited to 60 visits per therapy per Calendar Year.
Cardiac Rehabilitation		
All Covered Expenses	80% of Allowable Claim Limits Deductible applies	
Chemotherapy, Radiation Therapy, Dialysis Facilities Covered Services and Supplies		
All Covered Expenses	80% of Allowable Claim Limits Deductible applies	Contact Utilization Review for Coordination of Care.
Infusion Therapy Covered Services and Supplies		
Drugs in the Self-Injectable Physician Administered and Infusion Drug Specialty Program (https://www.gpatpa.com/docs/list.pdf) **Other Drugs Not in Program** (UR Notification required or Plan's standard UR penalty applies.)	80% of Allowable Claim Limits Deductible applies 80% of Allowable Claim Limits Deductible applies	UR Notification required for Drugs in Program. 50% benefit reduction penalty applies for failure to enroll and/or notify UR. See Self-injectable, Physician Administered and Infusion Drug Specialty Program in Utilization Review (UR) Program section.
Diabetic Self-Management Training		
All Covered Expenses	80% of Allowable Claim Limits Deductible applies	
Hospice		
All Covered Expenses	80% of Allowable Claim Limits Deductible applies	Contact Utilization Review for Coordination of Care for Inpatient and Homebound Hospice.

SCHEDULE OF BENEFITS – TRADITIONAL PLAN (Cont'd.)

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
Other Covered Services			
***Therapy Services** • Physical • Occupational • Speech	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	Limited to 60 visits per therapy per Calendar Year.
***Cardiac Rehabilitation**	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
***Chemotherapy/ Radiation Therapy/ Dialysis**	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	Contact Utilization Review for Coordination of Care.
***Infusion Therapy** **Drugs in the Self-Injectable Physician Administered and Infusion Drug Specialty Program** (https://www.gpatpa.com/docs/list.pdf) **Other Drugs Not in Program** (UR Notification required or Plan's standard UR penalty applies.)	80% of PPO rate Deductible applies 80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies 80% of Allowable Claim Limits Deductible applies	UR Notification required for Drugs in Program. 50% benefit reduction penalty applies for failure to enroll and/or notify UR. See Self-injectable, Physician Administered and Infusion Drug Specialty Program in Utilization Review (UR) Program section.
***Durable Medical Equipment**	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
***Orthotic Devices**	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
***Prosthetics**	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
Hearing Exams / Hearing Aids	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	Hearing aids are limited to $4,500 Calendar Year Maximum Benefit every five (5) years. Maximum Benefit does not apply to initial purchase of hearing aid/device if Medically Necessary due to Illness, Accidental Injury, Congenital Anomaly or Surgical Procedure.

SCHEDULE OF BENEFITS – TRADITIONAL PLAN (Cont'd.)

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
Other Covered Services			
***Home Health Care Services**	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	Limited to 120 visits per Calendar Year. Contact Utilization Review for Coordination of Care.
***Home Infusion Therapy** **Drugs in the Self-Injectable, Physician Administered and Infusion Drug Specialty Program** (https://www.gpatpa.com/docs/list.pdf) UR Notification required. 50% benefit reduction penalty applies for failure to enroll and/or notify UR. See Self-injectable, Physician Administered and Infusion Drug Specialty Program in Utilization Review (UR) Program section.	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	UR Notification required for Drugs in Program. 50% benefit reduction penalty applies for failure to enroll and/or notify UR. See Self-injectable, Physician Administered and Infusion Drug Specialty Program in Utilization Review (UR) Program section.
Other Drugs Not in Program UR Notification required or Plan's standard UR penalty applies	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	

SCHEDULE OF BENEFITS – HIGH DEDUCTIBLE HEALTH PLAN (Cont'd.)

LEVEL I BENEFITS – Payment Levels and Limits:
This section applies to covered services rendered by Hospitals and other Facilities shown in the preceding Level I Providers list and to charges for services rendered by Providers billing "as a Facility." The benefits shown apply to all such covered, licensed, accredited Providers of service **without regard to participation in a Preferred Provider Organization (PPO) network**.

Coordination of Care Requirements	
Coordination of Care required for the following services: • Inpatient Hospital/Facility Admissions • Inpatient Hospice • Home Health Care • Other Specified Level I and Level II Services	See Coordination of Care section for additional information.

Utilization Review (UR) Notification Requirements	
Utilization Review required for: • Drugs in the Self-injectable, Physician Administered and Infusion Drug Specialty Program (https://www.gpatpa.com/docs/list.pdf) Physician Administered or Infusion Therapy Drugs Not in Program	Non-compliance Penalties: Drugs in Program: 50% reduction in benefits (for failure to enroll in Program and/or notify UR) Drugs Not in Program: $250 (for failure to notify UR) See Self-injectable, Physician Administered and Infusion Drug Specialty Program in Comprehensive Medical Benefits section for more information.

Benefit Percentage For:	**Level I Benefit**	**Maximum Benefits, Limits & Provisions**
Gunnison Valley Health Systems Inpatient / Outpatient Services		
Gunnison Valley Health Systems Inpatient / Outpatient Services	100% of negotiated rate Deductible applies	
Hospital/Facility Inpatient Services		
Inpatient Hospital Services	100% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Contact Utilization Review for Coordination of Care.
Maternity Inpatient Hospital Services	100% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Contact Utilization Review for Coordination of Care.
Routine Newborn Care Inpatient Hospital Services (to date of mother's discharge)	100% of Allowable Claim Limits for nursery Room and Board/ancillary charges Deductible applies	
Skilled Nursing Facility	100% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Limited to 120 days per Calendar Year. Contact Utilization Review for Coordination of Care.
Rehabilitation Facility	100% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Contact Utilization Review for Coordination of Care.
Mental Disorders/Chemical Dependency, Drug and Substance Abuse Inpatient Hospital Services/ Residential Treatment Center	100% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Contact Utilization Review for Coordination of Care.

Emergency Room (Hospital Emergency Room Services/ Free-standing Emergency Room Facility Services)		
Emergency Room	100% of Allowable Claim Limits Deductible applies	If admitted Inpatient, contact Utilization Review for Coordination of Care.
Hospital/Facility Outpatient Diagnostic/Preventive Screening Services		
Select Diagnostic Medical Procedures (MRI, CT scan, etc.; see list in Comprehensive Medical Benefits section)	100% of Allowable Claim Limits Deductible applies	
All Other Diagnostic Lab and X-ray	100% of Allowable Claim Limits Deductible applies	

SCHEDULE OF BENEFITS – HIGH DEDUCTIBLE HEALTH PLAN (Cont'd.)

Benefit Percentage For:	Level I Benefit	Maximum Benefits, Limits & Provisions
Hospital/Facility Outpatient Diagnostic/Preventive Screening Services		
Routine Bone Density Test, Other Routine Diagnostic Lab and X-ray	100% of Allowable Claim Limits Deductible waived	Age and/or frequency limitations may apply.
Annual Mammogram (Routine screening) Additional Mammogram (Diagnostic)	100% of Allowable Claim Limits Deductible waived 100% of Allowable Claim Limits Deductible applies	
Colonoscopy (including polyp removal) (Routine or Diagnostic)	100% of Allowable Claim Limits Deductible waived	Benefit applies beginning at age 50 or Family history of colon cancer with or without diagnosis.
Women's Elective Sterilization Procedures		
All Covered Expenses	100% of Allowable Claim Limits Deductible waived	All FDA approved
Outpatient Surgery/Ambulatory Surgery Centers Covered Services and Supplies		
All Covered Expenses	100% of Allowable Claim Limits Deductible applies	
Outpatient Psychiatric Day Treatment Facility and Outpatient Chemical Dependency Drug Treatment Facility		
Day Treatment Facility/ Psychological Testing/ Outpatient Therapy (including group therapy)	100% of Allowable Claim Limits Deductible applies	
Physical, Occupational and Speech Therapy Services		
All Covered Expenses	100% of Allowable Claim Limits Deductible applies	Limited to 60 visits per therapy per Calendar Year.
Cardiac Rehabilitation		
All Covered Expenses	100% of Allowable Claim Limits Deductible applies	
Chemotherapy, Radiation Therapy, Dialysis Facilities Covered Services and Supplies		
All Covered Expenses	100% of Allowable Claim Limits Deductible applies	Contact Utilization Review for Coordination of Care.
Infusion Therapy Covered Services and Supplies		
Drugs in the Self-Injectable Physician Administered and Infusion Drug Specialty Program (https://www.gpatpa.com/docs/list.pdf) **Other Drugs Not in Program** (UR Notification required or Plan's standard UR penalty applies.)	100% of Allowable Claim Limits Deductible applies 100% of Allowable Claim Limits Deductible applies	UR Notification required for Drugs in Program. 50% benefit reduction penalty applies for failure to enroll and/or notify UR. See Self-injectable, Physician Administered and Infusion Drug Specialty Program in Utilization Review (UR) Program section.
Diabetic Self-Management Training		
All Covered Expenses	100% of Allowable Claim Limits Deductible applies	
Hospice		
All Covered Expenses	100% of Allowable Claim Limits Deductible applies	Contact Utilization Review for Coordination of Care for Inpatient and Homebound Hospice.

SCHEDULE OF BENEFITS – HIGH DEDUCTIBLE HEALTH PLAN (Cont'd.)

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
Other Covered Services			
***Therapy Services** • Physical • Occupational • Speech	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	Limited to 60 visits per therapy per Calendar Year.
***Cardiac Rehabilitation**	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
***Chemotherapy/ Radiation Therapy/ Dialysis**	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	Contact Utilization Review for Coordination of Care.
***Infusion Therapy** **Drugs in the Self-Injectable Physician Administered and Infusion Drug Specialty Program** (https://www.gpatpa.com/docs/list.pdf) **Other Drugs Not in Program** (UR Notification required or Plan's standard UR penalty applies.)	100% of PPO rate Deductible applies 100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies 100% of Allowable Claim Limits Deductible applies	UR Notification required for Drugs in Program. 50% benefit reduction penalty applies for failure to enroll and/or notify UR. See Self-injectable, Physician Administered and Infusion Drug Specialty Program in Utilization Review (UR) Program section.
***Durable Medical Equipment**	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
***Orthotic Devices**	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
***Prosthetics**	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
Hearing Exams/Hearing Aids	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	Hearing aids are limited to $4,500 Calendar Year Maximum Benefit every five (5) years. Maximum Benefit does not apply to initial purchase of hearing aid/device if Medically Necessary due to Illness, Accidental Injury, Congenital Anomaly or Surgical Procedure.

SCHEDULE OF BENEFITS – HIGH DEDUCTIBLE HEALTH PLAN (Cont'd.)

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
Other Covered Services			
***Home Health Care Services**	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	Limited to 120 visits per Calendar Year. Contact Utilization Review for Coordination of Care.
***Home Infusion Therapy** **Drugs in the Self-Injectable, Physician Administered and Infusion Drug Specialty Program** (https://www.gpatpa.com/docs/list.pdf) UR Notification required. 50% benefit reduction penalty applies for failure to enroll and/or notify UR. See Self-injectable, Physician Administered and Infusion Drug Specialty Program in Utilization Review (UR) Program section.	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	UR Notification required for Drugs in Program. 50% benefit reduction penalty applies for failure to enroll and/or notify UR. See Self-injectable, Physician Administered and Infusion Drug Specialty Program in Utilization Review (UR) Program section.
Other Drugs Not in Program UR Notification required or Plan's standard UR penalty applies	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	

COORDINATION OF CARE

Coordination of Care may be indicated for medical treatment that is Medically Necessary and not Experimental. Coordination of Care is provided by a Registered Nurse (RN) to assist the Plan Participant with coordination of medical care, prevent duplicate diagnostic testing and/or treatment, and identify and refer patients with diagnoses that would benefit from further Plan programs such as Case Management, Disease Management and/or Maternity Support.

COORDINATION OF CARE REQUIREMENTS

Contact GPA's HealthWatch department for Coordination of Care prior to receiving the following services:

- **Inpatient Hospital/Facility admissions (including admissions for Mental Disorders, Chemical Dependency, Drug and Substance Abuse);**
- **Inpatient and Home Hospice;**
- **Maternity;**
- **Radiation therapy, chemotherapy, dialysis or infusion therapy;**
- **Home Health Care;**
- **Transplant evaluation.**

CASE MANAGEMENT

During the Utilization Review process, catastrophic cases such as transplants, burns, spinal cord Injuries, cancer and other large cases will be identified and Case Management may be initiated. Case Management is provided by Nurses with specialized training and/or advanced national certification. The Nurse may monitor the medical care, consult with the Physicians, coordinate with the health care Providers and Facilities, and communicate with the patient and Family to promote receipt of appropriate, cost effective care to expedite the recovery process.

When Out-of-Network fees are negotiated by Case Management and/or Utilization Review on behalf of the Plan, Out-of-Network Covered Charges may be considered at the PPO Benefit level.

SELF-INJECTABLE, PHYSICIAN ADMINISTERED AND INFUSION DRUG SPECIALTY PROGRAM

Please contact GPA's HealthWatch department for any Drug administered in the Physician's office, Hospital (Inpatient/Outpatient), Drug Infusion Center, Home Health Care setting, or self-injected Drug that is in the Program. Drugs listed under the Plan's Self-injectable, Physician Administered and Infusion Drug Specialty Program are required for this Utilization Review. Refer to https://www.gpatpa.com/docs/list.pdf for the most recent listing. Under the Program, HealthWatch will review the patient's diagnosis and the FDA approved uses for that drug, including but not limited to, dosage, completion of the applicable diagnostic tests and the patient's overall medical condition.

The Plan retains discretionary authority to determine the most cost effective method of Drug purchasing, including purchasing from a Specialty Drug Pharmacy and delivery to the service Provider's Facility. Where there is a reasonable expectation of savings to the Plan without sacrificing the quality of care to the patient, the Plan may approve and pay for all or part of the charges including where the patient may receive the infusion, or site of care, including the Hospital Facility, Physician's office, Infusion Center and Home Health Care setting with no penalty if the alternative is used as directed under the Self-injectable, Physician Administered and Infusion Drug Specialty Program (https://www.gpatpa.com/docs/list.pdf) in the Comprehensive Medical Benefits Section.

ALTERNATIVE CARE

Through alternative care, Case Management may help the patient and the Plan Administrator obtain care/treatment for a serious Illness or Injury that is Medically Necessary and appropriate for the diagnosis. When alternative care and treatment are identified by Case Management as Medically Necessary and approved by the Plan Administrator, and where there is a reasonable expectation of savings to the Plan without sacrificing the quality of care to the patient, the Plan may approve and pay for all or part of the charges not shown as a Covered Expense or as a Covered Prescription Drug in this Plan Document. These expenses will be considered on the same basis as the care and treatment for which they are substituted. Benefits provided under this section are subject to all other limitations and provisions within the Plan. In exercising its authority, this Plan will act in a way so as not to discriminate against any Plan Participant. If the care is not being substituted for other Covered Expenses, it will be considered on the same basis as a same or similar Covered Expense or Covered Prescription Drug shown in this Plan Document, as determined by the Claims Administrator.

All benefits provided in this section are subject to Medical Necessity, Reasonableness, and Usual and Customary charges, the Allowable Claim Limits under the Claim Review and Audit Program.

SELECT DIAGNOSTIC MEDICAL PROCEDURES
The following is a list of Select Diagnostic Medical Procedures that may be performed in a Physician's office, the Outpatient department of a Hospital, free-standing center or an independent Facility. Benefits are available under the Plan as specified in the Schedule of Benefits:

1. Bone scan – Specialized x-ray of bone tissues using radioactive injection if more sensitive to bone irregularities than usual x-rays:
   a. Limited area;
   b. Multiple areas;
   c. Whole body;
   d. With vascular flow only;
   e. Three phase technique; or
   f. Tomographic (SPECT).
2. Cardiac stress test:
   a. Thallium – Use of radioactive dye to define areas of decreased blood flow in vessels of the heart while the patient exercises.
   b. Treadmill – Reading of the electrical patterns of the heart (EKG) while the patient exercises on a treadmill.
3. CT Scan – Computerized x-ray picture of a part of the body.
4. MRI (Magnetic Resonance Imaging) – Diagnostic imaging modality that uses magnetic and radio frequency fields to image body tissue non-invasively.
5. PET Scan (Positron Emission Tomography) – A three-dimensional imaging technique that allows visual examination of the internal organs and illustrates organ function.
6. Ultrasound, Echography and Sonography – The use of inaudible sound waves to outline the shape of organs and tissues in the body. A sonogram during Pregnancy is not considered a Select Diagnostic Medical Procedure and is payable under the Plan's Lab/X-ray Benefit.
7. Myelogram – x-ray of the spine after injection of a contrast medium (dye) into a space in the spinal canal.
8. Aortography, Angiography, Lymphangiography, Venography, Transcatheter, Transluminal Atherectomy and Diskography.
9. Nuclear medicine scans.

SELF-INJECTABLE, PHYSICIAN ADMINISTERED AND INFUSION DRUG SPECIALTY PROGRAM ("PROGRAM") (https://www.gpatpa.com/docs/list.pdf)
This program considers the complex nature of this type of Prescription Drug administration. The most common form of administration of these medications is via a controlled shot or injection. After some required training, this type of injectable medication may be administered by the patient or a family member. Other forms of these medications are infused into the body in a Specialty Facility. These medications are in the form of a liquid, must be administered in a medical setting by a trained care member, and are typically located in a Physician's office, Hospital, Infusion or Home Health Care setting.

It is important to confirm if the Drugs are part of the Program under the Plan prior to their administration. The listing for these medications is found at https://www.gpatpa.com/docs/list.pdf. This will require a call to GPA's HealthWatch department for Utilization Review. The review of medications may result in changes in the dosage, how the Drug may be purchased, and/or where the patient may receive treatment.

Participation in the Program will result in benefits being paid as stated in the Schedule of Benefits. If the patient does not participate in the Program but receives Drugs that are included under the Program, the patient will be responsible for the penalty stated in the Schedule of Benefits.

CALENDAR YEAR MAXIMUM BENEFIT
The Maximum Amount payable for Covered Expenses during a Calendar Year Benefit Period for each Covered Person is limited to a specific dollar amount, number of days or visits as specified in the Schedule of Benefits. The Calendar Year is from January 1 through December 31 of the same year. The initial Calendar Year Benefit Period is from a Covered Person's effective date through December 31 of the same year. Level I and Level II (PPO and Non-PPO) Covered Charges are combined to determine is a Lifetime Maximum Benefit has been met.

CONTINUITY OF CARE

If a Covered Person is receiving treatment, services or supplies from an Preferred Physician and that Preferred Physician terminates or is terminated from the Preferred Physician Network or if the Plan Administrator changes PPO Networks, benefits for such services, treatment or supplies will continue to be paid at the Preferred Physician benefit level for a period of ninety (90) days from the date of the Preferred Physician's termination if the treatment, services or supplies are being provided for special circumstances such as:

- An acute condition;
- A life-threatening Illness; or
- Past the twenty-fourth (24th) week of Pregnancy and the Covered Person is receiving treatment in accordance with the dictates of medical prudence.

Special circumstances mean a condition such that the treating Physician or health care Provider reasonably believes that discontinuing care by the treating Physician or Provider could cause harm to the patient. Special circumstances shall be identified by the treating Physician or health care Provider who

CLAIM REVIEW AND AUDIT PROGRAM

The Plan has arranged with ELAP Services, LLC ("ELAP") for a program of Claim review and auditing in order to identify charges billed in error, charges for excessive or unreasonable fees and charges for services which are not medically appropriate. Benefits for Claims which are selected for review and auditing will be reduced for any charges that are determined to be in excess of Allowable Claim Limits (as defined below). The determination of Allowable Claim Limits under this Program will supersede any other Plan provisions related to application of a Usual and Customary fee determination.

Medical care Providers will be given a fully detailed explanation of any charges that are found to be in excess of Allowable Claim Limits, and allowed the rights and privileges to file an appeal of the determination in accordance with the same rights and privileges accorded to Plan Participants, in exchange for the Provider's agreement not to bill the Plan Participant for charges which were not covered as a result of the Claim review and audit.

Any Plan Participant who continues to receive billings from the medical care Provider for these charges should contact ELAP or the Plan Administrator right away for assistance.

The Plan Administrator is identified in the General Information and Purpose section of this Summary Plan Description. ELAP may be contacted at:

ELAP Services, LLC
1550 Liberty Ridge, Suite 330
Wayne, PA 19087
Phone: 610-321-1030
Fax: 610-321-1031

The Plan Participant must pay for any normal cost-sharing features of the Plan, such as Deductibles, Coinsurance and Copayments, and any amounts otherwise excluded or limited according to the terms of the Plan.

The success of this program will be achieved through a comprehensive review of detailed records including, for example, itemized charges and descriptions of the services and supplies provided. Without this detailed information, the Plan will be unable to make a determination of the amount of Covered Medical Expenses that may be eligible for reimbursement. Any additional information required for the audit will be requested directly from the Provider of service and the Claimant. In the event that the Plan Administrator does not receive information adequate for the Claim review and audit within the time limits required under the Plan, it will be necessary to deny the Claim. Should such a denial be necessary, the Claimant and/or the Provider of service may appeal the denial in accordance with the provisions which may be found in the section, "Procedures for Claims and Appeals," in this Summary Plan Description.

In the following provisions of the Claim Review and Audit Program, the term "Plan Administrator" shall be deemed to mean ELAP:

"Allowable Claim Limits" means the charges for services and supplies, listed and included as Covered Medical Expenses under the Plan, which are Medically Necessary for the care and treatment of Illness or Injury, but only to the extent that such fees are within the Allowable Claim Limits. Examples of the determination that a charge is within the Allowable Claim Limit include, but are not limited to, the following guidelines:

1. **Errors, Unbundled and/or Unsubstantiated Charges.** Allowable Claim Limits will not include the following amounts:

    a. Charges identified as improperly coded, duplicated, unbundled and/or for services not performed;
    b. Charges for treating Injuries sustained or Illnesses contracted, including infections and complications, which, in the opinion of the Plan Administrator, can be attributed to medical errors by the Provider;

c. Charges that cannot be identified or understood; and
d. Charges that cannot be verified from audits of medical records.

2. **Guidelines.** The following guidelines will be used when determining Allowable Claim Limits:

a. Facilities. The Allowable Claim Limit for Claims by a Facility, including but not limited to, Hospitals, emergency and urgent care centers, rehabilitation and skilled nursing centers, and any other health care Facility, shall be the greater of (I) 112% of the Facility's most recent departmental cost ratio, reported to the Centers for Medicare and Medicaid Services ("CMS") and published in the American Hospital Directory as the "Medicare Cost Report" (the "CMS Cost Ratio"), or (II) the Medicare allowed amount for the services in the geographic area plus an additional 20%. If insufficient information is available to identify either the Facility's most recent departmental cost ratio or the Medicare allowed amount, the Allowable Claim Limit shall be either (I) or (II) herein that can be identified.
b. Ambulatory Health Care Centers. The Allowable Claim Limit for ambulatory health care centers, including Ambulatory Surgery Centers, which are independent Facilities shall be the Medicare allowed amount for the services in the geographic area plus an additional 20%. In the event that insufficient information is available to identify the Medicare allowed amount, the Allowable Claim Limit for such services shall be to the extent available either the Outpatient or Inpatient Medicare allowed amount for the service, plus an additional 20%.

c. Professional Providers. The Allowable Claim Limits for professional Providers shall be determined using the following:

i. For general medical and primary care Claims, the Medicare allowed amount in the geographic area plus an additional 40%;
ii. For Specialist medical and surgical care Claims, the Medicare allowed amount in the geographic area plus an additional 55%;
iii. For anesthesiologist Claims, the Medicare allowed amount in the geographic area plus an additional 100%; or
iv. For other non-Facility Claims and supplies (such as Durable Medical Equipment, laboratory services and supplies, ambulance, air ambulance, etc.), the Medicare allowed amount in the geographic area plus an additional 25%.

For purposes of determining the proper Allowable Claim Limits for professional Providers in categories (i), (ii), (iii) or (iv) above, the Plan Administrator shall determine the applicable category for each Claim based on the taxonomy code used by the professional Provider for that Claim. The Plan Administrator determines, in its sole discretion, the type of Provider for determining Allowable Claim Limits, as detailed above.

While this Plan typically pays professional Providers based on the Medicare allowed amounts above, certain services may be reimbursed at 110% of the Medicare allowed amount for the service. These services may include, but are not limited to, routine diagnostic tests, evaluation services, and services for ongoing therapy. A full list of services subject to this rule can be found here: www.planlimit.com/prof1. This list will be updated at least annually to reflect the Plan's current plan design.

d. Directly Contracted Providers. The Allowable Claim Limits for Directly Contracted Providers shall be the negotiated rate as agreed under the Direct Agreement.

e. Insufficient Information to Determine Allowable Claim Limit. In the event that insufficient information is available to determine Allowable Claim Limits for specific services or supplies using the guidelines listed in Section 2 above as may be applicable, ELAP may apply the following guidelines:

i. General Medical and/or Surgical Services. The Allowable Claim Limit for any covered services may be calculated based upon industry-standard resources including, but not limited to, published and publicly available fee and cost lists and comparisons, or any combination of such resources that, in the opinion of the Plan Administrator, results in the determination of a Reasonable expense under the Plan.
ii. Pharmaceuticals. The Allowable Claim Limit for pharmacy charges by a Provider may be determined by applying the Average Wholesale Price (AWP) as defined by REDBOOK at the rate of 112% of AWP.
iii. Medical and Surgical Supplies, Implants, Devices. The Allowable Claim Limit for charges for medical and surgical supplies made by a Provider may be based upon the invoice price (cost)

Review and Audit Program" for information regarding Plan provisions related to the audit and adjudication of certain eligible Claims under that Program.

PAYMENT OF CLAIMS

Plan benefits are payable to the Covered Employee, unless the Claimant gives written direction, at the time of filing proof of such loss, to pay directly the health care Provider rendering such services. Such payment to a health care Provider is subject to the approval of the Plan Administrator. If any such benefit remains unpaid at the death of the Covered Employee, if the Claimant is a minor, or if the Claimant is (in the opinion of the Plan Administrator) legally incapable of giving a valid receipt and discharge for any payment, the Plan Administrator may, at its option, pay such benefits to any one or more of the following relatives of the Claimant: wife, husband, mother, father, Child or Children, brother or brothers, sister or sisters. Such payment will constitute a complete discharge of the Plan's obligation to the extent of such payment, and the Plan Administrator will not be required to follow-up and determine how such paid money was used.

APPEAL PROCESS

The Plan provides for two (2) levels of appeal following an Adverse Benefit Determination. The Claimant has one hundred eighty (180) days following an initial Adverse Benefit Determination to file an appeal of that determination, and sixty (60) days following a second Adverse Benefit Determination to file an appeal of that determination. The appeal process will provide the Claimant with a reasonable opportunity for a full and fair review of the Claim and Adverse Benefit Determination and will include the following:

1. Receipt of written request by the Claims Administrator from the Claimant, or an Authorized Representative of the Claimant, with the proper form for review of Adverse Benefit Determination, which initiates the appeal process.

2. The Claimant will have the opportunity to submit written comments, documents, records, and other information relating to the Claim.

3. The Claimant will have the opportunity to review the Claim file and to present evidence and testimony as part of the internal Claims and appeals process.

4. The Claimant will be provided, free of charge and sufficiently in advance of the date that the notice of final internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Claimant to respond to such new evidence or rationale.

5. The Claimant will be provided, on request and free of charge: (a) reasonable access to, and copies of all documents, records, and other information relevant to the Claimant's Claim in possession of the Plan Administrator, ELAP Services, LLC ("ELAP") or the Claims Administrator; (b) information regarding any rule, guideline, protocol, or other similar criterion relied upon in making the Adverse Benefit Determination; (c) information regarding any voluntary appeals procedures offered by the Plan; (d) information regarding the Claimant's right to an external review process; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances.

6. The review of the Adverse Benefit Determination will take into account all comments, documents, records and other information submitted by the Claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination.

7. No deference will be afforded to the previous Adverse Benefit Determination.

8. The party reviewing the appeal may be neither the party who made the prior Adverse Benefit Determination, nor a subordinate of the party who made the prior Adverse Benefit Determination.

9. In deciding an appeal on which the Adverse Benefit Determination was based in whole or in part on a medical judgment, including whether a particular treatment, Drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the Claims Administrator, ELAP or the Plan Administrator, as appropriate depending on the level of appeal, will consult with a health care professional who has appropriate training and experience in the field of medicine involving the medical judgment. The health care professional consulted for the appeal will not be the health care professional or a subordinate of the health care professional consulted in connection with the Adverse Benefit Determination that is the subject of the appeal.

10. Medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination will be identified, even if the Plan did not rely upon their advice.

11. The first level of appeal will be the responsibility of the Claims Administrator and will be decided within thirty (30) days of the Claims Administrator's receipt of the request. The second level of appeal will be the responsibility of ELAP and will be decided within thirty (30) days of the Plan's receipt of the request.

For questions about appeal rights or for assistance, Claimants can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). Consumer assistance may be available in your State. Contact your State Department of Insurance to find out if consumer assistance for Claim appeals is available. See Appendix I for additional information.

FIRST APPEAL LEVEL

Requirements for First Appeal
The Claimant must file the first appeal, in writing, within one hundred eighty (180) days following receipt of the notice of an Adverse Benefit Determination. The Claimant's appeal must be addressed as follows:

Appeals Department
Group & Pension Administrators, LLC. dba (GPA)
Park Central 8
12770 Merit Drive, Suite 200
Dallas, Texas 75251

It shall be the responsibility of the Claimant to submit proof that the Claim is covered and payable under the provisions of the Plan. An appeal must include:

1. The name of the Employee/Claimant;
2. The Employee's/Claimant's Social Security number;
3. The group name or identification number;
4. All facts and theories supporting the Claim for benefits. **Failure to include any theories or facts in the appeal will result in such facts being inadmissible. In other words, the Claimant will lose the right to raise such factual arguments and theories which support this Claim if the Claimant fails to include them in the appeal;**
5. A statement in clear and concise terms of the reason or reasons for the disagreement with the handling of the Claim; and
6. Any material or information that the Claimant has which indicates that the Claimant is entitled to benefits under the Plan.

If the Claimant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on First Appeal
The Plan shall notify the Claimant of the Plan's Benefit Determination on review within a reasonable period of time, but not later than thirty (30) days after receipt of the appeal.

PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

FOR

GUNNISON COUNTY, COLORADO

COST PLUS PLAN

GUNNISON COUNTY, COLORADO EMPLOYEE DENTAL AND VISION BENEFIT PLAN

ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

It is the intention of the Plan Sponsor, **Gunnison County, Colorado**, to hereby amend and restate the Gunnison County, Colorado Employee Dental and Vision Benefit Plan, a program of benefits constituting a self-funded "Employee Welfare Benefit Plan"

Effective Date
The Plan Document is effective as of the date first set forth below, and each amendment is effective as of the date set forth therein (the "Effective Date").

Adoption of the Plan Document
The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description, This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has executed, and the Claims Administrator has acknowledged, this Plan Document as of the Plan effective date shown herein.

Effective Date of the Plan: **September 1, 2017**; Amended and restated effective: **January 1, 2020**

Gunnison County, Colorado:

By: _____
Printed Name: JONATHAN HOUCK
Title: CHAIR - GUNNISON BOCC
Date: 1/21/2020

TABLE OF CONTENTS

PAGE

GENERAL INFORMATION AND PURPOSE

This Plan Document describes the benefits for the Employees of **Gunnison County, Colorado**.

Introduction and Purpose
The Plan Sponsor has established the Plan for the benefit of Eligible Employees, in accordance with the terms and conditions described herein. Plan benefits may be self-funded through a benefit fund or a trust established by the Plan Sponsor and self-funded with contributions from Participants and/or the Plan Sponsor, or may be funded solely from the general assets of the Plan Sponsor. Participants in the Plan may be required to contribute toward their benefits.

The Plan Sponsor's purpose in establishing the Plan is to help offset, for Eligible Employees, the economic effects arising from a Non-occupational Injury or Illness. To accomplish this purpose, the Plan Sponsor must be cognizant of the necessity of containing health care costs through effective plan design, and of abiding by the terms of the Plan Document, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to the maximum feasible extent.

The purpose of this Plan Document is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain covered expenses for medical charges. The Plan Document is maintained by **Gunnison County, Colorado** and may be inspected at any time during normal working hours by any Covered Person.

Name of Plan
Gunnison County, Colorado Employee Medical Benefit Plan

Participating Employers
Gunnison County, Colorado

Plan Sponsor
Gunnison County, Colorado
200 E. Virginia
Gunnison, CO 81230
1-970-641-7623

Plan Administrator
Gunnison County, Colorado
200 E. Virginia
Gunnison, CO 81230
1-970-641-7623

Type of Plan
Self-Funded Employee Welfare Benefit Plan

Agent for Service of Legal Process
Legal Process may also be served on the Plan Administrator
Gunnison County, Colorado
200 E. Virginia
Gunnison, CO 81230
1-970-641-7623

Claims Administrator
Group & Pension Administrators, Inc. (GPA)
Park Central 8
12770 Merit Drive, Suite 200
Dallas, Texas 75251
972-238-7900 ♦ 800-827-7223
The Plan Administrator has retained the services of the Claims Administrator to administer Claims under the Plan.

Utilization Review
GPA's HealthWatch Department
Group & Pension Administrators, Inc. (GPA)
Park Central 8
12770 Merit Drive, Suite 200
Dallas, Texas 75251
972-744-2486 ♦ 866-206-3224

Plan Year
The twelve (12) month period beginning January 1 and ending December 31 of each Calendar Year

Employer Tax ID Number
84-6000770

GPA Group Number
H880141

Legal Entity; Service of Process
The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

INTRODUCTION

Gunnison County, Colorado, hereafter referred to as "Employer" hereby amends and restates the Gunnison County, Colorado Employee Medical Benefit Plan, a self-funded Employee Welfare Benefit Plan, hereafter referred to as the "Plan." The Plan's benefits and administration expenses are paid directly from the Employer's general assets, and the rights and privileges of which shall pertain to Employees and their Dependents with respect to such Plan. The Plan is not insured. Contributions received from Covered Persons are used to cover Plan costs and are expended immediately. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

PLAN ADMINISTRATOR AND DESIGNATED DECISION MAKER

The Plan is administered by the Plan Administrator. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

Notwithstanding any provisions of this Plan Document and Summary Plan Description to the contrary, the Plan Sponsor has the authority to, and hereby does, allocate certain Fiduciary responsibility to ELAP Services LLC (*the Designated Decision Maker or "DDM"*). The Fiduciary responsibility allocated to the DDM is limited to discretionary authority and ultimate decision-making authority with respect to any appeals of denied Claims, which shall be referred to the DDM by the Plan Administrator (the "Referred Appeals"). The Plan Sponsor has allocated additional Fiduciary responsibility to the DDM, limited to discretionary authority and ultimate decision-making authority with respect to the review and audit of certain Claims in accordance with the applicable Plan provisions under the section, "Claim Review and Audit Program". Such Claims selected as eligible for review and audit shall be identified by the DDM under guidelines to which the Plan Sponsor has agreed, and shall be referred to the DDM by the Plan Administrator. The DDM shall have no authority, responsibility or liability other than with respect to the Referred Appeals and its duties under the Claim Review and Audit Program.

The Plan Administrator shall establish the policies, practices and procedures of this Plan. The Plan Administrator and the DDM shall administer this Plan in accordance with its terms. It is the express intent of this Plan that the Plan Administrator and the DDM shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of which services, supplies, care and treatment are Experimental/Investigational), to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator and/or the DDM as to the facts related to any Claim for benefits and the meaning and intent of any provision of the Plan, or its application to any Claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator or the DDM decides, in its discretion, that the Covered Person is entitled to them.

DUTIES OF THE PLAN ADMINISTRATOR

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a Plan Participant's rights;
6. To prescribe procedures for filing a Claim for benefits, to review Claim denials and appeals relating to them and to uphold or reverse such denials;

7. To keep and maintain the Plan documents and all other records pertaining to the Plan;
8. To appoint and supervise a third party administrator to pay Claims;
9. To perform all necessary reporting as required by applicable law;
10. To ensure that the Plan is administered in accordance with applicable law;
11. To establish and communicate procedures to determine whether a Medical Child Support Order or national medical support notice is a QMCSO;
12. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
13. To perform each and every function necessary for or related to the Plan's administration.

DUTIES OF THE DESIGNATED DECISION MAKER

The DDM shall have the following duties with respect to the Referred Appeals and the Claim Review and Audit Program:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to benefits payable under the Plan and negotiating settlements, if appropriate;
6. To review Referred Appeals and to uphold or reverse any denials;
7. To keep and maintain records pertaining to the Referred Appeals;
8. To perform the duties in conjunction with the provisions of the Claim Review and Audit Program; and
9. To keep and maintain records pertaining to the Claim Review and Audit Program.

The duties of the DDM shall be limited to those set forth above.

PHYSICIAN-PATIENT RELATIONSHIP

The Plan is not intended to disturb the Physician-Patient relationship. Physicians and other healthcare Providers are not agents or delegates of the Plan Sponsor, Plan Administrator, Employer or Claims Administrator. The delivery of medical and other healthcare services on behalf of any Covered Person remains the sole prerogative and responsibility of the attending Physician or other healthcare Provider.

FREE CHOICE OF HOSPITAL AND PHYSICIAN

Nothing contained in this Plan shall in any way or manner restrict or interfere with the right of any person entitled to benefits hereunder to select a Hospital or to make a free choice of the attending Physician or professional Provider. However, benefits will be paid in accordance with the provisions of this Plan, and the Covered Person may have higher out-of-pocket expenses if the Covered Person uses the services of a Non-Preferred Provider Physician.

PREFERRED PROVIDER INFORMATION

The Preferred Provider Network (PPO) includes Physicians and other professional Providers who have contracted with the medical Provider Networks. For Physicians and all other professional Providers of service, this Plan contains provisions under which a Plan Participant may receive more benefits by using certain Providers. There is a section in the Schedule of Benefits which describes the benefits for PPO Providers (Level II). PPO Providers are individuals and entities that have contracted with the Plan to provide services to Plan Participants at pre-negotiated rates. A list of these Preferred Providers can be accessed on the PPO website free of charge. In addition, a Plan Participant may request a Preferred Provider list by contacting the Plan Administrator. The Preferred Provider list changes frequently; therefore, it is

recommended that a Plan Participant verify with the Provider that the Provider is still a Preferred Provider before receiving services.

The Preferred Provider Network (PPO) does **not** include services and supplies provided by Facilities such as Hospital Facilities, Ambulatory Surgery Center Facilities and dialysis clinics or Facilities. You may contact the Claims Administrator or the Plan Administrator with any questions regarding which Facilities may be included under the Claim Review and Audit Program, and which may be included under the PPO Network agreement.

For all Facility Providers and those Physicians and professional Providers not participating in the PPO, the Plan will identify the Reasonable cost for the services and supplies through its Claim Review and Audit Program. There is a section in this Summary Plan Description that fully describes the Claim Review and Audit Program. The benefits for Facility Providers are described in the Schedule of Benefits under Level I and the benefits for those Physicians and professional Providers not participating in the PPO (Non-PPO) are described in Level II.

This plan may use Allowable Claim Limits to determine Covered Charges in lieu of a PPO discount.

EFFECTIVE DATE

Effective Date of the Plan: **September 1, 2017**; Amended and restated effective: **January 1, 2020**

CLAIMS ADMINISTRATOR

The Claims Administrator of the Plan is shown in the General Information and Purpose section.

NAMED FIDUCIARY

The named Fiduciary to the Plan is **Gunnison County, Colorado**.

CONTRIBUTIONS TO THE PLAN

Contributions to the Plan are to be made on the following basis:

The Employer shall from time to time evaluate the costs of the Plan and determine the amount to be contributed by the Employer and the amount to be contributed by each Covered Employee.

Notwithstanding any other provision of the Plan, the Employer's obligation to pay Claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraph. Payment of said Claims in accordance with these procedures shall discharge completely the Employer's obligation with respect to such payments.

In the event that the Employer, if applicable, terminates the Plan, then as of the effective date of termination, the Employer and Covered Employees shall have no further obligation to make additional contributions to the Plan and the Plan shall have no obligation to pay Claims incurred after the termination date of the Plan.

CLAIMS PROCEDURE

the Plan Administrator shall provide adequate notice in writing to any covered Plan Participant whose Claim for benefits under this Plan has been denied, setting forth the specific reasons for such denial and written in a manner calculated to be understood by the Plan Participant. Further, the Plan Administrator shall afford a reasonable opportunity to any Plan Participant, whose Claim for benefits has been denied, for a fair review of the decision denying the Claim by the person designated by the Plan Administrator for that purpose.

Details of the Claims procedure are found in this Plan Document under the section entitled “Procedures for Claims and Appeals.”

PROTECTION AGAINST CREDITORS

No benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any Plan Participant, the Plan Administrator in its sole discretion may terminate the interest of such Plan Participant or former Plan Participant in such payment. And in such case the Plan Administrator shall apply the amount of such payment to or for the benefit of such Plan Participant or former Plan Participant, his/her spouse, parent, adult Child, guardian of a minor Child, brother or sister, or other relative of a Dependent of such Plan Participant or former Plan Participant, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of the Plan Administrator, benefit payments may be assigned to health care Providers.

AMENDING AND TERMINATING THE PLAN

This Document contains all the terms of the Plan. The Plan Sponsor expects to maintain this Plan indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan.

Any such amendment, suspension or termination shall be enacted, if the Plan Sponsor is a corporation, by written resolution of the Plan Sponsor's Board of Directors and officers, which shall be acted upon as provided in the Plan Sponsor's Articles of Incorporation or Bylaws, as applicable, and in accordance with applicable Federal and State law. In the event that the Plan Sponsor is a different type of entity, then such amendment, suspension or termination shall be taken and enacted in accordance with applicable Federal and State law and any applicable governing documents. In the event that the Plan Sponsor is a sole proprietorship, then such action shall be taken by the sole proprietor, in his own discretion.

If the Plan is terminated, the rights of the Covered Persons are limited to expenses incurred before termination. Previous contributions by the Employer shall continue to be used for the purpose of paying benefits under the provisions of this Plan with respect to Claims arising before such termination.

All amendments to this Plan shall become effective as of a date established by the Plan Sponsor and specified in the enabling resolution. Copies of all amendments shall be furnished by the Plan Administrator to the Trustees (if any) and any outside Provider of Plan administrative services.

SUMMARY OF MATERIAL REDUCTION (SMR)

A Material Reduction generally means any modification that would be considered by the average participant to be an important reduction in covered services or benefits. Examples include reductions in benefits or increases in Deductibles or copayments.

The Plan Administrator shall notify all Covered Employees of any Plan Amendment considered a Material Reduction in covered services or benefits provided by the Plan as soon as administratively feasible after its adoption, but no later than sixty (60) days after the date of adoption of the reduction. Covered Employees and beneficiaries must be furnished a summary of such reductions, and any changes so made shall be binding on each Covered Person. The sixty (60) day period for furnishing a summary of Material Reduction does not apply to any Employee covered by the Plan who would reasonably expect to receive a summary through other means within the next ninety (90) days.

Material Reduction disclosure provisions are subject to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any related amendments.

SUMMARY OF MATERIAL MODIFICATIONS (SMM)

A Summary of Material Modifications reports changes in the information provided within the Summary Plan Description. Examples include a change to Deductibles, eligibility or the addition or deletion of coverage.

The Plan Administrator shall notify all Covered Employees of any Plan Amendment considered a Summary of Material Modifications by the Plan as soon as administratively feasible after its adoption, but no later than within two hundred ten (210) days after the close of the Plan Year in which the changes became effective.

PLAN IS NOT A CONTRACT

This Plan Document constitutes the entire Plan. The Plan will not be deemed to constitute a contract of employment or give any Covered Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge or otherwise terminate the employment of any Covered Employee.

FEDERAL LAWS

Certain Federal laws apply to most group health programs. The following is an overview of the laws and their impact. The effect of these laws on the Plan is reflected in the provisions of the Plan. Should there be any conflict between the law and Plan provisions, the law will prevail.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (H.R. 3103, 1996)
The Health Insurance Portability and Accountability Act (HIPAA) was enacted, among other things, to improve portability and continuity of health care coverage.

HIPAA also requires that Plan Participants and beneficiaries receive a summary of any change that is a "Material Reduction in covered services or benefits under a group health plan" within sixty (60) days after the adoption of the modification or change, unless the Plan Sponsor provides summaries of modifications or changes at regular intervals of ninety (90) days or less.

PREGNANCY DISCRIMINATION ACT OF 1978
Most Employers must provide coverage for Pregnancy expenses in the same manner as coverage is provided for any other Illness. This requirement applies to Pregnancy expenses of an Employee or a covered Dependent spouse of an Employee.

FAMILY AND MEDICAL LEAVE ACT OF 1993(P.L. 103-3)
If a Covered Employee ceases active employment due to an Employer-approved Family Medical Leave of Absence in accordance with the requirements of Public Law 103, coverage availability will continue under the same terms and conditions which would have applied had the Employee continued in active employment. Contributions will remain at the same Employer/Employee levels as were in effect on the date immediately prior to the leave (unless contribution levels change for other Employees in the same classification).

OMNIBUS BUDGET RECONCILIATION ACT OF 1993 (OBRA 1993: PL 103-66)
OBRA 1993 requires that an eligible Dependent Child of an Employee will include a Child who is adopted by the Employee or placed with him for adoption prior to age eighteen (18) and a Child for whom the Employee or covered Dependent spouse is required to provide coverage due to a Medical Child Support Order (MCSO) which is determined by the Plan Sponsor to be a Qualified Medical Child Support Order (QMCSO). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under State law and having the force and effect of law under State law and which satisfies the QMCSO requirements.

Participants may obtain a copy of the QMCSO procedures from the Plan Sponsor or Plan Administrator without charge.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996
The Newborns' and Mothers' Health Protection Act of 1996 establishes restrictions on the extent to which group health plans and health insurance issuers may limit the length of stay for mothers and newborn Children following delivery, as follows:

Statement of Rights under the Newborns' and Mothers' Health Protection Act
"Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 vaginal delivery, or less than ninety-six (96) hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending Provider (i.e., 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 forty-eight (48) hour or ninety-six (96) hour stay is treated in a manner less favorable to the mother or newborn than any 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 of up to forty-eight (48) or ninety-six (96) hours. However, to use certain Providers or Facilities, or to reduce your out-of-pocket costs, you may be required to give notification. For information on notification, contact your Plan Administrator.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998
If you are receiving covered benefits for a mastectomy, you should know that your Plan complies with the Women's Health and Cancer Rights Act of 1998. The Act provides for:

1. Reconstruction of the breast(s) on which a covered mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and physical complications related to all stages of covered mastectomy, including lymphedema.

All applicable benefit provisions still apply, including existing Deductibles, Copays and/or Coinsurance.

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 ("GINA")
GINA prohibits the group health Plan from:

1. Adjusting premiums or contribution amounts for the group as a whole on the basis of Genetic Information.

2. Requesting or requiring an individual or a Family member to undergo a genetic test. However, subject to certain conditions, the Plan may request that an individual voluntarily undergo a genetic test as part of a research study as long as the results are not used for underwriting purposes.

3. Requesting, requiring or purchasing Genetic Information for underwriting purposes (which includes eligibility rules or determinations, computation of premium or contribution amounts and other activities related to the creation, renewal or replacement of coverage). The Plan is also prohibited from requesting, requiring or purchasing Genetic Information with respect to any individual prior to such individual's enrollment under the Plan or coverage. However, if the Plan obtains Genetic Information incidental to the collection of other information prior to enrollment, it will not be in violation of GINA as long as it is not used for underwriting purposes.

GINA allows the group health Plan to obtain and use the results of genetic tests for purposes of making payment determinations.

What is "Genetic Information" under GINA?

Under GINA, the term "Genetic Information" includes:

1. Information about an individual or his/her Family member's genetic tests (defined as analyses of the individual's DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations or chromosomal changes);

2. The manifestation of a Disease or disorder in the Family members of the individual. Family members are broadly defined under GINA to include individuals who are Dependents, as well as any other first, second, third or fourth degree relative. Further, Genetic Information includes that information of any fetus or embryo carried by a pregnant woman; and

3. Information obtained through genetic services (that is genetic tests, genetic counseling or genetic education) or participation in clinical research that includes genetic services.

Genetic Information does not include the sex or age of an individual.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 (MHPAEA)
The Mental Health Parity and Addiction Equity Act requires that, if a group health plan provides coverage for mental health conditions or for substance use disorders, benefits for such conditions must be provided in the same manner as benefits for any Illness. Also, the Plan may not have separate cost-sharing arrangements that apply only to mental health or substance use disorder benefits.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)
If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your Employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your Dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your Dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your Dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your State if it has a program that might help you pay the premiums for an Employer-sponsored plan.

If you or your Dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your Employer plan, your Employer must allow you to enroll in your Employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272).**

If you live in one of the following States, you may be eligible for assistance paying your Employer health plan premiums. The following list of States is current as of January 1, 2019. Contact your State for more information on eligibility:

ALABAMA – Medicaid	**FLORIDA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://www.medicaid.georgia.gov - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
IOWA – Medicaid	**KANSAS – Medicaid**
Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512

KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll Free: 1-888-852-3345, ext 5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739 or 651-431-2670	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: https://dhcfp.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other States have added a premium assistance program since **January 1, 2019**, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

PAPERWORK REDUCTION ACT STATEMENT
According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven (7) minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

PRIVACY OF PROTECTED HEALTH INFORMATION (PHI)
Effective April 14, 2004, the Plan will not use or disclose PHI except as permitted by this section or as otherwise permitted or required by law, including but not limited to the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA Privacy Standards"), as they may be amended from time to time. Nothing in this section shall be construed to prohibit the Plan Sponsor's receipt of "summary health information," as described in the HIPAA Privacy Standards, for certain Plan Sponsor-related purposes, including obtaining premium bids for health insurance, making Plan design and funding decisions, and modifying, amending or terminating the Plan.

PLAN SPONSOR'S OBLIGATIONS REGARDING PROTECTED HEALTH INFORMATION (PHI)
Effective April 14, 2004, the Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor to the Plan that the Plan has been amended to provide for the Plan Sponsor's receipt of PHI and that the Plan Sponsor agrees to comply with the following provisions:

1. The Plan Sponsor may use or disclose PHI for Plan enrollment purposes, including information as to whether an individual is enrolled in the Plan.

2. The Plan Sponsor may use or disclose PHI for Plan administration functions, including for payment or health care operations purposes (as those terms are defined by the HIPAA Privacy Standards), and including quality assurance, Claims processing, auditing and monitoring of the Plan.

3. The Plan Sponsor may not use or further disclose PHI other than as permitted or required by the Plan documents or by law.

4. The Plan Sponsor must ensure that any agents, including subcontractors, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with regard to the PHI.

5. The Plan Sponsor may not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or other Employee Benefit Plan of the Plan Sponsor.

6. The Plan Sponsor must report to the Plan any use or disclosure of the PHI of which the Plan Sponsor becomes aware that is inconsistent with the uses or disclosures provided for under the terms of the Plan.

7. The Plan Sponsor must make PHI available for access in accordance with the HIPAA Privacy Standards regarding an individual's right to access his/her PHI.

8. The Plan Sponsor must make PHI available for amendment and, if required by the HIPAA Privacy Standards, incorporate any amendment made to PHI in accordance with the HIPAA Privacy Standards regarding an individual's right to have his PHI amended.

9. The Plan Sponsor must make available information necessary to provide an accounting to an individual in accordance with the HIPAA Privacy Standards regarding an individual's right to receive an accounting of disclosures of his/her PHI.

10. The Plan Sponsor must make internal practices, books, and records relating to the use and disclosure of PHI available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Standards.

11. The Plan Sponsor must, if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Plan Sponsor must limit further uses and disclosures to those purposes that make the return or destruction not feasible.

12. The Plan Sponsor must ensure adequate separation between the Plan and the Plan Sponsor by restricting access to and use of the PHI to only those Employees of the Plan Sponsor with responsibilities related to the administrative functions the Plan Sponsor performs for the Plan, as such Employees may be designated or identified, by name, job title, or classification, from time to time in various Business Associate Agreements between the Plan and the Plan's Business Associates or in other documents governing the administration of the Plan.

13. The Plan Sponsor must ensure adequate separation between the Plan and the Plan Sponsor by maintaining a procedure for resolving any issues of noncompliance with provisions of the Plan document by persons described in paragraph 12 above through training, sanctions and other disciplinary action, as necessary.

14. The Plan Sponsor shall not directly or indirectly receive remuneration in exchange for any PHI without valid authorization that includes a specification of whether the PHI can be further exchanged for remuneration by the entity receiving PHI of the individual making authorization, except as otherwise allowed under the American Recovery and Reinvestment Act.

SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION (ePHI)
Effective April 20, 2006, the Plan will not use or disclose ePHI except as permitted by this section or as otherwise permitted or required by law, including but not limited to the requirements of 45 C.F.R. Sections 164.314(b)(1) and (2) and its implementing regulations, 45 C.F.R. parts 160, 162, and 164 of the Security Standards of the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA Security Standards"), as they may be amended from time to time. Nothing in this section shall be construed to prohibit the Plan Sponsor's receipt of "summary health information," as described in the HIPAA Security Standards, for certain Plan Sponsor-related purposes, including obtaining premium bids for health insurance, making Plan design and funding decisions, and modifying, amending or terminating the Plan.

PLAN SPONSOR'S OBLIGATIONS REGARDING ELECTRONIC PROTECTED HEALTH INFORMATION (ePHI)
Effective April 20, 2006, the Plan will disclose ePHI to the Plan Sponsor only upon receipt of an amendment to the Plan that the Plan has been amended to provide for the Plan Sponsor's receipt of ePHI and that the Plan Sponsor agrees to comply with the following provisions:

1. The Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that the Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan.

2. The Plan Sponsor shall ensure the adequate separation that is required by 45 C.F.R. Section 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures.

3. The Plan Sponsor shall ensure any agent, including a subcontractor, to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect such information.

4. The Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:

    a. The Plan Sponsor shall report to the Plan within a reasonable time after the Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's ePHI.

    b. The Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis semi-annually, or more frequently upon the Plan's request.

BREACH AND SECURITY INCIDENTS
Effective September 23, 2009, the Health Information Technology for Economic and Clinical Health Act (HITECH) of the American Recovery and Reinvestment Act of 2009 (ARRA) imposes notification in the event of a Breach of unsecured Protected Health Information (PHI).

The Plan Sponsor will report to the Privacy Official of the Plan any use or disclosure of PHI not permitted by HIPAA, along with any Breach of unsecured Protected Health Information. The Plan Sponsor will treat the Breach as being discovered in accordance with HIPAA's requirements. The Plan Sponsor will make the report to the Privacy Official not more than thirty (30) calendar days after the Plan Sponsor learns of such non-permitted use or disclosure. If a delay is requested by a law enforcement official in accordance with 45 C.F.R. § 164.412, the Plan Sponsor may delay notifying the Privacy Official for the time period specified by such regulation. The Plan Sponsor's report will at least:

1. Identify the nature of the Breach or other non-permitted use or disclosure, which will include a brief description of what happened, including the date of any Breach and the date of the discovery of any Breach;

2. Identify Protected Health Information that was subject to the non-permitted use or disclosure or Breach (such as whether full name, social security number, date of birth, home address, account number or other information was involved) on an individual-by-individual basis;

3. Identify who made the non-permitted use or disclosure and who received the non-permitted disclosure;

4. Identify what corrective or investigational action the Plan Sponsor took or will take to prevent further non-permitted uses or disclosures, to mitigate harmful effects and to protect against any further Breaches;

5. Identify what steps the individuals who were subject to a Breach should take to protect themselves; and

6. Provide such other information, including a written report, as the Privacy Official may reasonably request.

The Plan Sponsor will report to the Privacy Official within thirty (30) calendar days any attempted or successful: a) unauthorized access, use, disclosure, modification, or destruction of Electronic Protected Health Information; and b) interference with the Plan Sponsor's system operations in the Plan Sponsor's information systems, of which the Plan Sponsor becomes aware. The Plan Sponsor will make this report upon the Privacy Official's request, except if any such Security Incident resulted in a disclosure or Breach of Protected Health Information or Electronic Protected Health Information not permitted by the HITECH Act, the Plan Sponsor will make the report in accordance with the above.

FAIR LABOR STANDARDS ACT (FLSA §18B)

FLSA §18B, as added by the Affordable Care Act §1512, provides that, beginning October 1, 2013, an applicable Employer must provide each Employee, regardless of plan enrollment status or of part-time or full-time status, at the time of hiring, a written notice:

1. Informing the Employee of the existence of the Marketplace (referred to in the statute as the Exchange) including a description of the services provided by the Marketplace, and the manner in which the Employee may contact the Marketplace to request assistance;
2. If the Employer Plan's share of the total allowed costs of benefits provided under the Plan is less than sixty (60) percent of such costs, that the Employee may be eligible for a premium tax credit under section 36B of the Internal Revenue Code (the Code) if the Employee purchases a qualified health plan through the Marketplace; and
3. If the Employee purchases a qualified health plan through the Marketplace, the Employee may lose the Employer contribution (if any) to any health benefits plan offered by the Employer and that all or a portion of such contribution may be excludable from income for Federal income tax purposes.

For 2014, the Department of Labor will consider a notice to be provided at the time of hiring if the notice is provided within fourteen (14) days of an Employee's start date. With respect to Employees who are current Employees before October 1, 2013, Employers are required to provide the notice not later than October 1, 2013.

The notice must be provided in writing in a manner calculated to be understood by the average employee, free of charge. Alternatively, it may be provided electronically if the requirements of the Department of Labor's electronic disclosure safe harbor at 29 CFR 2520.104b-1(c) are met.

For more information, please visit: http://www.dol.gov/ebsa/newsroom/tr13-02.html.

SCHEDULE OF BENEFITS – TRADITIONAL PLAN

MAJOR MEDICAL BENEFITS FOR COVERED PERSONS

NOTE: All Claims are subject to review and/or audit to ensure that charges are payable in accordance with the terms and limitations of this Plan.

LEVEL I PROVIDERS – Facilities and Providers billing as a Facility to include, but not limited to:

- Hospitals (Inpatient and Outpatient treatment)
- Inpatient Facilities (such as Rehabilitation Facilities, Skilled Nursing Facilities and Hospice)
- Inpatient and Outpatient Facilities for treatment of Mental Disorders, Chemical Dependency, Drug and Substance Abuse
- Ambulatory Surgery Centers
- Dialysis Clinics
- Ambulance (air and ground)

LEVEL II PROVIDERS – Physicians and all other Providers of service

Maximum Benefits	
Lifetime Maximum Dollar Benefit (All Covered Essential Health Benefits)	Unlimited
Annual Maximum Dollar Benefit (All Covered Essential Health Benefits)	Unlimited

Deductible and Annual Out-of-Pocket Maximum	Level I Benefit Level II PPO / Non-PPO Benefit
Calendar Year Deductible • Per Covered Person • Family Limit*	 $800 $1,600
Benefit Percentage (unless otherwise noted)	80%
Annual Out-of-Pocket Maximum (Includes Deductible and Medical Copays; excludes Prescription Drug Copays**) • Per Covered Person • Family Limit*	 $3,200 $6,400

NOTE: The Calendar Year Deductibles and Annual Out-of-Pocket Maximums are determined by combining both Level I and Level II (PPO and Non-PPO) Covered Charges. See Comprehensive Medical Benefits section. Upon reaching the Annual Out-of-Pocket Maximum, Covered Medical Expenses are payable at 100% for the remainder of the Calendar Year. Any applicable Maximums or Limitations for specified services are also determined by combining Level I and Level II (PPO and Non-PPO) Covered Charges. The Covered Person's Coinsurance is determined by the Plan's Benefit Percentage reflected in this Schedule of Benefits. The Covered Person is responsible for the difference between the Plan's Benefit Percentage and 100%.

*Applies collectively to all Covered Persons in the same Family.

** Prescription Drug Copays apply to satisfy a separate Prescription Drug Out-of-Pocket Maximum.

SCHEDULE OF BENEFITS – TRADITIONAL PLAN (Cont'd.)

LEVEL I BENEFITS – Payment Levels and Limits:
This section applies to covered services rendered by Hospitals and other Facilities shown in the preceding Level I Providers list and to charges for services rendered by Providers billing "as a Facility." The benefits shown apply to all such covered, licensed, accredited Providers of service **without regard to participation in a Preferred Provider Organization (PPO) network**.

Coordination of Care Requirements	
Coordination of Care required for the following services: • Inpatient Hospital/Facility Admissions • Inpatient Hospice • Home Health Care • Other Specified Level I and Level II Services	See Coordination of Care section for additional information.

Benefit Percentage For:	Level I Benefit	Maximum Benefits, Limits & Provisions
Gunnison Valley Health Systems Inpatient / Outpatient Services		
Gunnison Valley Health Systems Inpatient / Outpatient Services	80% of negotiated rate Deductible applies	
Hospital/Facility Inpatient Services		
Inpatient Hospital Services	80% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Contact Utilization Review for Coordination of Care.
Maternity Inpatient Hospital Services	80% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Contact Utilization Review for Coordination of Care.
Routine Newborn Care Inpatient Hospital Services (to date of mother's discharge)	80% of Allowable Claim Limits for nursery Room and Board/ancillary charges Deductible applies	
Skilled Nursing Facility	80% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Limited to 120 days per Calendar Year. Contact Utilization Review for Coordination of Care.
Rehabilitation Facility	80% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Contact Utilization Review for Coordination of Care.
Mental Disorders/Chemical Dependency, Drug and Substance Abuse Inpatient Hospital Services/ Residential Treatment Center	80% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Contact Utilization Review for Coordination of Care.
Emergency Room (Hospital Emergency Room Services/ Free-standing Emergency Room Facility Services)		
Emergency Room	80% of Allowable Claim Limits Deductible applies	If admitted Inpatient, contact Utilization Review for Coordination of Care.
Hospital/Facility Outpatient Diagnostic/Preventive Screening Services		
Select Diagnostic Medical Procedures (MRI, CT scan, etc.; see list in Comprehensive Medical Benefits section)	80% of Allowable Claim Limits Deductible applies	
All Other Diagnostic Lab and X-ray	80% of Allowable Claim Limits Deductible applies	

SCHEDULE OF BENEFITS – TRADITIONAL PLAN (Cont'd.)

Benefit Percentage For:	Level I Benefit	Maximum Benefits, Limits & Provisions
Hospital/Facility Outpatient Diagnostic/Preventive Screening Services		
Routine Bone Density Test, Other Routine Diagnostic Lab and X-ray	100% of Allowable Claim Limits Deductible waived	Age and/or frequency limitations may apply.
Annual Mammogram (Routine screening) Additional Mammogram (Diagnostic)	100% of Allowable Claim Limits Deductible waived 80% of Allowable Claim Limits Deductible applies	
Colonoscopy (including polyp removal) (Routine or Diagnostic)	100% of Allowable Claim Limits Deductible waived	Benefit applies beginning at age 50 or Family history of colon cancer with or without diagnosis.
Women's Elective Sterilization Procedures		
All Covered Expenses	100% of Allowable Claim Limits Deductible waived	All FDA approved
Outpatient Surgery/Ambulatory Surgery Centers Covered Services and Supplies		
All Covered Expenses	80% of Allowable Claim Limits Deductible applies	
Outpatient Psychiatric Day Treatment Facility and Outpatient Chemical Dependency Drug Treatment Facility		
Day Treatment Facility/ Psychological Testing/ Outpatient Therapy (including group therapy)	80% of Allowable Claim Limits Deductible applies	
Physical, Occupational and Speech Therapy Services		
All Covered Expenses	80% of Allowable Claim Limits Deductible applies	Limited to 60 visits per therapy per Calendar Year.
Cardiac Rehabilitation		
All Covered Expenses	80% of Allowable Claim Limits Deductible applies	
Chemotherapy, Radiation Therapy, Infusion Therapy, Dialysis Facilities Covered Services and Supplies		
All Covered Expenses	80% of Allowable Claim Limits Deductible applies	Contact Utilization Review for Coordination of Care.
Diabetic Self-Management Training		
All Covered Expenses	80% of Allowable Claim Limits Deductible applies	
Hospice		
All Covered Expenses	80% of Allowable Claim Limits Deductible applies	Contact Utilization Review for Coordination of Care for Inpatient and Homebound Hospice.

SCHEDULE OF BENEFITS – TRADITIONAL PLAN (Cont'd.)

Benefit Percentage For:	Level I Benefit	Maximum Benefits, Limits & Provisions
Home Health Care Services		
All Covered Expenses	80% of Allowable Claim Limits Deductible applies	Limited to 120 visits per Calendar Year. Contact Utilization Review for Coordination of Care.
Ambulance - Air or Ground Transportation		
All Covered Expenses	80% of Allowable Claim Limits Deductible applies	
Urgent Care Facility (Minor Emergency Medical Clinic)		
All Covered Expenses	80% of Allowable Claim Limits Deductible waived	
Outpatient Clinic Visit – Facility		
Facility Expenses	80% of Allowable Claim Limits Deductible waived	
All Other Covered Hospital/Facility Services and Supplies		
All Other Covered Expenses	80% of Allowable Claim Limits Deductible applies	Coordination of Care required for Inpatient and other specified Level I and Level II services.

SCHEDULE OF BENEFITS – TRADITIONAL PLAN (Cont'd.)

LEVEL II BENEFITS – Payment Levels and Limits:
This section applies to covered services rendered by Physicians and all other Providers not listed in Level I. Benefits shown are payable **based upon the Provider's participation in the Preferred Provider Organization (PPO) network.** Non-PPO Covered Charges are subject to Allowable Claim Limits.

The "Level II PPO Benefit" applies to services rendered by Preferred Providers in the designated PPO Network (In-Network); the "Level II Non-PPO Benefit" applies to services rendered by Providers other than Preferred Providers (Out-of-Network).

Maximum Benefits, Limits and Provisions are subject to all other Plan exclusions, limitations and provisions set forth in this Plan.

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
Physician Services			
Physician Hospital Visits/Surgeon	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
Physician Hospital Visit for Mental Disorders/ Chemical Dependency, Drug and Substance Abuse	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
Emergency Room Physician	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
Maternity (Including prenatal care, delivery and postnatal care, except initial visit) Lab and X-ray Benefit applies. Initial Visit	80% of PPO rate Deductible applies 100% of PPO rate Deductible waived	80% of Allowable Claim Limits Deductible applies 100% of Allowable Claim Limits Deductible waived	Contact Utilization Review for Coordination of Care.
Routine Newborn Care (Inpatient routine pediatric care to date of mother's discharge)	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
***Lab and X-ray Benefits** **Select Diagnostic Medical Procedures** (MRI, CT scan, etc.; see list in Comprehensive Medical Benefits section) • Outpatient Hospital Interpretation • Free-standing or Independent Facility (includes interpretation)	 80% of PPO rate Deductible applies 80% of PPO rate Deductible applies	 80% of Allowable Claim Limits 80% of Allowable Claim Limits Deductible applies	

SCHEDULE OF BENEFITS – TRADITIONAL PLAN (Cont'd.)

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
Physician Services			
All Other Lab/X-ray • Outpatient Hospital Interpretation • Free-standing or Independent Facility (includes interpretation)	80% of PPO rate Deductible applies 80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies 80% of Allowable Claim Limits Deductible applies	
Gunnison County Family Physicians Office Expenses Including: • Office Visit • Examination • Treatment • Diagnostic tests • Office Surgery • Lab and X-rays • Allergy testing, serum/injections • Voluntary Second or Third Opinion (exam) • Medical Supplies	100% of contracted rate after $20 Copay Deductible waived		
All Other non-Gunnison County Family Physicians Office Expenses Including: • Office Visit • Examination • Treatment • Diagnostic tests • Voluntary Second or Third Surgical Opinion (exam) • Medical Supplies	100% of PPO rate after $40 Copay PCP $60 Copay Specialist Deductible waived	100% of Allowable Claim Limits $40 Copay PCP $60 Copay Specialist Deductible waived	
NOTE: For purposes of this Plan, Physicians considered a Primary Care Physician (PCP) are: Family Practitioner, General Practitioner, Internist, Pediatrician and OB/Gyn. All other Physicians are considered Specialists. A referral from a Primary Care Physician to a Specialist is not required.			
Office Surgery	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
Allergy Testing, Serum and Injections	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
Office Lab and X-ray	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
Select Diagnostic Medical Procedures (performed in Physician's Office)	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	

SCHEDULE OF BENEFITS – TRADITIONAL PLAN (Cont'd.)

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
Physician Services			
Mental Disorders/ Chemical Dependency, Drug and Substance Abuse Office Visit/ *Group Therapy/ *Psychological Testing	100% of PPO rate after $40 Copay Deductible waived	100% of Allowable Claim Limits after $40 Copay Deductible waived	
Chiropractic Services (Including x-rays)	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	Limited to $500 Calendar Year Maximum Benefit.
Complementary/ Alternative Medicine including Acupuncture, Therapeutic Massage, Nutrition Therapy, Rolfing and Naturopathy Care	100% of PPO rate after $40 Copay Deductible waived	100% of Allowable Claim Limits after $40 Copay Deductible waived	Limited to $1,000 Calendar Year Maximum Benefit.
***Urgent Care Facility** (Minor Emergency Medical Clinic)	80% of PPO rate Deductible waived	80% of Allowable Claim Limits Deductible waived	
Retail Limited Service Clinics (Includes Redi Clinics, MinuteClinics and Take Care Clinics)	100% of PPO rate after $40 Copay Deductible waived	100% of Allowable Claim Limits after $40 Copay Deductible waived	
All Other Covered Physician Services	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	

*** If these services are rendered by Providers billing as a Facility, please refer to the appropriate category under Level I for the benefit.**

SCHEDULE OF BENEFITS – TRADITIONAL PLAN (Cont'd.)

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
Other Covered Services			
***Therapy Services** • Physical • Occupational • Speech	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	Limited to 60 visits per therapy per Calendar Year.
***Cardiac Rehabilitation**	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
***Chemotherapy/ Radiation Therapy/ Infusion Therapy/ Dialysis**	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	Contact Utilization Review for Coordination of Care.
***Durable Medical Equipment**	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
***Orthotic Devices**	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
***Prosthetics**	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
Hearing Exams / Hearing Aids	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	Hearing aids are limited to $4,500 Calendar Year Maximum Benefit every five (5) years. Maximum Benefit does not apply to initial purchase of hearing aid/device if Medically Necessary due to Illness, Accidental Injury, Congenital Anomaly or Surgical Procedure.
***Home Health Care Services**	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	Limited to 120 visits per Calendar Year. Contact Utilization Review for Coordination of Care.
***Home Infusion Therapy**	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	Contact Utilization Review for Coordination of Care.

SCHEDULE OF BENEFITS – TRADITIONAL PLAN (Cont'd.)

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
Other Covered Services			
***Hospice**	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	Contact Utilization Review GPA Nurse Navigator℠ for Coordination of Care for Inpatient and Homebound Hospice.
Bereavement Counseling	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
Diabetic Self-Management Training	100% of PPO rate after $40 Copay PCP $60 Copay Specialist Deductible waived	100% of Allowable Claim Limits $40 Copay PCP $60 Copay Specialist Deductible waived	
***Temporomandibular Joint (TMJ) Disorders and Orthognathic Disorders (including Surgical and Non-Surgical Treatment)**	Related services will be considered at the applicable benefit level (Surgery, devices, diagnostic services, etc.)		
***Morbid Obesity**	Related services will be considered at the applicable benefit level (Surgery, devices, diagnostic services, etc.)		
***Ambulance — Air or Ground Transportation**	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	
***All Other Covered Expenses**	80% of PPO rate Deductible applies	80% of Allowable Claim Limits Deductible applies	

*** If these services are rendered by Providers billing as a Facility, please refer to the appropriate category under Level I for the benefit.**

Organ Transplant Services
Organ and Tissue Transplants, Donor Expenses Contact Utilization Review upon transplant evaluation for Coordination of Care. Refer to Employer's Organ Transplant Policy as Primary payer. See Major Medical Expense Benefits for additional information.

Preventive and Wellness Care Benefits

This benefit is payable for Covered Procedures incurred as part of a Preventive and Wellness Care Program and is not payable for treatment of a diagnosed Illness or Injury. Services must be identified and billed as routine or part of a routine physical exam or as specified below.

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Limits & Provisions
All Covered Wellness Benefits	100% of PPO rate Copay and Deductible waived	100% of Allowable Claim Limits Deductible applies	See age and frequency limits and other special provisions below

Examples of Covered Wellness Procedures to include but are not limited to:

1. Routine Physical Exam
2. Annual Well Woman Exam
3. *Annual Pap smear and other routine lab
4. *Annual Mammogram (routine)
5. *Bone Density test (routine)
6. *Annual PSA test (routine)
7. Well Baby Care Exam/Well Child Care Exam
8. Routine Immunizations
9. Flu vaccine/pneumonia vaccine
10. *Routine lab, x-ray, diagnostic testing and other medical screenings
11. Routine Vision Screening for Covered Dependent Children
12. Routine Hearing Screening for Covered Dependent Children
13. *Routine/Diagnostic Colonoscopy (including polyp removal - beginning at age 50 with or without a diagnosis or Family history of colon cancer)
14. Tobacco Use Screening/Cessation Intervention (limited to two attempts per Calendar Year with four tobacco cessation counseling sessions per attempt)
15. *All FDA approved Women's Contraceptive methods and Women's elective Sterilization procedures

NOTE: Refer to the definition of "Preventive Care" for a link to a website that lists additional services that may be covered for preventive treatment.

*** If these services are rendered by Providers billing as a Facility, please refer to the appropriate category under Level I for the benefit.**

SCHEDULE OF BENEFITS – HIGH DEDUCTIBLE HEALTH PLAN

MAJOR MEDICAL BENEFITS FOR COVERED PERSONS

NOTE: All Claims are subject to review and/or audit to ensure that charges are payable in accordance with the terms and limitations of this Plan.

LEVEL I PROVIDERS – Facilities and Providers billing as a Facility to include, but not limited to:

- Hospitals (Inpatient and Outpatient treatment)
- Inpatient Facilities (such as Rehabilitation Facilities, Skilled Nursing Facilities and Hospice)
- Inpatient and Outpatient Facilities for treatment of Mental Disorders, Chemical Dependency, Drug and Substance Abuse
- Ambulatory Surgery Centers
- Dialysis Clinics
- Ambulance (air and ground)

LEVEL II PROVIDERS – Physicians and all other Providers of service

Maximum Benefits	
Lifetime Maximum Dollar Benefit (All Covered Essential Health Benefits)	Unlimited
Annual Maximum Dollar Benefit (All Covered Essential Health Benefits)	Unlimited

Deductible and Annual Out-of-Pocket Maximum	Level I Benefit Level II PPO / Non-PPO Benefit
Calendar Year Deductible (Includes Covered Medical and Prescription Drug Expenses) • Per Covered Person • Family Limit*	 $4,000 $8,000
Benefit Percentage (unless otherwise noted)	100%
Annual Out-of-Pocket Maximum (Includes Calendar Year Deductible, Covered Medical and Prescription Drug Expenses) • Per Covered Person • Family Limit*	 $4,000 $8,000

NOTE: The Calendar Year Deductibles and Annual Out-of-Pocket Maximums are determined by combining both Level I and Level II (PPO and Non-PPO) Covered Charges. See Comprehensive Medical Benefits section. Upon reaching the Annual Out-of-Pocket Maximum, Covered Medical Expenses and Prescription Drug Expenses are payable at 100% for the remainder of the Calendar Year. Any applicable Maximums or Limitations for specified services are also determined by combining Level I and Level II (PPO and Non-PPO) Covered Charges.

* The Calendar Year Deductible per Covered Person (individual Deductible) is embedded in the Deductible Family Limit and the Annual Out-of-Pocket Maximum per Covered Person (individual Annual Out-of-Pocket) is embedded in the Annual Out-of-Pocket Maximum Family Limit. Each covered Family member is only required to satisfy his/her own individual Deductible and individual Annual Out-of-Pocket, not the entire Family Limit, in order to receive Plan benefits. The Deductible Family Limit and Annual Out-of-Pocket Maximum Family Limit are satisfied by two (2) or more Family members collectively; however, each Family member cannot contribute more than his/her own individual Deductible or individual Annual Out-of-Pocket Maximum.

SCHEDULE OF BENEFITS – HIGH DEDUCTIBLE HEALTH PLAN (Cont'd.)

LEVEL I BENEFITS – Payment Levels and Limits:
This section applies to covered services rendered by Hospitals and other Facilities shown in the preceding Level I Providers list and to charges for services rendered by Providers billing "as a Facility." The benefits shown apply to all such covered, licensed, accredited Providers of service **without regard to participation in a Preferred Provider Organization (PPO) network**.

Coordination of Care Requirements	
Coordination of Care required for the following services: • Inpatient Hospital/Facility Admissions • Inpatient Hospice • Home Health Care • Other Specified Level I and Level II Services	See Coordination of Care section for additional information.

Benefit Percentage For:	**Level I Benefit**	**Maximum Benefits, Limits & Provisions**
Gunnison Valley Health Systems Inpatient / Outpatient Services		
Gunnison Valley Health Systems Inpatient / Outpatient Services	100% of negotiated rate Deductible applies	
Hospital/Facility Inpatient Services		
Inpatient Hospital Services	100% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Contact Utilization Review for Coordination of Care.
Maternity Inpatient Hospital Services	100% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Contact Utilization Review for Coordination of Care.
Routine Newborn Care Inpatient Hospital Services (to date of mother's discharge)	100% of Allowable Claim Limits for nursery Room and Board/ancillary charges Deductible applies	
Skilled Nursing Facility	100% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Limited to 120 days per Calendar Year. Contact Utilization Review for Coordination of Care.
Rehabilitation Facility	100% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Contact Utilization Review for Coordination of Care.
Mental Disorders/Chemical Dependency, Drug and Substance Abuse Inpatient Hospital Services/ Residential Treatment Center	100% of Allowable Claim Limits for Room and Board/ancillary charges Deductible applies	Contact Utilization Review for Coordination of Care.
Emergency Room (Hospital Emergency Room Services/ Free-standing Emergency Room Facility Services)		
Emergency Room	100% of Allowable Claim Limits Deductible applies	If admitted Inpatient, contact Utilization Review for Coordination of Care.
Hospital/Facility Outpatient Diagnostic/Preventive Screening Services		
Select Diagnostic Medical Procedures (MRI, CT scan, etc.; see list in Comprehensive Medical Benefits section)	100% of Allowable Claim Limits Deductible applies	
All Other Diagnostic Lab and X-ray	100% of Allowable Claim Limits Deductible applies	

SCHEDULE OF BENEFITS – HIGH DEDUCTIBLE HEALTH PLAN (Cont'd.)

Benefit Percentage For:	Level I Benefit	Maximum Benefits, Limits & Provisions
Hospital/Facility Outpatient Diagnostic/Preventive Screening Services		
Routine Bone Density Test, Other Routine Diagnostic Lab and X-ray	100% of Allowable Claim Limits Deductible waived	Age and/or frequency limitations may apply.
Annual Mammogram (Routine screening) Additional Mammogram (Diagnostic)	100% of Allowable Claim Limits Deductible waived 100% of Allowable Claim Limits Deductible applies	
Colonoscopy (including polyp removal) (Routine or Diagnostic)	100% of Allowable Claim Limits Deductible waived	Benefit applies beginning at age 50 or Family history of colon cancer with or without diagnosis.
Women's Elective Sterilization Procedures		
All Covered Expenses	100% of Allowable Claim Limits Deductible waived	All FDA approved
Outpatient Surgery/Ambulatory Surgery Centers Covered Services and Supplies		
All Covered Expenses	100% of Allowable Claim Limits Deductible applies	
Outpatient Psychiatric Day Treatment Facility and Outpatient Chemical Dependency Drug Treatment Facility		
Day Treatment Facility/ Psychological Testing/ Outpatient Therapy (including group therapy)	100% of Allowable Claim Limits Deductible applies	
Physical, Occupational and Speech Therapy Services		
All Covered Expenses	100% of Allowable Claim Limits Deductible applies	Limited to 60 visits per therapy per Calendar Year.
Cardiac Rehabilitation		
All Covered Expenses	100% of Allowable Claim Limits Deductible applies	
Chemotherapy, Radiation Therapy, Infusion Therapy, Dialysis Facilities Covered Services and Supplies		
All Covered Expenses	100% of Allowable Claim Limits Deductible applies	Contact Utilization Review for Coordination of Care.
Diabetic Self-Management Training		
All Covered Expenses	100% of Allowable Claim Limits Deductible applies	
Hospice		
All Covered Expenses	100% of Allowable Claim Limits Deductible applies	Contact Utilization Review for Coordination of Care for Inpatient and Homebound Hospice.

SCHEDULE OF BENEFITS – HIGH DEDUCTIBLE HEALTH PLAN (Cont'd.)

Benefit Percentage For:	Level I Benefit	Maximum Benefits, Limits & Provisions
Home Health Care Services		
All Covered Expenses	100% of Allowable Claim Limits Deductible applies	Limited to 120 visits per Calendar Year. Contact Utilization Review for Coordination of Care.
Ambulance - Air or Ground Transportation		
All Covered Expenses	100% of Allowable Claim Limits Deductible applies	
Urgent Care Facility (Minor Emergency Medical Clinic)		
All Covered Expenses	100% of Allowable Claim Limits Deductible waived	
Outpatient Clinic Visit – Facility		
Facility Expenses	100% of Allowable Claim Limits Deductible applies	
All Other Covered Hospital/Facility Services and Supplies		
All Other Covered Expenses	100% of Allowable Claim Limits Deductible applies	Coordination of Care required for Inpatient and other specified Level I and Level II services.

SCHEDULE OF BENEFITS – HIGH DEDUCTIBLE HEALTH PLAN (Cont'd.)

LEVEL II BENEFITS – Payment Levels and Limits:
This section applies to covered services rendered by Physicians and all other Providers not listed in Level I. Benefits shown are payable **based upon the Provider's participation in the Preferred Provider Organization (PPO) network.** Non-PPO Covered Charges are subject to Allowable Claim Limits.

The "Level II PPO Benefit" applies to services rendered by Preferred Providers in the designated PPO Network (In-Network); the "Level II Non-PPO Benefit" applies to services rendered by Providers other than Preferred Providers (Out-of-Network).

Maximum Benefits, Limits and Provisions are subject to all other Plan exclusions, limitations and provisions set forth in this Plan.

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
Physician Services			
Physician Hospital Visits/Surgeon	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
Physician Hospital Visit for Mental Disorders/ Chemical Dependency, Drug and Substance Abuse	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
Emergency Room Physician	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
Maternity (Including prenatal care, delivery and postnatal care, except initial visit) Initial Visit	100% of PPO rate Deductible applies 100% of PPO rate Deductible waived	100% of Allowable Claim Limits Deductible applies 100% of Allowable Claim Limits Deductible waived	Contact Utilization Review for Coordination of Care.
Routine Newborn Care (Inpatient routine pediatric care to date of mother's discharge)	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
***Lab and X-ray Benefits Select Diagnostic Medical Procedures** (MRI, CT scan, etc.; see list in Comprehensive Medical Benefits section) • Outpatient Hospital Interpretation • Free-standing or Independent Facility (includes interpretation)	 100% of PPO rate Deductible applies 100% of PPO rate Deductible applies	 100% of Allowable Claim Limits Deductible applies 100% of Allowable Claim Limits Deductible applies	

SCHEDULE OF BENEFITS – HIGH DEDUCTIBLE HEALTH PLAN (Cont'd.)

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
Physician Services			
All Other Lab/X-ray • Outpatient Hospital Interpretation • Free-standing or Independent Facility (includes interpretation)	100% of PPO rate Deductible applies 100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies 100% of Allowable Claim Limits Deductible applies	
All Covered Physician Office Expenses Including: • Office Visit • Examination • Treatment • Diagnostic tests • Office Surgery • Lab and X-rays • Allergy testing, serum/injections • Voluntary Second or Third Surgical Opinion (exam) • Medical Supplies • Retail Limited Services Clinic	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
Mental Disorders/ Chemical Dependency, Drug and Substance Abuse Office Visit/ *Group Therapy/ *Psychological Testing	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
Chiropractic Services (Including x-rays)	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	Limited to $500 Calendar Year Maximum Benefit.
Complementary/ Alternative Medicine including Acupuncture, Therapeutic Massage, Nutrition Therapy, Rolfing and Naturopathy Care	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	Limited to $1,000 Calendar Year Maximum Benefit.
***Urgent Care Facility** (Minor Emergency Medical Clinic)	100% of PPO rate Deductible waived	100% of Allowable Claim Limits Deductible waived	
All Other Covered Physician Services	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	

*** If these services are rendered by Providers billing as a Facility, please refer to the appropriate category under Level I for the benefit.**

SCHEDULE OF BENEFITS – HIGH DEDUCTIBLE HEALTH PLAN (Cont'd.)

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
Other Covered Services			
***Therapy Services** • Physical • Occupational • Speech	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	Limited to 60 visits per therapy per Calendar Year.
***Cardiac Rehabilitation**	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
***Chemotherapy/ Radiation Therapy/ Infusion Therapy/Dialysis**	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	Contact Utilization Review for Coordination of Care.
***Durable Medical Equipment**	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
***Orthotic Devices**	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
***Prosthetics**	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
Hearing Exams/Hearing Aids	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	Hearing aids are limited to $4,500 Calendar Year Maximum Benefit every five (5) years. Maximum Benefit does not apply to initial purchase of hearing aid/device if Medically Necessary due to Illness, Accidental Injury, Congenital Anomaly or Surgical Procedure.
***Home Health Care Services**	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	Limited to 120 visits per Calendar Year. Contact Utilization Review for Coordination of Care.
***Home Infusion Therapy**	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	Contact Utilization Review for Coordination of Care.

SCHEDULE OF BENEFITS – HIGH DEDUCTIBLE HEALTH PLAN (Cont'd.)

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
Other Covered Services			
***Hospice**	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	Contact Utilization Review for Coordination of Care for Inpatient and Homebound Hospice.
Bereavement Counseling	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
Diabetic Self-Management Training	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
***Temporomandibular Joint (TMJ) Disorders and Orthognathic Disorders (including Surgical and Non-Surgical Treatment)**	Related services will be considered at the applicable benefit level (Surgery, devices, diagnostic services, etc.)		
***Morbid Obesity**	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
***Ambulance — Air or Ground Transportation**	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	
***All Other Covered Expenses**	100% of PPO rate Deductible applies	100% of Allowable Claim Limits Deductible applies	

*** If these services are rendered by Providers billing as a Facility, please refer to the appropriate category under Level I for the benefit.**

Organ Transplant Services
Organ and Tissue Transplants, Donor Expenses Contact Utilization Review upon transplant evaluation for Coordination of Care. Refer to Employer's Organ Transplant Policy as Primary payer. See Major Medical Expense Benefits for additional information.

Preventive and Wellness Care Benefits

This benefit is payable for Covered Procedures incurred as part of a Preventive and Wellness Care Program and is not payable for treatment of a diagnosed Illness or Injury. Services must be identified and billed as routine or part of a routine physical exam or as specified below.

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Limits & Provisions
All Covered Wellness Benefits	100% of PPO rate Deductible waived	100% of Allowable Claim Limits Deductible applies	See age and frequency limits and other special provisions below

Examples of Covered Wellness Procedures to include but are not limited to:

1. Routine Physical Exam
2. Annual Well Woman Exam
3. *Annual Pap smear and other routine lab
4. *Annual Mammogram (routine)
5. *Bone Density test (routine)
6. *Annual PSA test (routine)
7. Well Baby Care Exam/Well Child Care Exam
8. Routine Immunizations
9. Flu vaccine/pneumonia vaccine
10. *Routine lab, x-ray, diagnostic testing and other medical screenings
11. Routine Vision Screening for Covered Dependent Children
12. Routine Hearing Screening for Covered Dependent Children
13. *Routine/Diagnostic Colonoscopy (including polyp removal - beginning at age 50 with or without a diagnosis or Family history of colon cancer)
14. Tobacco Use Screening/Cessation Intervention (limited to two attempts per Calendar Year with four tobacco cessation counseling sessions per attempt)
15. *All FDA approved Women's Contraceptive methods and Women's elective Sterilization procedures

NOTE: Refer to the definition of "Preventive Care" for a link to a website that lists additional services that may be covered for preventive treatment.

*** If these services are rendered by Providers billing as a Facility, please refer to the appropriate category under Level I for the benefit.**

ORGAN TRANSPLANT POLICY

Organ and tissue transplant coverage is provided under a separate insurance policy by Tokio Marine HCC – Stop Loss Group (TMHCC) and is issued either by National Union Fire Insurance Company of Pittsburgh, Pa. or HCC Life Insurance Company. Such coverage pays benefits for certain organ and tissue transplants without regard to any benefits that may or may not be provided by this Major Medical Plan. Please contact TMHCC's Transplant Unit toll-free at 1-888-449-2377 for benefit information, pre-authorization of transplant services, and transplant network Provider access.

Pre-Authorization of Transplant Services
Pre-authorization of transplant services is required prior to seeing a transplant Provider for a consult and/or evaluation. Failure to do so could result in reduced benefits.

NOTICE - Transplant Network
In order to obtain 100% in-network benefits, you must use Providers in a transplant network approved by and accessed through TMHCC's Transplant Unit. Expenses billed by the transplant network Provider that are not covered by the TMHCC policy are subject to this Medical Plan's benefits and the payment terms and conditions of the transplant network Provider's contracted rates.

For more information, contact your Medical Plan Administrator and/or human resources department.

NOTE: The Employer's fully insured Organ Transplant Policy is the Primary payer for Organ, Tissue and Bone Marrow Transplants. In the event the Employer's Organ Transplant Policy does not cover some or all transplant related charges incurred by a Covered Person due to a pre-existing condition exclusion limitation, this Plan will consider the charges based on benefits below as the Secondary payer. See Coordination With Organ Transplant Policy section of this Plan Document.

Traditional Plan Organ Transplant Plan Benefits – Secondary Payer			
Benefit Percentage For:	**Transplant Program**	**Non-Transplant Program**	**Limits & Provisions**
Organ, Tissue and Bone Marrow Transplants (Non-experimental transplants only)	80% of Program rate Deductible applies	80% of Usual and Customary fees Deductible applies	Contact Utilization Review upon transplant evaluation for Coordination of Care and access to the Transplant Program.
Donor Expenses Donor expenses covered if recipient is covered by this Plan. Payable under recipient's Claim.	80% of Program rate Deductible applies	80% of Usual and Customary fees Deductible applies	
Organ Transplant Travel/Lodging Benefit	100% Deductible waived	Not covered	Transplant Program Travel/Lodging limited to $10,000 Maximum Benefit per Transplant.

High Deductible Health Plan Organ Transplant Plan Benefits – Secondary Payer			
Benefit Percentage For:	**Transplant Program**	**Non-Transplant Program**	**Limits & Provisions**
Organ, Tissue and Bone Marrow Transplants (Non-experimental transplants only)	100% of Program rate Deductible applies	100% of Usual and Customary fees Deductible applies	Contact Utilization Review upon transplant evaluation for Coordination of Care and access to the Transplant Program.
Donor Expenses Donor expenses covered if recipient is covered by this Plan. Payable under recipient's Claim.	100% of Program rate Deductible applies	100% of Usual and Customary fees Deductible applies	
Organ Transplant Travel/Lodging Benefit	100% Deductible waived	Not covered	Transplant Program Travel/Lodging limited to $10,000 Maximum Benefit per Transplant.

GPA HW CANCER CARE PROGRAM

The Plan provides benefit coverage for evidence-based cancer care services provided at local, regional and national cancer programs. The GPA HW Cancer Care Program will utilize specialized care coordination nurses to provide patient education and support while coordinating with the patient, Providers, Center of Excellence (COE), and Plan benefits. The principles for Certified Case Management and the guidelines of nationally recognized organizations, MCG (formerly Milliman Care Guidelines) and National Comprehensive Cancer Network (NCCN), including the NCCN Compendium of Care, will be utilized in the review of care for Medical Necessity and evidence-based medicine. In the event care is requested that is outside of the nationally recognized criteria, independent medical reviews by a Board Certified and actively practicing Oncologist or Physician of like specialty will be completed to ensure standard of medical care is provided for Plan Participants. GPA HW Cancer Care Program may utilize a panel of three (3) Board Certified and actively practicing Oncologists or Physicians of like specialty in the event of appeals. Should oncology care at a Center of Excellence benefit the patient and Plan, the HW Cancer Care Program nurse will gather the data from at least two (2) independent COE contracting sources. The COE contracts will be reviewed for comprehensiveness of contract and the COE's quality outcomes before selection. GPA HW Cancer Care Program will not limit member participation based on type of cancer.

SECOND OPINION

The Plan provides coverage for a Second Opinion through utilization of the Pathology/DiagnosticCOE, which may include a review of the diagnosis, review of the treatment plan or both. Second Opinions may require travel to a Pathology/DiagnosticCOE to qualify for benefits. A Second Opinion may consist solely of having pathology slides reviewed by a specialized lab or may include other services. Molecular testing is a covered benefit when coordinated by GPA's HealthWatch department's Cancer Care nurse.

CLINICAL TRIAL BENEFITS

Clinical Trials (Routine Patient Costs). Benefits are provided to Qualified Individuals for the Routine Patient Costs of items and services furnished in connection with participation in an Approved Clinical Trial. Routine Patient Costs include all items and services consistent with the coverage provided under this Plan that are typically covered for a Qualified Individual who is not enrolled in a clinical trial. Routine Patient Costs do not include:

1. The Investigational item, device, or service, itself;
2. Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

If one or more Participating Providers is participating in a clinical trial, the Plan may require that a Qualified Individual participate in the trial through such a Participating Provider if the Provider will accept the individual as a participant in the trial.

Approved Clinical Trial is a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and that is described in any of the following:

1. Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

    a. The National Institutes of Health.
    b. The Centers for Disease Control and Prevention.
    c. The Agency for Health Care Research and Quality.
    d. The Centers for Medicare & Medicaid Services.

e. A cooperative group or center of any of the entities described in (a) through (d) above or the Department of Defense or the Department of Veterans Affairs.
f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
g. The Department of Veterans Affairs, the Department of Defense, or the Department of Energy, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines:

    i. to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and
    ii. assures unbiased review of the highest scientific standards by Qualified Individuals who have no interest in the outcome of the review; or

2. The study or investigation is conducted under an Investigational new Drug application reviewed by the Food and Drug Administration; or
3. The study or investigation is a Drug trial that is exempt from having such an Investigational new Drug application.

A Qualified Individual must meet the following conditions:

1. The individual must be eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition; and
2. Either:

    a. The referring health care professional is a Participating Provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or
    b. The individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

Covered Persons are encouraged to contact GPA's HealthWatch department's Cancer Care Program at 1-800-843-6705 option 6 or cancercare@gpatpa.com for further information on clinical trial coverage.

Questions: If there are any questions regarding coverage or a specific provision of GPA's HealthWatch department's Cancer Care Program, please contact the Plan Administrator at 1-800-843-6705 option 6 or email cancercare@gpatpa.com.

PRESCRIPTION DRUG PLAN BENEFITS

High Deductible Health Plan		
Prescription Drug Expenses apply to satisfy the Medical Plan's Level I/Level II Calendar Year Deductible. The Plan requires the Covered Person to pay the entire cost of Prescription Drug Expenses until the Deductible has been met. After the Calendar Deductible and Annual Out-of-Pocket Maximum have been met, covered Prescription Drugs will be payable at 100% for the remainder of the Calendar Year.		
	Supply Limit	**Benefit**
Prescription Card Service Generic and Brand Name Drugs	30 – 90 days	100% after Deductible
Mail Order Service Generic and Brand Name Drugs	90 days	100% after Deductible
Specialty Drugs* Generic and Brand Name Drugs	30 days	100% after Deductible
* Specialty Drugs must be obtained through the Prescription Drug Plan's Specialty Pharmacy.		

Traditional Plan	
Prescription Drug Copays apply to satisfy a separate Prescription Drug Annual Out-of-Pocket Maximum. After the separate Prescription Drug Annual Out-of-Pocket Maximum has been met, covered Prescription Drugs will be payable at 100% for the remainder of the Calendar Year.	
Calendar Year Prescription Drug Deductible Per Covered Person	 $100
The Prescription Drug Deductible must be satisfied each Calendar Year before Copays apply.	
Prescription Drug Annual Out-of-Pocket Maximum Per Covered Person Family Limit*	 $3,000 $6,000
*Applies collectively to all Covered Persons in the same Family.	
Prescription Card Service Supply Limit Generic (Tier 1) Preferred Brand Name Drugs (Tier 2) Non-Preferred Brand Name Drugs (Tier 3)	**100% after applicable Copay** 30 days $5 Copay 75% Copay with a minimum $35 Copay and up to a maximum $150 Copay 75% Copay with a minimum $70 Copay and up to a maximum $150 Copay
Prescription Card Service – Generic Drugs Only Supply Limit Generic Drugs (Tier 1)	 90 days $15 Copay
Mail Order Service Supply Limit Generic (Tier 1) Preferred Brand Name Drugs (Tier 2) Non-Preferred Brand Name Drugs (Tier 3)	**100% after applicable Copay** 90 days $10 Copay 75% Copay with a minimum $80 Copay 75% Copay with a minimum $80 Copay
Specialty Drugs* Supply Limit Generic (Tier 1) Preferred Brand Name Drugs (Tier 2) Non-Preferred Brand Name Drugs (Tier 3)	**100% after applicable Copay** 30 days 85% Copay with a maximum $150 Copay 85% Copay with a maximum $150 Copay 85% Copay with a maximum $150 Copay
* Specialty Drugs must be obtained through the Prescription Drug Plan's Specialty Pharmacy.	

NOTE: Medications required for Preventive Care services may be covered at 100%, Copay and/or Deductible waived.

For Coordination of Benefits when this Plan is secondary, file the prescription receipt with the Drug Plan. Call the Prescription Claims Help Desk for a Claim form. See Plan Participant identification card for the phone number.

(Traditional Plan only) If the pharmacy charge is less than the Generic or Brand Copay, then the actual charge will become the Copay. Generic and Brand Name copayments apply separately to each prescription and refill and do not apply to the Calendar Year Deductible.

To be covered, Prescription Drugs must be:

1. Purchased from a participating licensed pharmacist;
2. Dispensed to the Covered Person for whom they are prescribed; and
3. Legally prescribed by a Qualified Prescriber.

DEFINITIONS

Brand Name Drugs (Tier 2 and Tier 3)
Trademark Drugs or substances marketed by the original manufacturer. Tier 2 Drugs are commonly used Preferred Brand Name Drugs shown on the Formulary Drug List as "Formulary Alternative(s)." Tier 3 Drugs are Non-Preferred Brand Name Drugs listed as "Non-Formulary" or not listed.

Generic Drugs (Tier 1)
Drugs or substances which:

1. Are not trademark Drugs or substances; and
2. May be legally substituted for trademark Drugs or substances.

Over the Counter (OTC) Drugs
Drugs which do not require a prescription from a Qualified Prescriber, unless otherwise specified.

Prescription Drugs
Legend Drugs or medicines which are prescribed by a Qualified Prescriber for the treatment of Illness, Injury or Pregnancy.

Qualified Prescriber
A licensed Physician, Dentist, or other health care Practitioner who may, in the legal scope of his/her practice, prescribe Drugs or medicines.

Specialty Drugs
Specialty pharmaceuticals include biotech Drugs produced using living organisms which are high cost or injectable Drugs that require heightened patient management and support.

Product Selection
The pharmacist substitutes more economically priced Generic equivalent Drugs whenever possible unless there is a specific request for a Brand Name by the prescribing Physician or when State law requires no substitution for the Brand Name Drug. **Under this program if the prescribing Physician does not specify the Brand Name, but the Covered Person requests the Brand product when there is a Generic substitute available, the Covered Person is required to pay the difference in cost between the Brand and Generic product in addition to the usual Brand Copay (applies to Prescription Card and Mail Order).**

Most pharmacists, as a courtesy to the patient, will ask whether a Generic Drug is acceptable to the Covered Person if the Physician has specified "product selection permitted" on the prescription. If the Physician has specified "dispense as written," no choice is given to the patient, and only the applicable Copay will be charged.

Miscellaneous Provisions
The following provisions may be included in your Prescription Drug Plan. Please contact the Prescription Card Service Customer Service phone number listed on the Plan Participant identification card for more information.

Step Therapy: The practice of starting Drug therapy for a medical condition with the most cost-effective and safest Drug available, then progressing to other more costly alternatives if necessary.

Therapeutic Substitution: A Physician-oriented service designed to increase the utilization of more cost-effective products. Substitutes are made for Non-Preferred Brand Name Drugs with either Generic or similar Preferred Brand Name Drugs in the same therapeutic class.

Drug Review

The Plan includes a Drug Review program which is automatically administered by the pharmacist through a nationwide computer network that verifies the eligibility of each Covered Person's card and protects the Covered Person from conflicting prescriptions which might prove harmful if taken at the same time. This program also guards against duplication of medications and incorrect dosage levels.

Covered and Excluded Drugs

The following Covered and Excluded Drug listings are not all inclusive. To find out if a particular Drug is covered, please contact the Prescription Card Service Customer Service phone number listed on the Plan Participant identification card.

NOTE: Some Drugs may require authorization and may only be covered, and/or covered for certain ages, if Medically Necessary.

Prescription Drug Plan – Covered Drugs

1. Legend Drugs (Drugs requiring a prescription either by Federal or State law) (there are certain Legend Drugs that may be excluded);
2. Insulin on prescription;
3. Disposable insulin needles/syringes, test strips and lancets on prescription;
4. Compounded medications of which at least one ingredient is a prescription legend Drug;
5. All FDA approved women's contraceptive Drugs and methods (Generic covered at 100%, Copay and/or Deductible waived; if no Generic available, Brand covered at 100%, Copay and/or Deductible waived);
6. Tobacco deterrent medications or any other tobacco use OTC cessation aids, all dosage forms limited to a 168-day supply per Plan Calendar Year (Generic covered at 100%, Copay and/or Deductible waived); if no Generic available, Brand covered at 100%, Copay and/or Deductible waived); and
7. Specialty Drugs.

NOTE: Quantity limitations may apply to some Covered Drugs in addition to those shown above.

NOTE: Refer to the definition of "Preventive Care" for a link to a website that lists additional Drugs that may be covered for preventive treatment.

Prescription Drug Plan – Excluded Drugs

1. Abortifacients;
2. Drugs for Cosmetic purposes;
3. Weight loss medications;
4. Immunization agents (except immunizations and vaccines as required for Preventive Care services; Generic covered at 100%, Copay and/or Deductible waived; if no Generic available, Brand covered at 100%, Copay and/or Deductible waived), biological sera, blood or blood plasma;
5. Therapeutic devices or appliances, including needles, syringes, support garments and other non-medical substances, regardless of intended use, except those listed above;
6. Charges for the administration or injection of any Drug;
7. Prescriptions which a Covered Person is entitled to receive without charge from any Workers' Compensation laws;
8. Drugs labeled "Caution-limited by Federal law to Investigational use," or Experimental Drugs, even though a charge is made to the individual;
9. Medication which is to be taken by or administered to an individual, in whole or in part, while he/she is a patient in a licensed Hospital, Extended Care Facility, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a Facility for dispensing pharmaceuticals; and
10. Any prescription refilled in excess of the number specified by the Physician, or any refill dispensed after one (1) year from the Physician's original order.

NOTE: Drugs excluded from the Prescription Drug Plan are not payable under Major Medical Expense Benefits.

(Traditional Plan only) A Prescription Drug dispensed by a retail pharmacy, Mail Order Service or Specialty Pharmacy for which a Copay applies is not considered a Claim for benefits under this Plan and, therefore, is not subject to the Plan's Claim Filing Procedures.

When Alternative Care and treatment are identified by Case Management as Medically Necessary and approved by the Plan Administrator, and where there is a reasonable expectation of savings to the Plan without sacrificing the quality of care to the Plan Participant (patient), the Plan may approve and pay for all or part of the charges not shown as a Covered Prescription Drug in this Plan Document.

PRESCRIPTION DRUG UTILIZATION REVIEW

The Prescription Drug benefit does not have unlimited coverage. As with all medical and Hospital services, Prescription Drug utilization is subject to determinations of Medical Necessity and appropriate use. Drug Utilization Review may be concurrent, retrospective or prospective.

Concurrent Drug Utilization Review generally occurs at the time of service and may include electronic Claim audits which may help to protect patients from potential Drug interactions or Drug-therapy conflicts or overuse/under use of medications.

Retrospective Drug Utilization Review generally involves Claim review and may include communication by the Prescription Drug Plan and/or Utilization Review with the prescribing Physician to coordinate care and verify diagnoses and Medical Necessity. It may include a peer review by a Physician of like specialty to the prescribing Physician reviewing the medical and pharmacy records to determine Medical Necessity.

Should Medical Necessity not be determined by the peer review Physician, the treating Physician and Plan Participant will be notified and provided with the peer review results. The Plan Participant and Physician will be forwarded information on the appeal process as outlined in this Plan.

Prospective Drug Utilization Review may include, among other things, Physician or pharmacy assignment in which one Physician and/or one pharmacy is selected to serve as the coordinator of prescription Drug services and benefits for the eligible Plan Participant. The Plan Participant will be notified in writing of this and will be required to designate a Physician and pharmacy as his/her Providers.

COORDINATION OF CARE

Coordination of Care may be indicated for medical treatment that is Medically Necessary and not Experimental. Coordination of Care is provided by a Registered Nurse (RN) to assist the Plan Participant with coordination of medical care, prevent duplicate diagnostic testing and/or treatment, and identify and refer patients with diagnoses that would benefit from further Plan programs such as Case Management, Disease Management and/or Maternity Support.

COORDINATION OF CARE REQUIREMENTS

Contact GPA's HealthWatch department for Coordination of Care prior to receiving the following services:

- **Inpatient Hospital/Facility admissions (including admissions for Mental Disorders, Chemical Dependency, Drug and Substance Abuse);**
- **Inpatient and Home Hospice;**
- **Maternity;**
- **Radiation therapy, chemotherapy, dialysis or infusion therapy;**
- **Home Health Care;**
- **Transplant evaluation.**

CASE MANAGEMENT

During the Utilization Review process, catastrophic cases such as transplants, burns, spinal cord Injuries, cancer and other large cases will be identified and Case Management may be initiated. Case Management is provided by Nurses with specialized training and/or advanced national certification. The Nurse may monitor the medical care, consult with the Physicians, coordinate with the health care Providers and Facilities, and communicate with the patient and Family to promote receipt of appropriate, cost effective care to expedite the recovery process.

When Out-of-Network fees are negotiated by Case Management and/or Utilization Review on behalf of the Plan, Out-of-Network Covered Charges may be considered at the PPO Benefit level.

ALTERNATIVE CARE

Through alternative care, Case Management may help the patient and the Plan Administrator obtain care/treatment for a serious Illness or Injury that is Medically Necessary and appropriate for the diagnosis. When alternative care and treatment are identified by Case Management as Medically Necessary and approved by the Plan Administrator, and where there is a reasonable expectation of savings to the Plan without sacrificing the quality of care to the patient, the Plan may approve and pay for all or part of the charges not shown as a Covered Expense or as a Covered Prescription Drug in this Plan Document. These expenses will be considered on the same basis as the care and treatment for which they are substituted. Benefits provided under this section are subject to all other limitations and provisions within the Plan. In exercising its authority, this Plan will act in a way so as not to discriminate against any Plan Participant. If the care is not being substituted for other Covered Expenses, it will be considered on the same basis as a same or similar Covered Expense or Covered Prescription Drug shown in this Plan Document, as determined by the Claims Administrator.

All benefits provided in this section are subject to Medical Necessity, Reasonableness, and Usual and Customary charges, the Allowable Claim Limits under the Claim Review and Audit Program.

DISEASE MANAGEMENT

Disease Management is an Employer sponsored voluntary program that is designed to help individuals with certain chronic health conditions to better manage their care. Utilization Review, provided through GPA's HealthWatch department, supports the relationship between the Physician and the patient by providing information regarding optimal treatment options. The objective is to help individuals stay healthy by providing customized health education information for the most appropriate medical care for each individual's Illness.

MATERNITY SUPPORT PROGRAM

A special Maternity Support Program is available from Utilization Review. The program is completely voluntary and provides educational tools to optimize the health of mothers and their newborns. To participate, Covered Persons should call Utilization Review as soon as they know they are pregnant, preferably during the first trimester. Benefits available are:

- Coordination of a proactive education program for maternity care;
- Assessment of the risk of a Pregnancy;
- Identification of personal health factors that could influence the Pregnancy; and
- Development of proactive, risk appropriate care delivery programs for covered Pregnancies and births.

GPA NURSE NAVIGATOR[SM]

GPA Nurse Navigator[SM] is a program that will assist Plan Participants with coordination of their medical care with various Provider options to accommodate medical care needs. The Plan Participant can contact Nurse Navigators at the number on his/her identification card to receive assistance in finding doctors, Hospitals and medical Providers. GPA Nurse Navigator[SM] will also assist the Plan Participant with scheduling appointments, retrieving medical records, completing notifications, consulting a Physician Advisor (if necessary), medication coordination, providing education by a Registered Nurse (RN) and assessing for referrals into GPA Care Management Programs.

COMPREHENSIVE MEDICAL BENEFITS

COVERED MEDICAL EXPENSES (COVERED EXPENSES)

Covered Medical Expenses mean the Reasonable and Usual and Customary charges, Allowable Claim Limit charges and/or contracted PPO charges incurred by or on behalf of a Covered Person for Hospital or other medical services listed below which are:

1. Ordered by a Physician or licensed Practitioner;
2. Medically Necessary for the treatment of an Illness or Injury;
3. Not of a luxury or personal nature; and
4. Not excluded under the Major Medical Exclusions and Limitations section of this Plan.

COVERED CHARGES

If a Covered Person incurs Covered Medical Expenses as the result of an Illness or Injury, all treatment is subject to benefit payment provisions shown in the Schedule of Benefits and as determined elsewhere in this document.

HOSPITALS, AMBULATORY SURGERY CENTERS AND OTHER FACILITIES

Facilities do not participate in the PPO Network. Charges for services rendered in these Facilities will be evaluated under the Claim Review and Audit Program, and Covered Charges will be determined based upon the Allowable Claim Limits. Please refer to the Claim Review and Audit Program section for additional information about the program and Allowable Claim Limits.

PHYSICIANS AND ALL OTHER COVERED PROVIDERS

Network Services (PPO): Network Services (PPO) are health care services provided by a Physician or other Provider in the designated PPO with which the Plan has contracted to provide services at specified fees. Network Covered Charges will be payable at the PPO benefit level.

This Plan may use Allowable Claim Limits to determine Covered Charges in lieu of a PPO discount.

Out-Of-Network Services (Non-PPO): Out-of-Network Services (Non-PPO) are health care services provided by a Physician or other Provider that is not in the Plan's designated PPO Network. Out-of-Network Covered Charges will be payable at the Non-PPO benefit level unless the Plan has a direct contract for discounting fees with an Out-of-Network Provider or Out-of-Network services are listed as a PPO benefit exception in the Schedule of Benefits, in which case, the PPO benefit level will apply.

HOSPITAL OR MEDICAL FACILITY FEES/PHYSICIAN FEES

The total cost for many medical services/procedures may be comprised of several components: Hospital or other medical Facility fees and Physician fees.

Hospital or Medical Facility Fees: The Hospital or medical Facility fees cover the cost of providing room and board and/or technicians, equipment, supplies and miscellaneous expenses involved in the care and treatment of a patient. Medical service fees billed by a Provider billing as a Facility may be separate from medical services billed by a Physician.

Physician Fees: The Physician fees cover the cost of medical services/procedures provided by a Physician or the professional fees billed by a Physician for the supervision, interpretation and consultation involved in the care and treatment of a patient. Each fee may be billed separately by the Physician providing the service.

SELECT DIAGNOSTIC MEDICAL PROCEDURES
The following is a list of Select Diagnostic Medical Procedures that may be performed in a Physician's office, the Outpatient department of a Hospital, free-standing center or an independent Facility. Benefits are available under the Plan as specified in the Schedule of Benefits:

1. Bone scan – Specialized x-ray of bone tissues using radioactive injection if more sensitive to bone irregularities than usual x-rays:
   a. Limited area;
   b. Multiple areas;
   c. Whole body;
   d. With vascular flow only;
   e. Three phase technique; or
   f. Tomographic (SPECT).
2. Cardiac stress test:
   a. Thallium – Use of radioactive dye to define areas of decreased blood flow in vessels of the heart while the patient exercises.
   b. Treadmill – Reading of the electrical patterns of the heart (EKG) while the patient exercises on a treadmill.
3. CT Scan – Computerized x-ray picture of a part of the body.
4. MRI (Magnetic Resonance Imaging) – Diagnostic imaging modality that uses magnetic and radio frequency fields to image body tissue non-invasively.
5. PET Scan (Positron Emission Tomography) – A three-dimensional imaging technique that allows visual examination of the internal organs and illustrates organ function.
6. Ultrasound, Echography and Sonography – The use of inaudible sound waves to outline the shape of organs and tissues in the body. A sonogram during Pregnancy is not considered a Select Diagnostic Medical Procedure and is payable under the Plan's Lab/X-ray Benefit.
7. Myelogram – x-ray of the spine after injection of a contrast medium (dye) into a space in the spinal canal.
8. Aortography, Angiography, Lymphangiography, Venography, Transcatheter, Transluminal Atherectomy and Diskography.
9. Nuclear medicine scans.

CALENDAR YEAR MAXIMUM BENEFIT
The Maximum Amount payable for Covered Expenses during a Calendar Year Benefit Period for each Covered Person is limited to a specific dollar amount, number of days or visits as specified in the Schedule of Benefits. The Calendar Year is from January 1 through December 31 of the same year. The initial Calendar Year Benefit Period is from a Covered Person's effective date through December 31 of the same year. Level I and Level II (PPO and Non-PPO) Covered Charges are combined to determine is a Lifetime Maximum Benefit has been met.

CONTINUITY OF CARE
If a Covered Person is receiving treatment, services or supplies from an Preferred Physician and that Preferred Physician terminates or is terminated from the Preferred Physician Network or if the Plan Administrator changes PPO Networks, benefits for such services, treatment or supplies will continue to be paid at the Preferred Physician benefit level for a period of ninety (90) days from the date of the Preferred Physician's termination if the treatment, services or supplies are being provided for special circumstances such as:

- An acute condition;
- A life-threatening Illness; or
- Past the twenty-fourth (24th) week of Pregnancy and the Covered Person is receiving treatment in accordance with the dictates of medical prudence.

Special circumstances mean a condition such that the treating Physician or health care Provider reasonably believes that discontinuing care by the treating Physician or Provider could cause harm to the patient. Special circumstances shall be identified by the treating Physician or health care Provider who

must request the Covered Person be permitted to continue treatment under the Physician's or Provider's care and agree not to seek payment from the patient of any amount for which the Covered Person would not be responsible if the Physician or health care Provider were still part of the Preferred Provider Organization (PPO) Network.

CHARGES RELATED TO ACCIDENTAL INJURIES
Prior to obtaining Accident details, the Maximum Benefit payable on charges arising from an Accidental Injury is $500. Once charges for the same related Claim equal or exceed $500, charges will be denied until expenses are determined to be an eligible benefit under this Plan.

TRADITIONAL PLAN

DEDUCTIBLE AMOUNT (LEVEL I and LEVEL II)
The Deductible amount for each Covered Person is the amount of Covered Expenses which must be incurred each Calendar Year before benefits are payable for Covered Medical Expenses incurred during the remainder of that year. It is the amount shown in the Schedule of Benefits as the Calendar Year Deductible. There is no Deductible carryover from one Calendar Year to the next for Covered Charges incurred and applied to the Deductible in the last three (3) months of a Calendar Year. Level I Covered Charges and Level II PPO and Non-PPO Covered Charges are combined to satisfy the Plan Calendar Year Deductible.

DEDUCTIBLE FAMILY LIMIT (LEVEL I and LEVEL II)
The Maximum Deductible amounts to be applied each Calendar Year to a Covered Employee and his/her covered Dependents will not be more than the Family Limit shown in the Schedule of Benefits. As soon as that limit is met (collectively) three (3) Family members have each satisfied their Deductible in the same Calendar Year, no further Deductibles will be applied to Covered Medical Expenses for any covered Family member during the remainder of that Calendar Year. To satisfy the Deductible Family Limit, each covered Family member can contribute no more than his/her own individual Deductible.

COINSURANCE
Coinsurance is the portion of Covered Medical Expenses shared by the Plan and the Covered Person in a specific ratio (i.e., 80%/20%) after the Calendar Year Deductible has been satisfied. The amount of Coinsurance paid by the Covered Person is applied to satisfy the Covered Person's Annual Out-of-Pocket Maximum.

ANNUAL OUT-OF-POCKET MAXIMUM (LEVEL I and LEVEL II)
The Annual Out-of-Pocket Maximum does not include expenses which are in excess of the Allowable Claim Limits (please refer to the Claim Review and Audit Program section for additional information regarding Allowable Claim Limits). The Annual Out-of-Pocket Maximum is the maximum dollar amount a Covered Person will pay for Covered Medical Expenses each Calendar Year including the Deductible and Medical Copays. Level I Covered Charges and Level II PPO and Non-PPO Covered Charges are combined to satisfy the Annual Out-of-Pocket Maximum. Upon reaching the Annual Out-of-Pocket Maximum, Covered Medical Expenses are payable at 100% for the remainder of the Calendar Year, excluding:

- Prescription Copays (subject to separate Prescription Drug Annual Out-of-Pocket Maximum);
- Any Covered Charges already paid at 100% in any one (1) Calendar Year period, unless otherwise specified in the Schedule of Benefits; and
- Charges in excess of Usual and Customary, Allowable Claim Limits,or charges for services that do not meet the Plan's definition of Reasonable.

ANNUAL OUT-OF-POCKET MAXIMUM FAMILY LIMIT (LEVEL I and LEVEL II)
The Annual Out-of-Pocket Maximum Family Limit is met when all covered Family members (collectively) incur the amount shown in the Schedule of Benefits as the Annual Out-of-Pocket Maximum Family Limit. To satisfy the Family Limit, each Covered Family member can contribute no more than his/her own individual Annual Out-of-Pocket Maximum.

OFFICE VISIT COPAY (PER VISIT)
The Office Visit Copay is the portion of Covered Medical Expenses, a flat dollar amount, payable by the Covered Person for Covered Charges provided by and billed by the Physician at the time of each Physician Office Visit. Whenever an Office Visit Copay applies, the Calendar Year Deductible is waived for that visit except for office procedures listed in the Schedule of Benefits which are not subject to the Office Visit Copay. The Office Visit Copay cannot be used to satisfy the Calendar Year Deductible but will apply to satisfy the Annual Out-of-Pocket Maximum.

Office Visit Copays for a Primary Care Physician and a Specialist are specified in the Schedule of Benefits. A referral from a Primary Care Physician to a Specialist is not required.

HIGH DEDUCTIBLE HEALTH PLAN

DEDUCTIBLE AMOUNT (LEVEL I and LEVEL II)
The Deductible amount for each Covered Person is the amount of Covered Medical and Prescription Drug Expenses which must be incurred each Calendar Year before benefits are payable for Covered Medical and Prescription Drug Expenses incurred during the remainder of that Calendar Year. It is the amount shown in the Schedule of Benefits as the Calendar Year Deductible. There is no Deductible carryover from one Calendar Year to the next for Covered Charges incurred and applied to the Deductible in the last three (3) months of a Calendar Year. Level I Covered Charges, Level II PPO/Non-PPO Covered Charges and Covered Prescription Drug Expenses are combined to satisfy the Calendar Year Deductible.

DEDUCTIBLE FAMILY LIMIT (LEVEL I and LEVEL II)
The Maximum Deductible amounts to be applied each Calendar Year to a Covered Employee and his/her covered Dependents will not be more than the Deductible Family Limit shown in the Schedule of Benefits. As soon as that limit is met (collectively), no further Deductibles will be applied to Covered Medical Expenses for any covered Family member during the remainder of that Calendar Year. To satisfy the Deductible Family Limit, each covered Family member can contribute no more than his/her own individual Deductible.

ANNUAL OUT-OF-POCKET MAXIMUM (LEVEL I and LEVEL II)
The Annual Out-of-Pocket Maximum does not include expenses which are in excess of the Allowable Claim Limits (please refer to the Claim Review and Audit Program section for additional information regarding Allowable Claim Limits). The Annual Out-of-Pocket Maximum is the maximum dollar amount a Covered Person will pay for Covered Medical and Prescription Drug Expenses each Calendar Year including the Deductible.

Level I Covered Charges, Level II PPO/Non-PPO Covered Charges and Covered Prescription Drug Expenses are combined to satisfy the Level I/Level II PPO/Non-PPO Annual Out-of-Pocket Maximum. Upon reaching the Annual Out-of-Pocket Maximum, Covered Medical and Prescription Drug Expenses are payable at 100% for the remainder of the Calendar Year, excluding:

- Any Covered Charges already paid at 100% in any one (1) Calendar Year period, unless otherwise specified in the Schedule of Benefits; and
- Charges in excess of Usual and Customary, Allowable Claim Limits or charges for services that do not meet the Plan's definition of Reasonable.

ANNUAL OUT-OF-POCKET MAXIMUM FAMILY LIMIT (LEVEL I and LEVEL II)
The maximum Annual Out-of-Pocket amounts to be applied each Calendar Year to a Covered Employee and his/her covered Dependents will not be more than the Annual Out-of-Pocket Maximum Family Limit shown in the Schedule of Benefits. As soon as that limit is met (collectively) no further Out-of-Pocket amounts will be applied to Covered Medical and Prescription Drug Expenses during the remainder of that Calendar Year. To satisfy the Family Limit, each Covered Family member can contribute no more than his/her own individual Annual Out-of-Pocket Maximum.

MAJOR MEDICAL EXPENSE BENEFITS

The following are Covered Medical Expenses under this Plan, unless specifically excluded under the Major Medical Plan Exclusions and Limitations. Benefits for these Covered Expenses will be payable as shown in the Schedule of Benefits. Charges are subject to the Reasonable and Usual and Customary amount, the Allowable Claim Limits under the Claim Review and Audit Program and/or the negotiated fee schedule of the Preferred Provider Organization (PPO).

Covered Medical Expenses are subject to any Maximum Benefit and/or limitation specified in the Schedule of Benefits.

Admit Kits. The charges for Hospital "admit kits."

Allergy Testing, Allergy Injections and Allergy Serums. The charges for allergy testing, allergy injections, allergy serums and treatment.

Ambulance Services. The charges for professional licensed ambulance service as follows:

1. Ground transportation when Medically Necessary and used locally to or from the nearest Facility qualified to render treatment;
2. Air ambulance where air transportation is medically indicated to transport a Covered Person to the nearest Facility qualified to render treatment (excluding commercial flights); or
3. "CARE" and "LIFE" flights in a life-threatening situation.

Ambulatory Surgery Center. The charges made by an Ambulatory Surgery Center.

Anesthesia. The charges for the cost and administration of an Anesthesia and/or anesthetic.

Assistant Surgeon. The charges for services of an assistant surgeon and/or Licensed Surgical Assistant when such a Provider is required to render technical assistance at an operation. The Covered Expense for such services shall be limited to 25% of the allowable surgical fee. See definition of Practitioner for covered Providers.

Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD). The charges for the diagnosis and treatment of Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD) with the exclusion of charges for education and training.

Audiologist. The charges of an Audiologist under direct supervision of a Physician for treatment of a hearing loss or an impaired hearing function.

Autism Spectrum Disorder. The charges for treatment of Autism Spectrum Disorder provided to a Dependent Child. Treatment includes all generally recognized services prescribed in relation to Autism Spectrum Disorder by the patient's primary care Physician. "Generally recognized services" may include services such as evaluation and assessment, applied behavior analysis, behavior training and management, Speech Therapy, Occupational Therapy, Physical Therapy and medications or nutritional supplements used to address symptoms of Autism Spectrum Disorder.

Birthing Center. The charges incurred for services in a Birthing Center.

Blood or Blood Components. The charges for the processing and administration of blood or blood components, but not for the cost of the actual blood or blood components if the Facility receives any replacement of blood used for which the patient is not financially responsible.

Breast Reduction (Reduction Mammoplasty). The charges for a reduction mammoplasty, if Medically Necessary.

Cardiac Rehabilitation. The charges for cardiac rehabilitation as deemed Medically Necessary provided services are rendered:

1. Under the supervision of a Physician;
2. In connection with a myocardial infarction, coronary occlusion or coronary bypass Surgery;
3. Initiated within twelve (12) weeks after other treatment for the medical condition ends; and
4. In a Facility whose primary purpose is to provide medical care for an Illness or Injury.

Chemotherapy. The charges for chemotherapy.

Chiropractic Services. The charges for Chiropractic Services, to include x-rays.

Clinical and Pathological Laboratory Tests. The charges for clinical and pathological laboratory tests and examinations including fees for professional interpretation of their results.

Clinical Trials (Routine Patient Costs). Benefits are provided to Qualified Individuals for the Routine Patient Costs of items and services furnished in connection with participation in an Approved Clinical Trial. Routine Patient Costs include all items and services consistent with the coverage provided under this Plan that are typically covered for a Qualified Individual who is not enrolled in a clinical trial. Routine Patient Costs do not include:

1. The Investigational item, device, or service, itself;
2. Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

If one or more Participating Providers is participating in a clinical trial, the Plan may require that a Qualified Individual participate in the trial through such a Participating Provider if the Provider will accept the individual as a participant in the trial.

Approved Clinical Trial is a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and that is described in any of the following:

1. Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

    a. The National Institutes of Health.
    b. The Centers for Disease Control and Prevention.
    c. The Agency for Health Care Research and Quality.
    d. The Centers for Medicare & Medicaid Services.
    e. A cooperative group or center of any of the entities described in (a) through (d) above or the Department of Defense or the Department of Veterans Affairs.
    f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    g. The Department of Veterans Affairs, the Department of Defense, or the Department of Energy, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines:

        i. to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and
        ii. assures unbiased review of the highest scientific standards by Qualified Individuals who have no interest in the outcome of the review; or

2. The study or investigation is conducted under an Investigational new Drug application reviewed by the Food and Drug Administration; or

3. The study or investigation is a Drug trial that is exempt from having such an Investigational new Drug application.

A Qualified Individual must meet the following conditions:

1. The individual must be eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition; and
2. Either:

    a. The referring health care professional is a Participating Provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or
    b. The individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

A *life-threatening condition* means any Disease or condition from which the likelihood of death is probable unless the course of the Disease or condition is interrupted.

Complementary/ Alternative Medicine including Acupuncture, Therapeutic Massage, Nutrition Therapy, Rolfing and Naturopathy Care. The charges for complementary/alternative medicine including Acupuncture, therapeutic massage, nutrition therapy, rolfing and naturopathy care.

Contraceptives. The charges for all FDA approved women's contraceptive methods.

Corneal Transplants. The charges for services and supplies in connection with corneal transplants on the same basis as any other Illness.

Cosmetic Surgery. The charges for Cosmetic Surgery only in the following situations:

1. Reconstructive Surgery as a result of an accidental bodily Injury;
2. The surgical correction required as a result of a congenital Disease or Congenital Anomaly;
3. Reconstructive Surgery following neoplastic (cancer) Surgery;
4. Reconstruction of the breast on which a mastectomy has been performed;
5. Surgery and reconstruction of the other breast to produce symmetrical appearance;
6. Coverage for prostheses and physical complications related to all stages of covered mastectomy including lymphedema, in a manner determined in consultation with the attending Physician and patient; and
7. Removal of breast implants if deemed to be Medically Necessary and reconstructive breast Surgery after implant removal. Breast reconstruction is not covered if the original implants were for cosmetic reasons. However, the removal of the implant is covered, if Medically Necessary, even if the original implant was for cosmetic reasons.

NOTE: The Plan's breast reconstruction Surgery benefits are subject to the requirements of the mastectomy provision of the Women's Health and Cancer Rights Act of 1998.

Custom Bras for Prostheses. The charges for custom bras for prostheses following a mastectomy, limited to six (6) per Calendar Year.

Dental Expenses and Oral Surgery Procedures. The charges for the following Dental expenses and Oral Surgery procedures:

1. Excision of impacted or partially impacted teeth;
2. Cutting procedures in the oral cavity for excision of tumors and cysts of the jawbone;
3. External incision and drainage of cellulitis;
4. Open or closed reduction of a fracture or dislocation of the jaw; and
5. Treatment necessitated by Accidental Injury to sound natural teeth if services are performed within one (1) year from the date of the Accident.

If Medically Necessary for Dental work or Oral Surgery to be performed at an Outpatient Facility or Hospital, only the Facility and related anesthesia fees are Covered Charges.

Diabetic Supplies. The charges for glucometers and insulin pumps and insulin pump supplies when ordered by a Physician. The charges for insulin, insulin syringes, insulin pump supplies, test strips and lancets on prescription are covered by the Prescription Drug Card or Mail Order Service.

Diabetic Training. The charges for diabetic self-management medical and nutritional training for diagnosed cases of diabetes rendered by a licensed Practitioner when recommended as a course of treatment by a Physician.

Diagnostic Tests. The charges for electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar well established diagnostic tests generally approved by Physicians throughout the United States.

Diagnostic X-Rays. The charges for radiation services including diagnostic x-rays and interpretation.

Dialysis. The charges for dialysis. Dialysis charges may be subject to Medicare rules and reimbursement rates.

Dietitian. The charges for services of a licensed Dietitian when recommended by a licensed MD or DO except for services which are otherwise excluded by the Plan.

Drugs. The charges for Drugs requiring the written prescription of a licensed Physician; such Drugs must be Medically Necessary for the treatment of an Illness or Injury. See Prescription Drug Plan section. Prescription Drugs are covered by the Prescription Drug Card, Mail Order Service, or Specialty Pharmacy and not payable under Major Medical Expense Benefits.

Durable Medical Equipment. The charges for rental or purchase of a wheelchair, Hospital bed and other Durable Medical Equipment prescribed by a Physician and required for therapeutic use, whichever is most cost effective. Benefits will be provided for the repair, adjustment or replacement of purchased Durable Medical Equipment or components only within a reasonable time period of purchase subject to the life expectancy of the equipment.

Elastic/Surgical Stockings. The charges for elastic/surgical stockings when ordered by a Physician, limited to three (3) pairs per Calendar Year.

Free-standing Emergency Room Facility. The charges for a Free-standing Emergency Room Facility and for services rendered therein.

Group Therapy. The charges for group therapy for treatment of Mental Disorders, Chemical Dependency, Drug and Substance Abuse.

Hearing Exam and Aids/Devices. The charges for an Annual routine hearing examination and charges for hearing aids, as specified in the Schedule of Benefits.

Hearing Screening. The charges for hearing screening as required for Preventive Care for Children.

Heart Valve Replacements. The charges for heart valve replacements on the same basis as any other Illness.

Home Health Care. The charges by a Home Health Care Agency for care for a Homebound patient in accordance with a Home Health Care Plan. Home Health Care Visit means a visit by a member of a home health care team. Each visit that lasts for a period of four (4) hours or less is treated as one (1) home health care visit. If the visit exceeds four (4) hours, each period of four (4) hours is treated as one (1) visit and any part of a four (4) hour period that remains is treated as one (1) home health care visit.

Home Health Care Plan Covered Services and Supplies are limited to:

1. Part-time or intermittent nursing care visits by a Registered Nurse (RN), a Licensed Practical Nurse (LPN), a Licensed Vocational Nurse (LVN), or Public Health Nurse who is under the direct supervision of a Registered Nurse (RN);
2. Part-time or intermittent Home Health Aide services which consist primarily of caring for the patient;
3. Physical, Occupational, Speech and respiratory Therapy services by licensed therapists;
4. Services of a Licensed Clinical Social Worker (LCSW); and
5. Medical supplies, Drugs and medications prescribed by a Physician, and laboratory services provided by or on behalf of a Hospital, but only to the extent that they would have been covered under this Plan if the patient had remained in the Hospital. **NOTE:** Home Infusion Therapy is a separate benefit and charges are not considered under Home Health Care.

Home Infusion Therapy. The charges for Home Infusion Therapy by a licensed Provider to include intravenous infusion or injection of fluids, nutrition or medication furnished in the home setting.

Hospice Care. The charges relating to Hospice care provided that the Covered Person has a life expectancy of six (6) months or less. Covered Hospice expenses are limited to:

1. Room and Board for confinement in a Hospice;
2. Ancillary charges furnished by the Hospice while the Covered Person is confined therein, including rental of Durable Medical Equipment which is used solely for treating an Injury or Illness;
3. Medical supplies, Drugs and medicines prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition;
4. Physician services and/or nursing care by a Registered Nurse (RN), a Licensed Practical Nurse (LPN) or a Licensed Vocational Nurse (LVN);
5. Home health aide services;
6. Charges for home care furnished by a Hospital or Home Health Care Agency, under the direction of a Hospice, including Custodial Care if it is provided during a regular visit by a Registered Nurse (RN), a Licensed Practical Nurse (LPN), a Licensed Vocational Nurse (LVN) or a home health aide;
7. Medical social services by licensed or trained social workers, psychologists or counselors;
8. Nutrition services provided by a licensed Dietitian; and
9. Bereavement counseling.

Hospital. The charges for:

1. The actual Room and Board expenses incurred for a Semi-Private room or 100% of the most common Private room rate for a Hospital that does not have Semi-Private accommodations;
2. The actual expense incurred for confinement in an Intensive Care Unit, a Cardiac Care Unit or Burn Unit;
3. Miscellaneous Hospital services and supplies during Hospital confinement;
4. Inpatient Charges for nursery Room and Board;
5. Outpatient Hospital services and supplies; and
6. Hospital Emergency Room services and supplies.

Immunizations. The charges for Immunizations and vaccinations to include complications incurred as a result of such Immunizations.

Infertility. The charges for diagnostic testing for the initial diagnosis of infertility. Also covered are the charges for Surgery to treat the underlying cause of infertility.

Infusion Therapy. The charges for infusion therapy.

Maternity Care. The charges for maternity care, on the same basis as any Illness covered under this Plan for Covered Employees and covered Dependents. Plan coverage for a Hospital stay in connection with childbirth for both the mother and the newborn Child will be no less than: forty-eight (48) hours following a normal vaginal delivery, or ninety-six (96) hours following a cesarean section, unless a shorter stay is agreed to by both the mother and her attending Physician.

Medical Services Outside the United States. The charges for medical services incurred outside the United States and its territories provided that:

1. Treatment is a result of a Medical Emergency, and services are Medically Necessary and recognized as usual treatment for that condition;
2. Medical expenses are considered Reasonable and Usual and Customary based on the nearest U.S. geographic location to point of service;
3. Procedures are approved by the AMA;
4. All usual Plan provisions, Maximum Benefits, exclusions and limitations apply;
5. Expenses must be filed in U.S. dollar amounts;
6. Services must be translated into English; and
7. Benefits may not be assigned to a Provider.

Medical Supplies. The charges for dressings, sutures, casts, splints, trusses, crutches, braces (except dental braces), Corrective Shoes and other necessary medical supplies.

Mental Disorders, Chemical Dependency, Drug and Substance Abuse. The charges for treatment of Mental Disorders, Chemical Dependency, Drug and Substance Abuse to include Inpatient, Outpatient Psychiatric Day Treatment Facility, Outpatient Chemical Dependency/Drug Treatment Facility, Outpatient therapy and Office Visit expenses. Benefits for Mental Disorders are subject to the provisions of the Mental Health Parity Act and any related amendments.

Midwife. The charges for the services of a Certified Nurse Midwife (CNM).

Morbid Obesity. The charges for the treatment of Morbid Obesity only when the treatment meets Utilization Review's criteria for Medical Necessity to include surgical treatment, non-surgical treatment and complications from such treatment.

Multiple Surgical Procedures. The charges for multiple Surgical Procedures when two (2) or more procedures are performed during the same operation. The Covered Expenses are as follows:

1. When multiple or bilateral Surgical Procedures that increase the time and amount of patient care are performed, the Covered Expense is the allowable fee for the major procedure plus 50% of the allowable fee for each of the lesser ones or the actual fee charged, whichever is less. This provision will not apply to those procedures which are not subject to the Multiple Procedures Reduction Rules per Medicare; and
2. When an incidental procedure is performed through the same incision, the Covered Expense is the fee for the major Surgical Procedure only. Examples of incidental procedures are: excision of a scar, appendectomy, lysis of adhesions, etc.

Nerve Stimulators. The charges for nerve stimulators and TENS units.

Occupational Therapy. The charges for Occupational Therapy for treatment rendered by a licensed Occupational Therapist under supervision of a Physician at a Facility whose primary purpose is to provide medical care for an Injury or Illness.

Organ and Tissue Transplants. The charges related to or in connection with human Organ and Tissue Transplants and organ Donor expenses will be considered first by the Employer's fully-insured Organ and Tissue Transplant Policy as the Primary payer. Such insurance policy will be referred to as the "Organ Transplant Policy" throughout this Plan Document. If charges related to human organ and tissue transplants and organ Donor expenses incurred by a Covered Person on this Plan are not covered by the Employer's fully-insured Organ Transplant Policy, the charges will be considered by this Plan. See Coordination With Organ Transplant Policy section. Covered Charges will be payable based on the information shown in the Organ Transplant Policy section. All charges are subject to the Eligibility provisions of this Plan at the time care and services are provided.

Orthotic Devices. The charges for Orthotic Devices when Medically Necessary and prescribed by a Physician or licensed Practitioner, medically designed for a given patient and used to support, align, prevent or correct deformities or to improve the function of movable parts of the body.

Oxygen. The charges for oxygen and other gases and their administration.

Phenylketonuria. The charges for formulas necessary for the treatment of phenylketonuria or other heritable Diseases. The benefits will be paid on the same basis that benefits would be paid for Drugs ordered by a Physician. Phenylketonuria means an inherited condition that may cause severe intellectual disability if not treated.

Physical Therapy. The charges for Physical Therapy for the treatment or services rendered by a licensed Physical Therapist under direct supervision of a Physician at a Facility or institution whose primary purpose is to provide medical care for an Illness or Injury.

Physician. The charges for the services of a legally qualified Physician for medical care and/or surgical treatment including Office Visits, home visits, Hospital Inpatient care, Hospital Outpatient visits/exams, clinic care and second/third opinion consultations.

Prosthetics. The charges for Prosthetics including artificial limbs and eyes to replace natural limbs and eyes and other necessary prosthetic devices, but not the replacement thereof, unless the replacement is necessary because of physiological changes.

Psychological Testing. The charges for psychological testing.

Radiation Therapy. The charges for radiation therapy.

Rehabilitation Facility. The charges incurred for rehabilitative and habilitative services and devices and/or confinement in a Rehabilitation Facility.

Residential Treatment Center. The charges for treatment of Mental Disorders, Chemical Dependency, Drug and Substance Abuse in a Residential Treatment Center.

Routine Newborn Care. The charges for Routine Newborn Care for a well newborn Child for Nursery Room and Board and routine Inpatient services required for the healthy newborn following birth. Covered Expenses will also include charges for pediatric services, newborn hearing exams and circumcision. Benefits will be payable from the date of birth until the date the mother is discharged. Covered Charges are subject to a separate Calendar Year Deductible and considered an expense of the Child.

Sales Tax. The applicable sales tax for covered services and supplies.

Second or Third Surgical Opinion. The charges incurred for a second or third surgical opinion when Surgery or other non-surgical treatment has been recommended.

Skilled Nursing Facility/Extended Care Facility. The charges incurred for confinement in a Skilled Nursing Facility/Extended Care Facility; however, such expenses are limited as follows:

1. The attending Physician certifies that confinement is Medically Necessary. Only charges incurred in connection with care related to the Injury or Illness for which the Covered Person was Hospital confined will be eligible; and
2. Semi-Private daily Room and Board limit.

Sleep Disorders. The charges for the treatment of Sleep Disorders and sleep apnea to include sleep studies/diagnostic testing, Surgery, Facility, devices and equipment. However, Surgical Procedures to correct snoring are not covered.

Speech Language Pathologist/Speech Therapy. The charges of a legally qualified Speech Language Pathologist under direct supervision of a Physician for restorative Speech Therapy for speech loss or

speech impairment due to an Illness, Injury or Congenital Anomaly or due to Surgery performed because of an Illness or Injury, other than a functional nervous disorder (i.e., stuttering, repetitive speech).

Sterilization. The charges for all FDA approved women's elective sterilization procedures. Also covered are the charges for elective vasectomies for Covered Employees, covered Dependent spouses and Domestic Partners.

Surgical Lens Implants. The charges for surgical lens implants for cataracts and other Diseases of the eye.

Surgical Procedure. The charges incurred for a Medically Necessary Surgical Procedure.

Temporomandibular Joint (TMJ) Disorders and Orthognathic Disorders. The charges for medical treatment of Temporomandibular Joint (TMJ) Syndrome, orthognathic disorders (including Surgical and non-Surgical treatment) and related services to include the initial diagnostic visit, x-rays of the joint, injections into the joint and surgical repair of the temporomandibular joint, to exclude dental and orthodontic services.

Tobacco Use Screening/Cessation Intervention. The charges for tobacco use screening/cessation intervention.

Total Parenteral Nutrition (TPN). The charges for hyperalimentation or total parenteral nutrition (TPN) for persons recovering from or preparing for Surgery.

Urgent Care Facility (Minor Emergency Medical Clinic). The charges for an Urgent Care Facility and for services rendered therein.

Vision Screening. The charges for routine vision screening as required for Preventive Care for Children.

Wellness Procedures. The charges for covered wellness procedures listed as Preventive and Wellness Care Benefits.

MAJOR MEDICAL PLAN EXCLUSIONS AND LIMITATIONS

GENERAL EXCLUSIONS AND LIMITATIONS

The following exclusions and limitations apply to expenses incurred by all Covered Persons:

Abortion. Charges for services or supplies rendered to any Covered Employee or Dependent in connection with an elective abortion, unless the elective abortion is Medically Necessary and the life of the Covered Person would be endangered if the fetus were carried to term, or if Pregnancy was the result of a criminal act such as rape or incest, or if a fetal or chromosomal abnormality existed which was diagnosed prior to the abortion. Benefits for treatment of complications arising from, or as the result of, any elective abortion will be payable on the same basis as an Illness.

Adoption Fees. Charges for adoption fees.

Blood Procurement. Charges incurred for procurement and storage of one's own blood except for procurement and storage of one's own blood if obtained within three (3) months prior to a scheduled Surgery.

Botox. Charges for Botox injections unless Medically Necessary and not Cosmetic.

Chiropractic Maintenance Therapy. Charges for Chiropractic Services for maintenance therapy in accordance with Utilization Review's criteria for maintenance care.

Claim Received After Filing Deadline. Charges for a Claim received after twelve (12) months from the date the service was rendered.

Close Relative. Charges for treatment, services and supplies provided by a Close Relative of the Covered Person, as defined in this Plan.

Consultations Online/Telephone. Charges for telephone or online consultations with a Physician and/or other Providers.

Continuous Passive Motion Equipment. Charges for purchase or rental of Continuous Passive Motion (CPM) equipment, unless used for post surgical rehabilitation.

Cosmetic. Charges incurred in connection with the care or treatment of, or operations which are performed for, Cosmetic purposes of any kind, including treatment or Surgery for complications or correction of Cosmetic Surgery or treatment, *except* for Cosmetic Surgery procedures listed as covered in Major Medical Expense Benefits.

Counseling. Charges for marriage counseling and Family counseling.

Custodial Care. Charges for Custodial Care and maintenance care. Unless specifically mentioned otherwise, the Plan does not provide benefits for services and supplies intended primarily to maintain a level of physical or mental function.

Deductible/Coinsurance. Any portion of the billed charges for services or supplies which the Provider offers to waive, such as the portion which would not be paid by the Plan due to Deductible or Coinsurance provisions.

Dental. Charges incurred for treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue or alveolar processes; however, benefits will be payable for covered Oral Surgery procedures and treatment required because of Accidental Injury to sound natural teeth. This exception shall not in any event be deemed to include charges for treatment for the repair or replacement of a denture or bridgework. Injury to teeth from chewing or biting is not considered an Accidental Injury.

Education. Charges for education or training of any type including those for learning disabilities, except diabetic self-management medical training for diagnosed cases of diabetes and behavior training for treatment of Autism Spectrum Disorder.

Excess. Charges that are not payable under the Plan due to application of any Plan maximum or limit or because the charges are in excess of the Usual and Customary amount, Allowable Claim Limits or are for services not deemed to be Reasonable or Medically Necessary, based upon the Plan Administrator's determination as set forth by and within the terms of this document.

Experimental. Charges for research studies and Experimental medical procedures, treatment, Drugs, devices and related services considered to be Experimental/Investigational in nature as defined in the Plan Definitions except clinical trials listed as covered in Major Medical Expense Benefits. The Claims Administrator retains the right to have such medical expenses reviewed by an independent panel of peer reviewers to determine whether such expenses are considered accepted, standard medical treatment or are Experimental/Investigational.

Experimental Transplants. Charges related to or in connection with Experimental Organ, Tissue and Bone Marrow Transplants including any animal organ transplants.

Fees. Charges for completion of form fees, missed appointment fees or late fees.

Foot Care. Charges for callus or corn paring or excision, toenail trimming, any manipulative procedure for weak or fallen arches, flat or pronated foot, foot strain, Orthopedic Shoes (unless attached to a brace), orthotic insoles or other devices for support of the feet, except for:

1. An open cutting operation for the treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions;
2. Removal of nail roots; or
3. Foot treatment required because of a metabolic or peripheral vascular Disease.

Gender Reassignment. Charges related to or in connection with gender reassignment procedures.

Genetic Testing. Charges for genetic testing except as required under Preventive Services.

Government. Charges for Hospital confinement, medical or surgical services or other treatment furnished or paid for by or on behalf of the United States, or any State, province or other political subdivision unless there is an unconditional requirement to pay such charges whether or not there is insurance.

Hair Loss/Wigs. Charges for treatment of hair loss including wigs, hairpieces and hair transplants.

Home Health Care Plan Exclusions. Charges for:

1. Services and supplies not included in the Home Health Care Plan;
2. Services of a person who is a Close Relative of the Covered Person;
3. Services of any social worker unless designated LCSW;
4. Transportation services;
5. Food or home delivered meals; and
6. Custodial Care and housekeeping.

Hypnotherapy, Behavior Training and Biofeedback. Charges for hypnotherapy, behavior training (except behavior training for treatment of Autism Spectrum Disorder) and biofeedback.

Illegal Acts. Charges for Injury or Illness incurred as a result of illegal acts involving violence or threat of violence to another person, or in which the Covered Person illegally used a firearm, explosive or other weapon likely to cause physical harm or death, whether or not the Covered Person was charged, convicted or received any type of fine, penalty, imprisonment or other sentence or punishment, unless such Injury is the result of a medical condition (either physical or mental) or is the result of the Covered Person being the victim of an act of domestic violence.

Illegal in the United States. Charges for any services or supplies not considered legal in the United States.

Incurred by Other Persons. Charges for expenses actually incurred by other persons.

Infertility. Charges related to or in connection with the treatment of infertility to include fertility studies, sterility studies, procedures to restore or enhance fertility (except Surgical Procedures to treat the underlying cause of infertility), artificial insemination or in-vitro fertilization or other similar procedures.

I.Q. Testing. Charges for I.Q. testing.

Medicare. Charges for benefits that are provided, or which would have been provided had the Participant enrolled in, applied for, or maintained eligibility for such care and service benefits, under Title XVIII of the Federal Social Security Act of 1965 (Medicare), including any amendments thereto, or under any Federal law or regulation, except as provided in the sections entitled "Coordination of Benefits" and "Medicare."

Negligence. Charges for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any licensed Provider.

Newborns of Dependent Children. Charges related to or in connection with newborns of Dependent Children, unless the newborn Child meets the definition of an Eligible Dependent.

Not Acceptable. Charges that are not accepted as standard practice by the AMA, ADA, or the FDA.

Not Certified/Authorized. Charges for treatment, services or supplies that are not certified by a Physician or Practitioner who is attending the Covered Person as being required for the treatment of Injury or Disease, and performed by an appropriate Practitioner.

Not Connected with Active Illness. Charges for hospitalization primarily for x-rays, laboratory tests, diagnostic study, physiotherapy, hydrotherapy, medical observation, convalescent or rest care, or any medical examination or test not connected with an active Illness or Injury, unless otherwise specified for Preventive and Wellness Care Benefits or otherwise specified as covered in this Plan.

Not Legally Obligated to Pay. Charges incurred for which the Covered Person, in the absence of this coverage, is not legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage.

Not Medically Necessary. Charges incurred in connection with services and supplies which are not Medically Necessary for treatment of an active Illness or Injury unless listed as Covered Wellness Procedures in the Preventive and Wellness section of the Schedule of Benefits or otherwise specified as covered in this Plan.

Not Rendered by/Provided under Supervision of Physician. Charges for Physicians' fees for any treatment which is not rendered by or provided under the supervision of a Physician.

Nutritional Supplements. Charges for nutritional supplements and related supplies, whether or not prescribed by a Physician. The Plan will consider charges for nutritional supplements, feeding tubes and related supplies only if a Covered Person is unable to get nutrition by any other means and nutritional supplements for treatment of Autism Spectrum Disorder.

Occupational. Charges arising out of or in the course of any occupation for wage or profit, whether or not the Covered Person is entitled to benefits under any Workers' Compensation or Occupational Disease Law, or any such similar law.

Organ Transplant Policy. Charges for all transplant services covered under the Employer's fully-insured Organ Transplant Policy. See Organ Transplant Policy section.

Personal Convenience. Charges incurred for services or supplies which constitute personal comfort or beautification items, television or telephone use, or charges in connection with Custodial Care.

Portable Uterine Monitors. Charges for portable uterine monitors unless approved by Utilization Review and/or Case Management.

Prior to Coverage. Charges for services that are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein.

Prior to Effective Date. Charges incurred prior to the effective date of coverage under the Plan, or after coverage is terminated.

Private Duty Nursing. Charges for Private Duty Nursing except as payable under Home Health Care.

Provider Error. Charges for services required as a result of unreasonable Provider error.

Riot/Civil Insurrection. Charges resulting from or sustained as a result of participation in a riot or civil insurrection.

Self-inflicted. Charges incurred in connection with any self-inflicted Injury or Illness unless the Injury or Illness is a result of a medical condition (either physical or mental) or is the result of the Covered Person being the victim of an act of domestic violence.

Sexual Dysfunctions. Charges for treatment of sexual dysfunctions or inadequacies that do not have a physiological or organic basis.

Speech Therapy. Charges for Speech Therapy to correct pre-speech deficiencies or therapy to improve speech skills not fully developed unless related to an Illness or Injury.

Sterilization Reversal. Charges resulting from or in connection with the reversal of a sterilization procedure.

Subrogation, Reimbursement, and/or Third Party Responsibility. Charges for treatment of an Injury or Illness not payable by virtue of the Plan's subrogation, reimbursement, and/or third party responsibility provisions.

Surrogate Fees. Charges for surrogate fees.

Travel Outside the United States. Charges incurred as the result of travel outside the United States or its territories specifically to receive medical treatment.

Vision Correction Surgery. Charges for any Surgical Procedure for the correction of a visual refractive problem including radial keratotomy, lasik or similar Surgical Procedures.

Vision Exam and Eyewear. Charges incurred in connection with routine vision exams or eye refractions, and the purchase or fitting of eyeglasses and contact lenses. This exclusion/limitation shall not apply to routine vision screenings as required for Preventive Care for Children or the initial purchase of eyeglasses or contact lenses following cataract Surgery.

War. Charges incurred as a result of war or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country.

Weight Loss Programs. Charges for weight loss programs even when recommended by a Physician.

NOTE: With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Injury if the Injury results from being the victim of an act of domestic violence or a documented medical condition. To the extent consistent with applicable law, this exception will not require this Plan to provide particular benefits other than those provided under the terms of the Plan.

COORDINATION OF BENEFITS

The Coordination of Benefits provision is intended to prevent the payment of benefits which exceed Covered Expenses. It applies when the Plan Participant is also covered by another plan or plans. When more than one coverage exists, one plan (primary plan) normally pays its benefits in full and the other plans (secondary plans) pay a reduced benefit. This Plan may pay either its benefits in full or at a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of Allowable Expenses. Only the amount paid by this Plan will be charged against the Plan Benefit Maximums.

For organ and tissue transplants, see Coordination With Organ Transplant Policy section. The reduced Benefits payable under this Plan for organ and tissue transplants which, when added to the benefits payable by the Organ Transplant Policy, will not exceed benefits payable under this Plan, if this Plan were primary.

The Coordination of Benefits provision applies whether or not a Claim is filed under the other plan or plans. If needed, authorization must be given to this Plan to obtain information as to benefits or services available from the other plan or plans, or to recover overpayments.

All benefits contained in the Plan Document are subject to this provision except Prescription Drug expenses.

EXCESS INSURANCE

If at the time of Injury, Illness, Disease or disability there is available, or potentially available, any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage.

For purposes of this Coordination of Benefits provision, the term "plan" as used herein will mean any plan providing benefits or services for medical or dental treatment, and such benefits or services are provided by:

1. Group insurance or any other arrangement for coverage for Covered Persons in a group whether on an insured or uninsured basis, including but not limited to:
   a. Hospital indemnity benefits; and
   b. Hospital reimbursement-type plans which permit the Covered Person to elect indemnity at the time of Claims;
2. Hospital or medical service organizations on a group basis, group practice and other group pre-payment plans;
3. Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision;
4. A Licensed Health Maintenance Organization (HMO);
5. Any Coverage for students which is sponsored by, or provided through, a school or other educational institution;
6. Any coverage under a governmental program, and any coverage required or provided by any statute;
7. Group automobile insurance;
8. Individual automobile insurance coverage on an automobile leased or owned by the Employer; or
9. Any individual automobile insurance, including No-Fault Automobile Insurance on an individual basis.

"Plan" will be construed separately with respect to each policy, contract, or other arrangement for benefits or services, and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

"Allowable Expense" is the Usual and Customary charge within Allowable Claim Limits for any Medically Necessary, Reasonable, eligible item of expense, at least a portion of which is covered under this Plan. When some other plan provides benefits in the form of services rather than cash payments, the Reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any other plan include the benefits that would have been payable had Claim been duly made.

In the case of HMO (Health Maintenance Organization) plans, this Plan will not consider any charges in excess of what an HMO Provider has agreed to accept as payment in full. Further, when an HMO is primary and the Covered Person does not use an HMO Provider, this Plan will not consider as allowable expenses any charges that would have been covered by the HMO had the Covered Person used the services of an HMO Provider.

"Claim Determination Period" is a Calendar Year, a Plan Year or that portion of a Calendar or Plan Year during which the Covered Person, for whom Claim is made, has been covered under this Plan.

COORDINATION PROCEDURES

Notwithstanding the other provisions of this Plan, benefits that would be payable under this Plan will be reduced so that the sum of benefits payable under this Plan and all benefits payable under all other plans will not exceed the total of Allowable Expenses incurred during any Claim Determination Period with respect to Covered Persons eligible for:

1. Benefits, either as an insured person or Employee or as a Dependent, under any other plan which has no provision similar in effect to this provision.

2. Dependents' benefits under this Plan who are also eligible for benefits:

    a. As an insured person or Employee under any other plan; or
    b. As a Dependent Child of an insured person or Employee covered under any other plan.

3. A Covered Person under this Plan who is also eligible for benefits as an insured person or Employee under any other plan and has been covered continuously for a longer period of time under such other plan.

For the purpose of determining the applicability of and for implementing this provision or any provision of similar purpose in any other plan, the Plan Administrator may, without the consent of or notice to any person, release to or obtain from any other insurance company or other organization or person any information with respect to any person which the Plan Administrator deems to be necessary for such purposes. Any Covered Person claiming benefits under this Plan will furnish to the Plan Administrator such information as may be necessary to implement this provision or to determine its applicability.

ORDER OF BENEFIT DETERMINATION

Each plan makes its Claim payment according to where it falls in this order, if Medicare is not involved:

1. If a plan contains no provision for Coordination of Benefits, then it pays primary before all other plans.

2. The plan which covers the Covered Person as an Employee (or named insured) pays primary as though no other plan existed; remaining recognized charges are paid under a secondary plan which covers the Claimant as a dependent.

3. If the Covered Person is a Dependent Child:

    a. Whichever parent has a birthday anniversary which occurs earlier in the Calendar Year shall be considered to have the primary plan;
    b. If birthday anniversaries are the same, then the plan of the parent who has been covered under his/her plan for the longer period of time will be primary; and
    c. If the plan with which this Plan is to be coordinated does not include the requirements shown above, then the plan without such requirements will be primary.

4. If the Covered Person is a Dependent Child and the parents are divorced, then:

    a. The plan of the parent with custody pays first, unless a court order or decree specifies the other parent to have financial responsibility, in which case that parent's plan would pay first; or
    b. The plan of a step-parent with whom the Child lives pays second (if applicable).

5. If the order set out in 1, 2, 3 or 4 above does not apply in a particular case, then the plan which has covered the Covered Person for the longest period of time will pay first.

FACILITY OF PAYMENT

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plan or plans, the Plan Administrator will have the right, exercisable alone and in its sole discretion, to pay to any insurance company or other organization or person making such other payments any amounts it will determine in order to satisfy the intent of this provision, and amounts so paid will be deemed paid under this Plan and to the extent of such payments, the Plan Administrator will be fully discharged from liability under this Plan.

The benefits that are payable will be charged against any applicable Maximum payment or benefit of this Plan rather than the amount payable in the absence of this provision.

RIGHT OF RECOVERY

In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the Maximum Amount of payment necessary at that time to satisfy the intent of this Article, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the Covered Person or his or her Dependents. **Please see the Recovery of Payments provision for more details.**

COORDINATION WITH ORGAN TRANSPLANT POLICY

Covered Persons who are eligible for the Employer's fully-insured Organ Transplant Policy will be entitled to benefits under this Plan only after consideration of transplant expenses by the Employer's Organ Transplant Policy. The Organ Transplant Policy is always the Primary payer and pays before any benefits under this Plan are considered unless the insured person is eligible for Medicare or is a Dependent covered by another employer's group plan. This Plan will always be the Secondary payer unless charges are not covered by the Organ Transplant Policy. This Plan may pay either its benefits in full or a reduced amount which, when added to the benefits payable by the Organ Transplant Policy, will not exceed the benefits payable under this Plan if this Plan were Primary. Only the amount paid by this Plan will be charged against the Plan Maximums. This Plan will fully coordinate its benefits, as Secondary payer, against the benefits provided under the above referenced transplant policy.

COORDINATION WITH MEDICARE

Notwithstanding all other provisions of this Plan, Covered Persons who are eligible for Medicare benefits may be entitled to benefits under this Plan which will be coordinated with Medicare in accordance with the Coordination of Benefits provision of this Plan and subject to the rules and regulations as specified by the Tax Equity and Fiscal Responsibility Act of 1982 as they may be amended from time to time. This Plan is

primary to Medicare coverage for all active Employees and Dependents (regardless of age) unless Medicare states otherwise for certain medical conditions. In the event that this Plan is secondary to Medicare, benefits payable under this Plan will be reduced by benefits that would be payable for the same services under Medicare Parts A and B whether or not the Covered Person is enrolled in Medicare Parts A and B.

COORDINATION WITH AUTOMOBILE INSURANCE COVERAGE

The Plan's liability for expenses arising out of an automobile Accident is based on the type of automobile insurance law enacted by the Covered Person's State. Nationally, there are three types of State automobile insurance laws:

1. No-Fault Automobile Insurance laws;
2. Financial responsibility laws; or
3. Other automobile liability insurance laws.

COORDINATION WITH AUTOMOBILE NO-FAULT COVERAGE

Except as required by law, the Plan is secondary to any No-Fault Automobile coverage. It is not intended to reduce the level of coverage that would otherwise be available through a No-Fault Automobile Insurance policy nor does it intend to be primary in order to reduce the premiums or cost of No-Fault Automobile coverage.

If the Covered Person or his/her covered Dependent incur Covered Charges as a result of an automobile Accident (either as driver, passenger or pedestrian), the amount of Covered Charges that the Plan will pay is limited to:

1. Any Deductible under the automobile coverage;
2. Any Copayment under the automobile coverage;
3. Any expense properly excluded by the automobile coverage that is a Covered Charge; and
4. Any expense that the Plan is required to pay by law.

An individual is considered to be covered under an automobile insurance policy if he/she is either:

1. An owner or principal named insured of the policy;
2. A Family member of a person insured under the policy; or
3. A person who would be eligible for medical expense benefits under an automobile insurance policy if this Plan did not exist.

COORDINATION WITH FINANCIAL RESPONSIBILITY LAW

The Plan is secondary to automobile coverage or to any other party who may be liable for the Covered Person's medical expenses resulting from the automobile Accident.

If the Covered Person's State has a "financial responsibility" law which does not allow the Plan to pay benefits as secondary or which does not allow the Plan to advance payments with the intent of subrogating or recovering the payment, the Plan will not pay any benefits related to an automobile Accident for the Covered Person or their Dependents.

COORDINATION WITH OTHER AUTOMOBILE LIABILITY INSURANCE

If the Covered Person's State does not have a No-Fault Automobile Insurance law or a "financial responsibility" law, this Plan is secondary to their automobile insurance coverage or to any other party who may be liable for the Covered Person's medical expenses resulting from the automobile Accident.

COORDINATION WITH UNDERINSURED/UNINSURED MOTORIST COVERAGE

If the Covered Person is involved in an automobile Accident and, as a result of the Accident, the Plan pays benefits, and if the Covered Person receives a settlement from their underinsured or uninsured motorist policy, the Plan is entitled to receive, from the proceeds of the settlement with the underinsured or uninsured motorist coverage, the expenses of the Plan. The Plan is not entitled to receive any recovery that is in excess of its expenses. The Plan agrees to payment of benefits prior to the receipt by the Covered Person of any recovery from their underinsured or uninsured motorist policy. The Covered Person agrees to notify the Plan of the existence of a recovery from an underinsured or uninsured motorist policy and further agrees to remit to the Plan the proceeds of any recovery received from an underinsured or uninsured motorist policy up to the expenditures made by the Plan. Any expenses by the Plan which are in excess of the proceeds received by the underinsured/uninsured motorist policy will be the responsibility of the Plan pursuant to the terms and conditions of the Plan.

SUBROGATION AND REIMBURSEMENT PROVISIONS

PAYMENT CONDITION

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, sickness, Disease or disability is caused in whole or in part by, or results from the acts or omissions of Covered Persons, Plan Beneficiaries and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereafter in this section as "Covered Person(s)") or a third party, where another party may be responsible for expenses arising from an incident and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance and/or guarantor(s) of a third party (collectively "Coverage").

2. A Covered Person(s), his/her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Covered Person(s) and/or his/her attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Covered Person(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Covered Person shall be a trustee over those Plan assets.

3. In the event a Covered Person(s) settles, recovers, or is reimbursed by any Coverage, the Covered Person(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s) for charges Incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Covered Person(s) fails to reimburse the Plan out of any judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

4. If there is more than one party responsible for charges paid by the Plan, or that may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, in regards to an unallocated settlement fund meant to compensate multiple injured parties of which the Covered Person(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the Plan may seek reimbursement.

SUBROGATION

1. As a condition to participating in and receiving benefits under this Plan, the Covered Person(s) agrees to assign to the Plan the right to subrogate and pursue any and all Claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Covered Person(s) fails to so pursue said rights and/or action.

2. If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any Claim which any Covered Person(s) may have against any Coverage and/or party causing the sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Person is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Covered Person is also obligated to hold any and all funds so

received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

3. The Plan may, at its discretion, in its own name or in the name of the Covered Person(s) commence a proceeding or pursue a Claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

4. If the Covered Person(s) fails to file a Claim or pursue damages against:

   a. The responsible party, its insurer, or any other source on behalf of that party;
   b. Any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
   c. Any policy of insurance from any insurance company or guarantor of a third party;
   d. Workers' Compensation or other liability insurance company; or
   e. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverages;

   then the Covered Person(s) authorizes the Plan to pursue, sue, compromise and/or settle any such Claims in the Covered Person(s) and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such Claims. The Covered Person(s) assigns all rights to the Plan or its assignee to pursue a Claim and the recovery of all expenses from any and all sources listed above.

RIGHT OF REIMBURSEMENT

1. The Plan shall be entitled to recover 100% of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Covered Person(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Covered Person(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If the Covered Person's/ Covered Persons' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Covered Person are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or Claim on the part of the Covered Person(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery, will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person(s).

5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, Injury, Disease or disability.

PARTICIPANT IS A TRUSTEE OVER PLAN ASSETS

1. Any Covered Person who receives benefits and is, therefore, subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is, therefore, deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any Injury or Accident. By virtue of this status, the Covered Person understands that he/she is required to:

    a. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;
    b. Instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;
    c. In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Plan Participant obtains a settlement, judgment or other source of coverage to include the Plan or its authorized representative as a payee on the settlement draft; and
    d. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

2. To the extent the Covered Person disputes this obligation to the Plan under this section, the Covered Person or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorney's fees, for which he/she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

3. No Covered Person, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section, will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

RELEASE OF LIABILITY

The Plan's right to reimbursement extends to any incident related care that is received by the Covered Person(s) ("Incurred") prior to the liable party being released from liability. The Covered Person's/Covered Persons' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Covered Person has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be incurred, and for which the Plan will be asked to pay.

EXCESS INSURANCE

If at the time of Injury, sickness, Disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section. The Plan's benefits shall be excess to:

1. The responsible party, its insurer, or any other source on behalf of that party;
2. Any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
3. Any policy of insurance from any insurance company or guarantor of a third party;
4. Workers' Compensation or other liability insurance company; or
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

SEPARATION OF FUNDS

Benefits paid by the Plan, funds recovered by the Covered Person(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person(s), or filing of bankruptcy by the Covered Person(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

WRONGFUL DEATH CLAIMS

In the event that the Covered Person(s) dies as a result of his/her injuries and a wrongful death or survivor Claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply.

OBLIGATIONS

1. It is the Covered Person(s) obligation at all times, both prior to and after payment of medical benefits by the Plan to:

    a. Cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
    b. Provide the Plan with pertinent information regarding the sickness, Disease, disability or Injury, including Accident reports, settlement information and any other requested additional information;
    c. Take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
    d. Do nothing to prejudice the Plan's rights of subrogation and reimbursement;
    e. Promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received;
    f. To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan.
    g. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement;
    h. Not settle or release, without the prior consent of the Plan, any Claim to the extent that the Plan Beneficiary may have against any responsible party or Coverage;
    i. Instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft;
    j. In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft; and
    k. Make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Covered Person over settlement funds is resolved.

2. If the Covered Person(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid, to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person(s).

3. The Plan's right to reimbursement and/or subrogation is in no way dependent upon the Covered Person(s)' cooperation or adherence to these terms.

OFFSET

If timely repayment is not made, or the Covered Person(s) and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Covered Person's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the

Covered Person(s) in an amount equivalent to any outstanding amounts owed by the Covered Person to the Plan. This provision applies even if the Covered Person has disbursed settlement funds.

MINOR STATUS

1. In the event the Covered Person(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his/her estate insofar as these subrogation and reimbursement provisions are concerned.

2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

LANGUAGE INTERPRETATION

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

SEVERABILITY

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

CLAIM REVIEW AND AUDIT PROGRAM

The Plan has arranged with the "Designated Decision Maker" ("DDM") for a program of Claim review and auditing in order to identify charges billed in error, charges for excessive or unreasonable fees and charges for services which are not medically appropriate. Benefits for Claims which are selected for review and auditing will be reduced for any charges that are determined to be in excess of Allowable Claim Limits (as defined below). The determination of Allowable Claim Limits under this Program will supersede any other Plan provisions related to application of a Usual and Customary fee determination.

Medical care Providers will be given a fully detailed explanation of any charges that are found to be in excess of Allowable Claim Limits, and allowed the rights and privileges to file an appeal of the determination in accordance with the same rights and privileges accorded to Plan Participants, in exchange for the Provider's agreement not to bill the Plan Participant for charges which were not covered as a result of the Claim review and audit.

Any Plan Participant who continues to receive billings from the medical care Provider for these charges should contact the DDM or the Plan Administrator right away for assistance.

The Plan Administrator is identified in the General Information and Purpose section of this Summary Plan Description. The DDM may be contacted at:

ELAP Services, LLC
1550 Liberty Ridge, Suite 330
Wayne, PA 19087
Phone: 610-321-1030
Fax: 610-321-1031

The Plan Participant must pay for any normal cost-sharing features of the Plan, such as Deductibles, Coinsurance and Copayments, and any amounts otherwise excluded or limited according to the terms of the Plan.

The success of this program will be achieved through a comprehensive review of detailed records including, for example, itemized charges and descriptions of the services and supplies provided. Without this detailed information, the Plan will be unable to make a determination of the amount of Covered Medical Expenses that may be eligible for reimbursement. Any additional information required for the audit will be requested directly from the Provider of service and the Claimant. In the event that the Plan Administrator does not receive information adequate for the Claim review and audit within the time limits required under the Plan, it will be necessary to deny the Claim. Should such a denial be necessary, the Claimant and/or the Provider of service may appeal the denial in accordance with the provisions which may be found in the section, "Procedures for Claims and Appeals," in this Summary Plan Description.

In the following provisions of the Claim Review and Audit Program, the term "Plan Administrator" shall be deemed to mean the DDM:

"Allowable Claim Limits" means the charges for services and supplies, listed and included as Covered Medical Expenses under the Plan, which are Medically Necessary for the care and treatment of Illness or Injury, but only to the extent that such fees are within the Allowable Claim Limits. Examples of the determination that a charge is within the Allowable Claim Limit include, but are not limited to, the following guidelines:

1. **Errors, Unbundled and/or Unsubstantiated Charges.** Allowable Claim Limits will not include the following amounts:

    a. Charges identified as improperly coded, duplicated, unbundled and/or for services not performed;
    b. Charges for treating Injuries sustained or Illnesses contracted, including infections and complications, which, in the opinion of the Plan Administrator, can be attributed to medical errors by the Provider;

c. Charges that cannot be identified or understood; and
d. Charges that cannot be verified from audits of medical records.

2. **Guidelines.** The following guidelines will be used when determining Allowable Claim Limits:

a. Facilities. The Allowable Claim Limit for Claims by a Facility, including but not limited to, Hospitals, emergency and urgent care centers, rehabilitation and skilled nursing centers, and any other health care Facility, shall be the greater of (I) 112% of the Facility's most recent departmental cost ratio, reported to the Centers for Medicare and Medicaid Services ("CMS") and published in the American Hospital Directory as the "Medicare Cost Report" (the "CMS Cost Ratio"), or (II) the Medicare allowed amount for the services in the geographic area plus an additional 20%. If insufficient information is available to identify either the Facility's most recent departmental cost ratio or the Medicare allowed amount, the Allowable Claim Limit shall be either (I) or (II) herein that can be identified.

b. Ambulatory Health Care Centers. The Allowable Claim Limit for ambulatory health care centers, including Ambulatory Surgery Centers, which are independent Facilities shall be the Medicare allowed amount for the services in the geographic area plus an additional 20%. In the event that insufficient information is available to identify the Medicare allowed amount, the Allowable Claim Limit for such services shall be to the extent available either the Outpatient or Inpatient Medicare allowed amount for the service, plus an additional 20%.

c. Professional Providers. The Allowable Claim Limits for professional Providers shall be determined using the following:

i. For general medical and primary care Claims, the Medicare allowed amount in the geographic area plus an additional 40%;
ii. For Specialist medical and surgical care Claims, the Medicare allowed amount in the geographic area plus an additional 55%;
iii. For anesthesiologist Claims, the Medicare allowed amount in the geographic area plus an additional 100%; or
iv. For other non-Facility Claims and supplies (such as Durable Medical Equipment, laboratory services and supplies, ambulance, air ambulance, etc.), the Medicare allowed amount in the geographic area plus an additional 25%.

For purposes of determining the proper Allowable Claim Limits for professional Providers in categories (i), (ii), (iii) or (iv) above, the Plan Administrator shall determine the applicable category for each Claim based on the taxonomy code used by the professional Provider for that Claim. The Plan Administrator determines, in its sole discretion, the type of Provider for determining Allowable Claim Limits, as detailed above.

d. Directly Contracted Providers. The Allowable Claim Limits for Directly Contracted Providers shall be the negotiated rate as agreed under the Direct Agreement.

e. Insufficient Information to Determine Allowable Claim Limit. In the event that insufficient information is available to determine Allowable Claim Limits for specific services or supplies using the guidelines listed in Section 2 above as may be applicable, the DDM may apply the following guidelines:

i. General Medical and/or Surgical Services. The Allowable Claim Limit for any covered services may be calculated based upon industry-standard resources including, but not limited to, published and publicly available fee and cost lists and comparisons, or any combination of such resources that, in the opinion of the Plan Administrator, results in the determination of a Reasonable expense under the Plan.
ii. Pharmaceuticals. The Allowable Claim Limit for pharmacy charges by a Provider may be determined by applying the Average Wholesale Price (AWP) as defined by REDBOOK at the rate of 112% of AWP.
iii. Medical and Surgical Supplies, Implants, Devices. The Allowable Claim Limit for charges for medical and surgical supplies made by a Provider may be based upon the invoice price (cost)

to the Provider, plus an additional 12%. The documentation used as the resource for this determination will include, but not be limited to, invoices, receipts, cost lists or other documentation as deemed appropriate by the Plan Administrator.

iv. Physician, Medical and Surgical Care, Laboratory, X-ray, and Therapy. The Allowable Claim Limit for these services may be determined based upon the 60th percentile of Fair Health (FH®) Allowed Benchmarks.

Comparable Services or Supplies. In the event that insufficient information is available to determine Allowable Claim Limits for specific services or supplies using the guidelines listed in Section 2 above, Allowable Claim Limits will be determined considering the most comparable services or supplies based upon comparative severity and/or geographic area to determine the Allowable Claim Limit. The Plan Administrator reserves the right, in its sole discretion, to determine any Allowable Claim Limit amount for certain conditions, services and supplies using accepted industry-standard documentation, applied without discrimination to any Covered Person.

In the event that a determination of Allowable Claim Limit for a Claim exceeds the actual Charges billed for the services and/or supplies, the actual Charges billed for the Claim shall be the Allowable Claim Limit.

PROCEDURES FOR CLAIMS AND APPEALS

The procedures outlined below must be followed by Claimants to obtain payment of benefits under this Plan.

NOTICE AND PROOF OF CLAIM

Written notice and proof of an incurred Claim should always be filed with the Claims Administrator as soon as possible. **Claims must be filed within twelve (12) months from the date of service to be covered by the Plan.** If an individual's coverage under the Plan ceases, all Claims incurred prior to termination of coverage **must** be filed within twelve (12) months from the date of service, or the Claims will not be covered by the Plan.

Claims **must** be filed sooner in certain circumstances:

- If the Plan is terminated, all Claims incurred prior to the Plan termination **must** be received within ninety (90) days after the termination or the Claims will not be covered.

Any Claims incurred after termination of Plan coverage for any reason are not covered under the Plan.

Customarily, there are four types of Claims: Pre-service (Urgent), Pre-service (Non-urgent), Concurrent Care, and Post-service.

- A “Pre-service Claim” is a Claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. Because the Plan does not require Claimants to obtain approval of a medical service prior to getting treatment on an urgent or non-urgent basis, there are no “Pre-service Claims.” The Claimant simply follows the Plan's procedures with respect to notice that is required after receipt of treatment, and files the Claim as a Post-service Claim.

- A “Concurrent Claim” arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either: (a) the Plan determines that the course of treatment should be reduced or terminated, or (b) the Claimant requests an extension of the course of treatment beyond that which the Plan has approved. Because the Plan does not require Claimants to obtain approval of medical services prior to getting treatment, there is no need to contact Utilization Review to request an extension of a course of treatment. The Claimant simply follows the Plan's procedures with respect to notice that is required after receipt of treatment, and files the Claim as a Post-service Claim.

- A “Post-service Claim” is a Claim for a benefit under the Plan after the services have been rendered.

A Post-service Claim is considered to be filed when the following information is received by the Claims Administrator with a Form CMS-1500 or Form UB-04 or any successor forms:

1. The date of service;
2. The name, address, telephone number, and tax identification number of the Provider of the services or supplies;
3. The place where the services were rendered;
4. The diagnosis and procedure codes;
5. The amount of charges (including any PPO re-pricing information);
6. The name of the Plan;
7. The name of the Covered Employee; and
8. The name of the patient.

Each Claimant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses

were incurred, or that the benefit is covered under the Plan. This includes any substantiating documentation, Coordination of Benefits information or other information that may be required by the Plan as proof. If the Plan Administrator in its sole discretion determines that the Claimant has not incurred a Covered Expense, or that the benefit is not covered under the Plan, or if the Claimant fails to furnish such proof as is requested, no benefits shall be payable under the Plan.

CLAIMS DETERMINATION

The Plan Administrator shall notify the Claimant, in accordance with the provisions set forth below, of any Adverse Benefit Determination within the following timeframes:

- If the Claimant has provided all of the information needed to process the Claim in a reasonable period of time, but not later than thirty (30) days after receipt of the Claim. This period may be extended by the Plan for up to fifteen (15) days, provided that the Plan Administrator: (a) determines that such an extension is necessary due to matters beyond the control of the Plan, and (b) notifies the Claimant, prior to the expiration of the initial thirty (30) day processing period, of the circumstances requiring the extension of time, and the date by which the Plan expects to render a decision. If an extension has been requested, then the Plan Administrator shall notify the Claimant of any Adverse Benefit Determination prior to the end of the fifteen (15) day extension period.

- If additional information is requested from the Claimant to process the Claim during the initial processing period, then the Claimant will be notified of a determination of benefits prior to the end of the extension period. If additional information is requested from the Claimant during the extension period, then the Claimant will be notified of the determination by a date agreed to by the Plan Administrator and the Claimant.

- Notice to the Claimant of a rescission of coverage will be provided at least thirty (30) days in advance of the retroactive termination of coverage by the Plan.

A Benefit Determination is required to be made within the period of time beginning when a Claim is deemed to be filed in accordance with the procedures of the Plan.

For purposes of the Plan's provisions for internal Claims and appeals and external review processes, a "Claim" for benefits is defined as a request for a plan benefit made by a Claimant in accordance with a plan's reasonable procedure for filing benefit Claims. A call from a Provider who wants to know if an individual is covered under the Plan, or if a certain procedure or treatment is a covered expense before the treatment is rendered, is not a "Claim" since an actual Claim for benefits is not being filed with the Plan. Likewise, presentation of a prescription to a pharmacy does not constitute a Claim.

An "Adverse Benefit Determination" is defined as a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, rescission of coverage, termination, or failure to provide or make a payment for a Claim that is based on:

1. A determination of an individual's eligibility to participate in a plan or health insurance coverage;
2. A determination that a benefit is not a covered benefit;
3. The imposition of a source-of-Injury exclusion, PPO Provider network exclusion, or other limitation on otherwise covered benefits; or
4. A determination that a benefit is Experimental, Investigational, or not Medically Necessary or appropriate.

Although it is not a Claim for benefits, the definition of an adverse benefit determination also includes a rescission of coverage under the Plan. A "rescission of coverage" is defined as a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

NOTICE OF ADVERSE BENEFIT DETERMINATION

If the initial Benefit Determination is an Adverse Benefit Determination, notification will be sent to the Claimant and will include the following information:

1. Information sufficient to identify the Claim involved, including the date of the service, the health care Provider, the Claim amount (if applicable), and, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

2. The reason or reasons for the Adverse Benefit Determination or final internal Adverse Benefit Determination, including the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, used in denying the Claim. In the case of a final internal Adverse Benefit Determination, this description must also include a discussion of the decision;

3. References to the Plan specific provisions on which the Adverse Benefit Determination is based;

4. A description of any additional material or information necessary for the Claimant to perfect the Claim, and an explanation of why such material or information is necessary;

5. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action following an Adverse Benefit Determination on final review;

6. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's Claim;

7. The identity of any medical or vocational experts consulted in connection with a Claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided upon request);

8. If an internal rule, guideline, protocol, or other similar criterion was relied on in making the Adverse Benefit Determination, either the specific rule, guideline, protocol or other similar criterion, or a statement that such information was relied on in making the Adverse Benefit Determination, and that a copy of the rule, guideline, protocol or other criterion will be provided free of charge on request; and

9. If the Adverse Benefit Determination is based on a medical judgment (such as Medical Necessity or whether the treatment was Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon written request.

PHYSICAL EXAMINATION

The Plan Administrator or Claims Administrator has the right to have the Claimant examined as often as reasonably necessary while a Claim is pending. Benefits are payable under this Plan only if they are Medically Necessary for the Illness or Accidental Injury of the Covered Person. This Plan reserves the right to make a Utilization Review to determine whether services are Medically Necessary for the proper treatment of the Covered Person. All such information will be confidential.

CLAIMS AUDIT

Once a written Claim for benefits is received, the Claims Administrator, acting on the discretionary authority of the Plan Administrator, may elect to have such Claim reviewed or audited for accuracy and reasonableness of charges as part of the adjudication process. This process may include, but may not be limited to, identifying: (a) charges for items/services that may not be covered or may not have been delivered, (b) duplicate charges and (c) charges beyond the reasonable, necessary and Usual and Customary guidelines as determined by the Plan. In addition, please refer to the section entitled "Claim

Review and Audit Program" for information regarding Plan provisions related to the audit and adjudication of certain eligible Claims under that Program.

PAYMENT OF CLAIMS

Plan benefits are payable to the Covered Employee, unless the Claimant gives written direction, at the time of filing proof of such loss, to pay directly the health care Provider rendering such services. Such payment to a health care Provider is subject to the approval of the Plan Administrator. If any such benefit remains unpaid at the death of the Covered Employee, if the Claimant is a minor, or if the Claimant is (in the opinion of the Plan Administrator) legally incapable of giving a valid receipt and discharge for any payment, the Plan Administrator may, at its option, pay such benefits to any one or more of the following relatives of the Claimant: wife, husband, mother, father, Child or Children, brother or brothers, sister or sisters. Such payment will constitute a complete discharge of the Plan's obligation to the extent of such payment, and the Plan Administrator will not be required to follow-up and determine how such paid money was used.

APPEAL PROCESS

The Plan provides for two (2) levels of appeal following an Adverse Benefit Determination. The Claimant has one hundred eighty (180) days following an initial Adverse Benefit Determination to file an appeal of that determination, and sixty (60) days following a second Adverse Benefit Determination to file an appeal of that determination. The appeal process will provide the Claimant with a reasonable opportunity for a full and fair review of the Claim and Adverse Benefit Determination and will include the following:

1. Receipt of written request by the Claims Administrator from the Claimant, or an Authorized Representative of the Claimant, with the proper form for review of Adverse Benefit Determination, which initiates the appeal process.

2. The Claimant will have the opportunity to submit written comments, documents, records, and other information relating to the Claim.

3. The Claimant will have the opportunity to review the Claim file and to present evidence and testimony as part of the internal Claims and appeals process.

4. The Claimant will be provided, free of charge and sufficiently in advance of the date that the notice of final internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Claimant to respond to such new evidence or rationale.

5. The Claimant will be provided, on request and free of charge: (a) reasonable access to, and copies of all documents, records, and other information relevant to the Claimant's Claim in possession of the Plan Administrator, the Designated Decision Maker (DDM) or the Claims Administrator; (b) information regarding any rule, guideline, protocol, or other similar criterion relied upon in making the Adverse Benefit Determination; (c) information regarding any voluntary appeals procedures offered by the Plan; (d) information regarding the Claimant's right to an external review process; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances.

6. The review of the Adverse Benefit Determination will take into account all comments, documents, records and other information submitted by the Claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination.

7. No deference will be afforded to the previous Adverse Benefit Determination.

8. The party reviewing the appeal may be neither the party who made the prior Adverse Benefit Determination, nor a subordinate of the party who made the prior Adverse Benefit Determination.

9. In deciding an appeal on which the Adverse Benefit Determination was based in whole or in part on a medical judgment, including whether a particular treatment, Drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the Claims Administrator, the DDM or the Plan Administrator, as appropriate depending on the level of appeal, will consult with a health care professional who has appropriate training and experience in the field of medicine involving the medical judgment. The health care professional consulted for the appeal will not be the health care professional or a subordinate of the health care professional consulted in connection with the Adverse Benefit Determination that is the subject of the appeal.

10. Medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination will be identified, even if the Plan did not rely upon their advice.

11. The first level of appeal will be the responsibility of the Claims Administrator and will be decided within thirty (30) days of the Claims Administrator's receipt of the request. The second level of appeal will be the responsibility of the DDM and will be decided within thirty (30) days of the Plan's receipt of the request.

For questions about appeal rights or for assistance, Claimants can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). Consumer assistance may be available in your State. Contact your State Department of Insurance to find out if consumer assistance for Claim appeals is available. See Appendix I for additional information.

FIRST APPEAL LEVEL

Requirements for First Appeal
The Claimant must file the first appeal, in writing, within one hundred eighty (180) days following receipt of the notice of an Adverse Benefit Determination. The Claimant's appeal must be addressed as follows:

Appeals Department
Group & Pension Administrators, Inc. (GPA)
Park Central 8
12770 Merit Drive, Suite 200
Dallas, Texas 75251

It shall be the responsibility of the Claimant to submit proof that the Claim is covered and payable under the provisions of the Plan. An appeal must include:

1. The name of the Employee/Claimant;
2. The Employee's/Claimant's Social Security number;
3. The group name or identification number;
4. All facts and theories supporting the Claim for benefits. **Failure to include any theories or facts in the appeal will result in such facts being inadmissible. In other words, the Claimant will lose the right to raise such factual arguments and theories which support this Claim if the Claimant fails to include them in the appeal;**
5. A statement in clear and concise terms of the reason or reasons for the disagreement with the handling of the Claim; and
6. Any material or information that the Claimant has which indicates that the Claimant is entitled to benefits under the Plan.

If the Claimant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on First Appeal
The Plan shall notify the Claimant of the Plan's Benefit Determination on review within a reasonable period of time, but not later than thirty (30) days after receipt of the appeal.

The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Notice of Benefit Determination on First Appeal
The Claimant will be notified of the Benefit Determination on appeal. If there is an Adverse Benefit Determination on appeal, the notification will include the following information:

1. The reason or reasons for the Adverse Benefit Determination;

2. References to the Plan provisions on which the Adverse Benefit Determination is based;

3. A description of any additional material or information necessary for the Claimant to perfect the Claim, and an explanation of why such material or information is necessary;

4. 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;

5. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action following an Adverse Benefit Determination on final review;

6. A description of voluntary appeal procedures offered by the Plan and, upon the Claimant's request, any additional information about the voluntary appeal procedures;

7. If an internal rule, guideline, protocol, or other similar criterion was relied on in making the Adverse Benefit Determination, either the specific rule, guideline, protocol or other similar criterion or a statement that such was relied on in making the Adverse Benefit Determination, and that a copy of the rule, guideline, protocol or other criterion will be provided free of charge on request;

8. If the Adverse Benefit Determination is based on a medical judgment (such as Medical Necessity or whether or not treatment is Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge on request;

9. The identity of any medical or vocational experts consulted in connection with the Claim, even if the Plan did not rely upon their advice; and

10. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State Insurance Regulatory Agency.

Furnishing Documents in the Event of an Adverse Determination
In the case of an Adverse Benefit Determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to Notice of Benefit Determination on First Appeal, as appropriate.

SECOND APPEAL LEVEL

Adverse Decision on First Appeal; Requirements for Second Appeal
Upon receipt of notice of the Plan's Adverse Benefit Determination regarding the first appeal, the Claimant has sixty (60) days to file a second appeal of the denial of benefits. The Claimant again is entitled to a "full and fair review" of any denial made at the first appeal, which means the Claimant has the same rights during the second appeal as he or she had during the first appeal. As with the first appeal, the Claimant's second appeal must be in writing and must include all of the items set forth in the section entitled "Requirements for First Appeal."

Timing of Notification of Benefit Determination on Second Appeal
The Plan shall notify the Claimant of the Plan's Benefit Determination on review within a reasonable period of time, but not later than thirty (30) days after receipt of the second appeal.

The period of time within which the Plan's determination is required to be made shall begin at the time the second appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Second Appeal
The same information must be included in the Plan's response to a second appeal as a first appeal, except for: (a) a description of any additional information necessary for the Claimant to perfect the Claim and an explanation of why such information is needed; and (b) a description of the Plan's review procedures and the time limits applicable to the procedures. See the section entitled "Notice of Benefit Determination on First Appeal."

Furnishing Documents in the Event of an Adverse Determination
In the case of an Adverse Benefit Determination on the second appeal, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to the Notice of Benefit Determination on First Appeal, as appropriate.

Decision on Second Appeal to be Final
If, for any reason, the Claimant does not receive a written response to the appeal within the appropriate time period set forth above, the Claimant may assume that the appeal has been denied. The decision will be final, binding and conclusive, and will be afforded the maximum deference permitted by law. **All Claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within three (3) years after the Plan's Claim review procedures have been exhausted. Any action with respect to a Fiduciary's Breach of any responsibility, duty or obligation hereunder must be brought within three (3) years after the date of service.**

Appointment of Authorized Representative
A Claimant is permitted to appoint an Authorized Representative to act on his behalf with respect to a benefit Claim or appeal of an Adverse Benefit Determination. An Assignment of Benefits by a Claimant to a Provider will not constitute appointment of that Provider as an Authorized Representative. To appoint such a representative, the Claimant must complete a form which can be obtained from the Plan Administrator or the Claims Administrator. In the event a Claimant designates an Authorized Representative, all future communications from the Plan will be with the Authorized Representative, rather than the Claimant, unless the Claimant directs the Plan Administrator, in writing, to the contrary.

PROVIDER OF SERVICE APPEAL RIGHTS

A Claimant may appoint the Provider of service as the Authorized Representative with full authority to act on his or her behalf in the appeal of a denied Claim. An Assignment of Benefits by a Claimant to a Provider of service will not constitute appointment of that Provider as an Authorized Representative. However, in an effort to ensure a full and fair review of the denied Claim, and as a courtesy to a Provider of service that is not an Authorized Representative, the Plan will consider an appeal received from the Provider in the same manner as a Claimant's appeal, and will respond to the Provider and the Claimant with the results of the review accordingly. Any such appeal from a Provider of service must be made within the time limits and under the conditions for filing an appeal specified under the section, "Appeal Process," above. **Providers requesting such appeal rights under the Plan must agree to pursue reimbursement for Covered Medical Expenses directly from the Plan, waiving any right to recover such expenses from the Claimant, and comply with the conditions of the section, "Requirements for First Appeal," above.**

For purposes of this section, the Provider's waiver to pursue Covered Medical Expenses does not include the following amounts, which will remain the responsibility of the Claimant:

- Deductibles;

- Copayments;
- Coinsurance;
- Penalties for failure to comply with the terms of the Plan;
- Charges for services and supplies which are not included for coverage under the Plan; and
- Amounts which are in excess of any stated Plan maximums or limits. **Note: This does not apply to amounts found to be in excess of Allowable Claim Limits, as defined in the section, "Claim Review and Audit Program."** The Provider must agree to waive the right to balance bill for these amounts.

Also, for purposes of this section, if a Provider indicates on a Form UB-04 or on a Form CMS-1500 (or similar Claim form) that the Provider has an Assignment of Benefits, then the Plan will require no further evidence that benefits are legally assigned to that Provider.

Contact the Claims Administrator or the Plan Administrator for additional information regarding Provider of service appeals.

EXTERNAL REVIEW OF ADVERSE BENEFIT DETERMINATIONS

When the internal appeals procedures have been exhausted, the Claimant may elect to have an additional and final opportunity for a review of an Adverse Benefit Determination (including a final internal Adverse Benefit Determination) by an independent review organization (IRO). The IRO will be accredited by URAC or a similar nationally recognized accrediting organization for the purpose of conducting an independent and unbiased review.

The request for an external review must be filed by the Claimant within four (4) months following the Claimant's receipt of the notice of Adverse Benefit Determination or final internal Adverse Benefit Determination. However, if the Plan fails to strictly adhere to all the requirements of the internal Claims and appeals process with respect to a Claim, the Claimant will be deemed to have exhausted the internal Claims and appeals process, and the Claimant may initiate an external review and pursue any available remedies under applicable law, such as judicial review.

The Plan's external review process applies to any eligible Adverse Benefit Determination or final internal Adverse Benefit Determination on appeal, except that a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Participant or beneficiary failed to meet the requirements for eligibility under the terms of the Plan is not eligible for the external review process.

There are two (2) types of external reviews; standard and expedited. An external review is a standard external review unless the timing required to perform a standard external review involves circumstances that would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the final internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency services but has not yet been discharged from the Facility. In such cases, the Plan will consider the external review to be an expedited review.

EXPEDITED EXTERNAL REVIEW FOR URGENT OR EMERGENCY CARE

This Plan does not require a Claimant to obtain prior approval for pre-service urgent care Claims or Emergency care services before getting treatment; therefore, neither the internal appeals nor the external review procedures will apply to these Claims. In an Emergency or urgent care situation, the Claimant should follow instructions from his/her health care Provider, and file the Claim as a post-service Claim. If the post-service Claim results in an Adverse Benefit Determination, the Claimant may file an appeal in accordance with the Plan's provisions for "Appeal Process," which are explained above.

Appeals of Claims involving concurrent care will be subject to the Plan's provisions for expedited external review, as explained below.

PROCEDURES FOR INITIATION OF AN EXTERNAL REVIEW

Standard External Review

A request for an external review must include the same information that is required for an internal appeal, listed above in the section, "Appeal Process."

Once the request for a standard external review is filed, the Plan will have five (5) business days to do a preliminary review of the request to determine whether it is eligible and whether all of the information and forms required to process the external review have been provided.

Within one (1) business day following completion of the preliminary review, the Plan will notify the Claimant in writing whether the request is eligible for external review.

- If the request is complete but is not eligible for external review, the notice will contain an explanation of the reason that the request is ineligible.

- If the request is incomplete, the notice will describe the information or materials needed to make the request complete. The Claimant must submit the information or materials needed within forty-eight (48) hours following receipt of the notice, or the expiration of the original four (4) month filing period, whichever is later.

An eligible request which is complete and timely filed will be assigned to an independent review organization (IRO) by the Plan. The Plan will have arrangements to access at least three (3) accredited IROs to which external reviews will be assigned on a random or rotated basis to ensure an independent and unbiased review.

The assigned IRO will notify the Claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the Claimant may submit to the IRO, in writing and within ten (10) business days following receipt of the notice, any additional information that the IRO must consider when conducting the external review.

Within five (5) business days after the date of assignment of the IRO, the Plan must provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or final internal Adverse Benefit Determination. Failure by the Plan to timely provide the documents and information will not delay the conduct of the external review, and the IRO may decide to reverse the Adverse Benefit Determination or final internal Adverse Benefit Determination. In this case, the IRO will notify the Plan and the Claimant within one (1) business day following the decision to reverse the determination.

The assigned IRO will forward any information which is submitted by the Claimant to the Plan, and the Plan may reconsider its Adverse Benefit Determination or final internal Adverse Benefit Determination; however, reconsideration by the Plan will not delay the external review. If the Plan decides to reverse its Adverse Benefit Determination or final internal Adverse Benefit Determination, it may terminate the external review and notify the IRO and the Claimant within one (1) business day of the decision.

The IRO will provide written notice to the Claimant and the Plan of the final external review decision within forty-five (45) days following receipt of the request for review. The notice will contain:

- A general description of the reason for the request for external review, including information sufficient to identify the Claim (including the date or dates of service, the health care Provider, the Claim amount (if applicable), and, upon request, the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial;

- The date the IRO received the request for external review and the date on which it made the decision;

- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and the evidence-based standards that were relied on in making the decision;
- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the Claimant;
- A statement that judicial review may be available to the Claimant; and
- Current contact information, including a phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793. See Appendix I for additional information.

Expedited External Review

A final internal Adverse Benefit Determination concerning an admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency services but has not yet been discharged from the Facility will be considered for an expedited external review. These are considered to be pre-service **non-urgent** care Claims and concurrent Claims.

The procedures that apply to standard external reviews will apply to expedited external reviews, except that:

- The preliminary review of the request to determine whether it is eligible and whether all of the information and forms required to process the external review have been provided must be conducted immediately, and the Plan must immediately notify the Claimant regarding the eligibility determination;
- Upon a determination that a request is eligible for external review following the preliminary review, the Plan will immediately assign an IRO pursuant to the requirements set forth for standard external reviews;
- The Plan must provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or final internal Adverse Benefit Determination to the assigned IRO electronically, by phone, facsimile or any other available expeditious method; and
- The IRO must provide notice of the final external review decision as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO received the request for an expedited external review. If the notice is not in writing, the assigned IRO must provide written confirmation of the decision to the Claimant and the Plan within forty-eight (48) hours following the notice.

DECISION FOLLOWING AN EXTERNAL REVIEW

Upon receipt of a notice from the IRO reversing the decision of an Adverse Benefit Determination or final internal Adverse Benefit Determination, the Plan will immediately provide coverage or payment for the Claim. An external review decision is binding on the Plan as well as the Claimant, except to the extent other remedies are available under State or Federal law.

RECOVERY OF PAYMENTS

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such, this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Covered Person or Dependent on whose behalf such payment was made.

A Covered Person, Dependent, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within thirty (30) days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Covered Person or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any Claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agree to be bound by the terms of this Plan and agree to submit Claims for reimbursement in strict accordance with their State's health care practice acts, ICD-10 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on Claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within thirty (30) days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Covered Person, Provider or other person or entity to enforce the provisions of this section, then that Covered Person, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Covered Persons and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Covered Persons) shall assign, or be deemed to have assigned, to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Covered Person(s) are entitled, for or in relation to Facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

1. In error;
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
3. Pursuant to a misstatement made to obtain coverage under this Plan within two (2) years after the date such coverage commences;
4. With respect to an ineligible person;
5. In anticipation of obtaining a recovery if a Covered Person fails to comply with the Plan's Subrogation and Reimbursement Provisions; or
6. Pursuant to a Claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or Disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any Claim for benefits under this Plan by a Covered Person or by any of his covered Dependents if such payment is made with respect to the Covered Person or any person covered or asserting coverage as a Dependent of the Covered Person.

If the Plan seeks to recoup funds from a Provider due to a Claim being made in error, a Claim being fraudulent on the part of the Provider, and/or the Claim is the result of the Provider's misstatement, said Provider shall, as part of its Assignment of Benefits from the Plan, abstain from billing the Covered Person for any outstanding amount(s).

GENERAL PROVISIONS

RIGHT OF RECOVERY
In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan in a total amount, at any time, in excess of the Maximum Amount of benefits payable under this Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such amount, and any future benefits payable to the Covered Person or his or her Dependents. See the Recovery of Payments provision for full details.

MISSTATEMENT OF AGE
If age is a factor in determining eligibility or amount of coverage and there has been a misstatement of age, the coverages or amounts of benefits, or both, for which the person is covered shall be adjusted in accordance with the Covered Person's true age. Any such misstatement of age shall neither continue coverage otherwise validly terminated, nor terminate coverage otherwise validly in force. Benefits will be adjusted following the date of the discovery of such misstatement.

WAIVER OR ESTOPPEL
No term, condition or provision of the Plan shall be waived, and there shall be no estoppel against the enforcement of any provision of the Plan, except by written direction of the Plan Administrator. No such waiver shall be deemed a continuing waiver unless specifically stated. Each waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than that specifically waived.

WORKERS' COMPENSATION NOT AFFECTED
This Plan is not in lieu of and does not affect any requirement for coverage by Workers' Compensation Insurance or, where permitted and applicable, any other alternative form of Workers' Compensation benefits.

CONFORMITY WITH LAW
This Plan shall be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay Claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Plan Document.

CONFORMITY WITH STATUTE(S)
Any provision of the Plan which is in conflict with statutes that are applicable to this Plan is hereby amended to conform to the minimum requirements of said statute(s).

NOTICES
All payments or notices of any kind to Employees, Participants, beneficiaries, or Plan officials may be mailed to the address for that person last appearing on the records of the Plan Administrator. When such a notice is mailed by first class mail, it is deemed to have been: (a) duly delivered on the date post-marked; and (b) duly received three (3) calendar days after being deposited, postage prepaid, in the United States Mail. When such a notice is delivered in person, it is deemed to have been received the same day as delivery. Each person must keep the Plan Administrator notified of his current address. If there is doubt about the accuracy of an address, the Plan may give notice, by registered mail, to any such person's last address,

that payments and other mail are being withheld pending receipt of a proper mailing address from that person.

STATEMENTS
All statements made by the Employer or by a Covered Person will, in the absence of fraud, be considered representations and not warranties, and no statements made for the purpose of obtaining benefits under this document will be used in any contest to avoid or reduce the benefits provided by the document unless contained in a written application for benefits and a copy of the instrument containing such representation is or has been furnished to the Covered Person.

Any Covered Person, who knowingly and with intent to defraud the Plan, files a statement of Claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any material fact, commits a fraudulent act. The Covered Person may be subject to prosecution by the United States Department of Labor. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both.

FRAUD
The following actions by a Covered Person or a Covered Person's knowledge of such actions being taken by another, constitute fraud and will result in immediate, indefinite and permanent termination of all coverage under this Plan for the entire Family unit of which the Covered Person is a member:

1. Attempting to submit a Claim for benefits (which includes attempting to fill a prescription) for a person who is not a Covered Person in the Plan;
2. Attempting to file a Claim for a Covered Person for services that were not rendered or Drugs or other items that were not provided;
3. Providing false or misleading information in connection with enrollment in the Plan; or
4. Providing any false or misleading information to the Plan.

MISCELLANEOUS
Section titles are for convenience of reference only and are not to be considered in interpreting this Plan.

No failure to enforce any provision of this Plan shall affect the right thereafter to enforce such provision, nor shall such failure affect its right to enforce any other provision of this Plan.

ALLOCATION AND APPORTIONMENT OF BENEFITS
The Plan reserves the right to allocate the Deductible amount to any Covered Charges and to apportion the benefits to the Covered Person and any assignees. Such allocation and apportionment shall be conclusive and shall be binding upon the Covered Person and all assignees.

FACILITY OF PAYMENT
If a Claimant is a minor or is physically or mentally incapable of giving a valid release for payment, the Claims Administrator, at its option, may make payment to a party who has assumed responsibility for the care of such person. Such payments will be made until Claim is made by a guardian. If a Claimant dies while benefits remain unpaid, benefits will be paid at the Claim Administrator's option to:

1. The person or institution on whose charges Claim is based; or
2. A surviving relative (wife, husband, mother, father, Child or Children, brother or brothers, sister or sisters).

Such payment will release the Plan Administrator and Claims Administrator of all further liability to the extent of payment.

ELIGIBILITY FOR COVERAGE

Coverage provided under this Plan for Employees and their Dependents shall be in accordance with the Eligibility, Effective Date, and Termination provisions as stated in this Plan Document as follows.

NOTE: A Covered Person previously terminated under this Plan due to fraud, or the actions being taker by another which constituted fraud, as addressed within the Fraud section of this Plan, will be immediately, indefinitely and permanently terminated from all coverage under this Plan and ineligible for future enrollment in this Plan.

EMPLOYEE ELIGIBILITY

An Employee will be considered eligible for coverage on the first day of the month following the Date of Hire provided he/she:

1. Is a Non-variable Hour Employee regularly scheduled to work for the Employer on a Full-time or Part-time Employment basis for at least thirty (30) hours per week; or
2. Is a Variable Hour Employee who averages at least thirty (30) hours per week or 1,560 hours per year for a complete Measurement Period and is currently in a Stability Period, as determined by the Plan Sponsor. An Employee will remain eligible throughout the Stability Period regardless of a change in employment status (including, but not limited to, a reduction in hours) provided the individual continues to be an employee in accordance with the Affordable Care Act (as amended).

MEASUREMENT PERIOD INFORMATION FOR VARIABLE HOUR AND ONGOING EMPLOYEES

Initial Administrative Period:	zero (0) days
Ongoing Administrative Period:	zero (0) days
Initial Measurement Period:	three (3) months
Initial Measurement Period starts on:	The first day of the month following the Date of Hire
Standard Measurement Period for Ongoing Employees:	twelve (12) months
Standard Measurement Period starts each year on:	January 1
Stability Period:	twelve (12) months

See the “Definitions” section for the definitions of “Administrative Period,” “Measurement Period” and “Stability Period.”

DEPENDENT ELIGIBILITY

A Dependent, **as defined in the Plan Definitions**, will be considered eligible for coverage on the date the Employee becomes eligible for Dependent coverage or the date the Dependent is acquired, subject to all limitations and requirements of this Plan, and in accordance with the following:

1. A newborn or adopted Child of a Covered Employee will be considered eligible and will be covered from the moment of birth or from the date of adoption or Placement for Adoption for **thirty (30) days** for Injury or Illness, including the Medically Necessary care and treatment of medically diagnosed congenital defects, birth abnormalities and prematurity, Routine Newborn Care and Well Baby Care. Written notification must be received by the Plan Administrator within thirty (30) days after the

Child's date of birth, date of adoption or Placement for Adoption for continued coverage. A newborn Child of a Dependent Child is not eligible for this Plan unless the newborn Child meets the definition of an Eligible Dependent.

2. A new spouse of a Covered Employee and any Dependent Children of a new spouse who meet the Plan's definition of Dependent will be considered eligible and will be covered on the date of the Covered Employee's marriage, provided the spouse and/or his/her Children are enrolled as Dependents of the Covered Employee within thirty (30) days after the date of marriage.

3. A Domestic Partner of a Covered Employee who meets the Plan's definition of a Dependent will be considered eligible for this Plan on the date the "Statement of Domestic Partnership" is executed.

4. A Child of a Covered Employee who meets the Plan's definition of a Dependent will be considered eligible if the Child is under twenty-six (26) years of age.

5. If a Dependent of a Covered Employee is to be enrolled in the Plan, other than at the time of his/her eligibility or birth, adoption, court order or marriage to the Covered Employee, that Dependent would be considered a Late Enrollee unless he/she qualifies for a Special Enrollment.

6. A spouse and/or Child of a Covered Employee who previously was not eligible for the Plan will be considered eligible on the date he/she meets the Plan's definition of Dependent.

The Eligibility provisions are subject to the requirements of the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993), effective August 10, 1993, as the same may be later amended.

If an Employee or Dependent has a change in eligibility while covered under this Plan (i.e., from Employee to Dependent, from Dependent to Employee) and no interruption in coverage has occurred, the Plan will consider that coverage has been continuous.

A person cannot be covered as a Dependent of more than one (1) Employee under this Plan. In addition, an Employee cannot be covered as both an Employee and a Dependent under this Plan.

NOTE: A Dependent who was enrolled on the most recent restated date of this Plan, January 1, 2020, and who was previously covered by the Plan, will also be considered eligible to continue coverage under this Plan. However, a Dependent Child will only be considered eligible until the qualifying age of twenty-six (26) unless otherwise specified in the definition of Dependent.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS / PLACEMENT FOR ADOPTION

The Plan will comply with the rules relating to adopted Children, Children placed for adoption, Qualified Medical Child Support Orders ("QMCSO"), and National Medical Support Notices (“NMSN”). The Plan will use the following rules related to Children placed for adoption, QMCSOs and NMSNs.

This Plan will provide benefits in accordance with the applicable requirements of any QMCSO or NMSN. A QMCSO is a Medical Child Support Order of a court or of certain administrative agencies that creates, recognizes or assigns to a Child of a Plan Participant the right to receive health benefit coverage under the Plan. A NMSN is an order issued by a State agency requiring the Plan to cover a Child. To be qualified, a Medical Child Support Order must comply with State and Federal laws and contain the following:

1. The name and last known mailing address (if any) of both the Plan Participant and the Child covered under the order except that, to the extent provided in the order, the name and mailing address of an official of a State or a political subdivision thereof may be substituted for the mailing address of any such Alternate Recipient.

2. A reasonable description of the type of coverage to be provided by the Plan for each Child (or the manner in which the type of coverage will be determined).

3. The period of coverage to which the order applies.

In addition, a QMCSO or NMSN will generally not be considered qualified if it requires the Plan to provide certain benefits or options which are not otherwise provided by the Plan. The Plan Administrator will notify the Plan Participant of the receipt of a Medical Child Support Order and the procedures for determining whether it is a Qualified Medical Child Support Order or a NMSN. The Plan Administrator will then determine within a reasonable period of time whether the Medical Child Support Order is a QMCSO or NMSN.

Plan Participants may request and receive, free of charge, a copy of Plan procedures relating to QMCSOs and NMSNs.

If an Employee is not enrolled in the Plan, and the Employee would otherwise be eligible for coverage, the Plan must enroll the Eligible Employee and the Child(ren) covered by the QMCSO.

This Plan will also provide benefits to Dependent Children placed for adoption on the same basis as natural Children even prior to the adoption becoming final. A Child will be considered "Placed for Adoption" with a Plan Participant if the Plan Participant has assumed a legal obligation for total or partial support of the Child in anticipation of adoption of the Child. For this reason, if a Child is placed with a Plan Participant for adoption by an adoption agency or other entity, the Plan Participant must provide to the Plan Administrator documentation (e.g., signed court order) that the adoption agency or other entity had legal custody of the Child on the date that the Child was placed with the Plan Participant for adoption. The Plan Administrator will determine within a reasonable period of time whether a Child has been "Placed for Adoption."

The Plan Administrator has final, discretionary authority to determine: (1) whether a Medical Child Support Order qualifies as a QMCSO or NMSN; and (2) whether a Child has been "Placed for Adoption.”

EFFECTIVE DATE OF COVERAGE

EMPLOYEE EFFECTIVE DATE

An Eligible Employee, properly enrolled in the Plan, will be referred to as a "Covered Employee."

Each Employee's coverage under the Plan shall become effective on the first day of the month following the Date of Hire provided the Employee completes the eligibility requirement(s) of the Plan and written or electronic application for coverage is made on or before or within thirty (30) days after the date the Employee eligibility requirement(s) are met.

DEPENDENT EFFECTIVE DATE

Dependent coverage under the Plan shall become effective on the date Dependent eligibility requirements are met, provided the Employee makes written or electronic application for Dependent coverage on or before or within thirty (30) days after the date Dependent eligibility requirements are met subject to the enrollment requirements as follows:

1. In order to become covered under the Plan, Eligible Dependents must be identified on an Enrollment and/or Change form.

2. If the Employee makes a request for Dependent coverage on or before or within thirty (30) days immediately following his/her own effective date, then each Eligible Dependent will become effective on the same date the Employee's coverage is effective.

3. If an Employee makes a request to add a Dependent Child to the Plan in accordance with a Qualified Medical Child Support Order (QMCSO), the effective date of coverage for the Dependent Child will be the date specified in the QMCSO. Child(ren) covered by QMCSOs may be enrolled in this Plan if the Employee would otherwise be eligible for coverage regardless of whether the Employee is currently enrolled. The Plan must enroll the Eligible Employee and the Child(ren) covered by the Notice without any enrollment restrictions (i.e., they will not be considered Late Enrollees).

4. If the Covered Employee makes a request to add a Dependent spouse and/or Child who previously was not eligible for the Plan within thirty (30) days of such Dependent becoming entitled to Special Enrollment rights, the effective date of coverage is the date the individual meets the Plan's definition of Dependent.

LATE ENROLLEE

An Employee or Dependent who enrolls in the Plan more than thirty (30) days after the date of his/her initial eligibility is considered a Late Enrollee unless he/she qualifies for a Special Enrollment.

EMPLOYEE AND DEPENDENT SPECIAL ENROLLMENT PERIODS

The Plan provides Special Enrollment rights and Special Enrollment Periods for Employees and their Dependents who previously declined to enroll in the Plan and who remain eligible for the Plan.

SPECIAL ENROLLMENT PERIOD FOR LOSS OF ELIGIBILITY FOR OTHER COVERAGE

Eligible Employees and Eligible Dependents who do not enroll in the Plan at their initial opportunity because of other health coverage and subsequently lose eligibility for that other coverage (except for cause or nonpayment of premium) have Special Enrollment rights. Special Enrollment in this Plan must be requested within thirty (30) days after the date eligibility for other coverage ends. If an individual enrolls during a Special Enrollment Period, he/she is considered a Special Enrollee; he/she will not be considered a Late Enrollee.

Individuals who previously declined coverage in the Plan because of other coverage may be eligible to enroll in the Plan during the Special Enrollment Period if eligibility for other coverage is lost as a result of one of the following:

1. Legal separation, divorce, death, termination of employment or reduction in the number of hours worked;
2. Loss of Dependent status;
3. The plan no longer offers any benefits to a class of similarly situated individuals;
4. Moving out of an HMO service area with no other coverage option available;
5. Termination of a benefit package option, unless a substitute is offered;
6. Employer contributions were terminated; or
7. COBRA Continuation Coverage was exhausted.

Loss of coverage due to an individual's failure to pay premiums or contributions does not qualify for a Special Enrollment Period. Voluntarily dropping coverage does not trigger Special Enrollment rights because there is no loss of eligibility.

Length of Special Enrollment Period for Loss of Eligibility for Other Coverage
A request for a Special Enrollment due to loss of eligibility for other coverage must be made no later than thirty (30) days after the exhaustion of COBRA coverage or the termination of other non-COBRA coverage as a result of the loss of eligibility or termination of Employer contributions toward that coverage.

Effective Date of Coverage Following Special Enrollment for Loss of Eligibility for Other Coverage
The effective date of coverage for an Eligible Employee and his/her Eligible Dependents who make written or electronic application for coverage during a Special Enrollment Period will be the day following the date of loss of other coverage.

SPECIAL ENROLLMENT PERIOD FOR NEW DEPENDENT

1. An Employee who previously declined enrollment and who remains eligible for coverage under the Plan has Special Enrollment rights when the Eligible Employee acquires a new Dependent through marriage, birth, adoption or Placement for Adoption.

2. A new spouse is entitled to Special Enrollment rights when he/she becomes the spouse of a Covered Employee or when a Child becomes a Dependent of a Covered Employee through birth, adoption or Placement for Adoption.

3. A person is entitled to Special Enrollment rights when the person becomes a Dependent of a Covered Employee through marriage, birth, adoption or Placement for Adoption.

4. An Employee who previously declined enrollment and remains eligible for coverage under the Plan has Special Enrollment rights for himself/herself and the Employee's spouse if a Child becomes a Dependent of the Employee through birth, adoption or Placement for Adoption.

Length of Special Enrollment Period for New Dependents
A request for a Special Enrollment due to acquiring new Dependents must be made no later than thirty (30) days after the date of marriage, birth, adoption or Placement for Adoption.

Effective Date of Coverage Following New Dependent Special Enrollment
The effective date of coverage for an Eligible Employee and his/her Eligible Dependents who make written or electronic application for coverage during a New Dependent Special Enrollment Period will be as follows:

1. In the case of marriage: the date of marriage;

2. In the case of a Dependent's birth: the date of birth; or

3. In the case of a Dependent's adoption or Placement for Adoption: the date of such adoption or Placement for Adoption.

NOTE: Proof of Qualifying Event for Special Enrollment will be required.

SPECIAL ENROLLMENT PERIOD UNDER THE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009 (CHIPRA)

Eligible Employees and Eligible Dependents who do not enroll in the Plan at their initial opportunity because of the Eligible Employee's and/or Eligible Dependent's coverage under Medicaid or a State Children's Health Insurance Program (CHIP) and subsequently lose eligibility for Medicaid or CHIP coverage have Special Enrollment rights. Special Enrollment in this Plan must be requested within sixty (60) days after the date eligibility for Medicaid or CHIP ends. If an individual enrolls during a Special Enrollment Period, he/she is considered a Special Enrollee; he/she will not be considered a Late Enrollee.

Eligible Employees and Eligible Dependents who do not enroll in the Plan at their initial opportunity but become eligible for a premium assistance subsidy under Medicaid or CHIP have Special Enrollment rights. Special Enrollment in this Plan must be requested within sixty (60) days after the date eligibility for Medicaid or CHIP premium assistance is determined. If an individual enrolls during a Special Enrollment Period, he/she is considered a Special Enrollee; he/she will not be considered a Late Enrollee.

ANNUAL OPEN ENROLLMENT PERIOD FOR THE EMPLOYEE MEDICAL BENEFIT PLAN

The Annual Open Enrollment Period for the Plan is a period of time designated by the Employer each year for coverage to become effective January 1, provided written or electronic application for coverage is made before the end of the Annual Open Enrollment Period or within thirty (30) days after the Annual Open Enrollment Period. All Eligible Employees and Dependents not currently enrolled in the Plan may do so during the Annual Open Enrollment Period. All Covered Employees are required to re-enroll in the Plan. If application to enroll is made more than thirty (30) days after the Annual Open Enrollment Period ends, the Employee and/or Dependent must wait until the Plan's next Open Enrollment Period to enroll.

The Plan allows a choice of Plan Options: High Deductible Health Plan and Traditional Plan. An Eligible Employee can elect one (1) Plan Option for himself/herself and the same option for his/her Eligible Dependents.

LATE ENROLLEE

A Late Enrollee is an Employee or Dependent who gave up his/her initial opportunity to enroll in the Plan. A Late Enrollee can only enroll once a year during the Annual Open Enrollment Period for the Plan unless he/she qualifies for a Special Enrollment.

EMPLOYEE LATE ENROLLEE

An Employee is considered a Late Enrollee if:

1. He/she makes written or electronic application for coverage under the Plan more than thirty (30) days after the date of his/her initial eligibility;
2. He/she is not eligible for a Special Enrollment; or
3. He/she failed to enroll by the end of a Special Enrollment Period.

Effective Date of Coverage for Employee Late Enrollees
The effective date of coverage for an Employee who is a Late Enrollee will be the effective date of the Annual Open Enrollment for the Plan.

DEPENDENT LATE ENROLLEE

A Dependent is considered a Late Enrollee if:

1. The Covered Employee makes written or electronic application for Dependent coverage after the thirty (30) day period immediately following his/her effective date of coverage and the Dependent was not enrolled by the end of a Special Enrollment Period;

2. The Covered Employee makes a written or electronic request to add a Dependent after the thirty (30) day period immediately following the date of birth, date of marriage, date of adoption or date of Placement for Adoption; or

3. An Eligible Employee (not currently enrolled in the Plan) makes a written or electronic request to add a new Dependent more than thirty (30) days after the Dependent's date of birth, date of marriage, date of adoption or date of Placement for Adoption.

Effective Date of Coverage for Dependent Late Enrollees
The effective date of coverage for each Dependent who is a Late Enrollee will be the effective date of the Annual Open Enrollment for the Plan.

The Eligibility and Effective Date provisions are subject to the requirements of the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as they may be amended.

COVERAGE CHANGES

A request for coverage change (addition or deletion of coverage) can be made as follows:

1. A written request for deletion of coverage can be made by signing and completing a Change Form. Deletion of coverage is subject to the Plan's Termination provisions; or
2. A written request for addition of coverage can be made by signing and completing an Enrollment or Change Form. The Effective Date of Coverage is subject to the Plan's Annual Open Enrollment, Eligibility, Effective Date, Special Enrollment Period and Late Enrollee provisions.

PLAN OPTION CHANGES

The Plan allows a choice of Plan Options. Plan Option changes can only be made once a year during the Annual Open Enrollment Period for the Plan unless there is a Special Enrollment. See section entitled Employee and Dependent Special Enrollment Periods.

TERMINATION OF COVERAGE

EMPLOYEE COVERAGE TERMINATION

An Employee's coverage shall automatically terminate at midnight on the earliest of the following dates:

1. The date employment terminates;
2. The date the Employee ceases to be eligible or ceases to be in a class of Employees eligible for coverage;
3. The end of the Stability Period for Employees failing to qualify during the previous Standard Measurement Period;
4. The date the Employee fails to make any required contribution for coverage;
5. The date the Plan is terminated; or with respect to any Employee's benefit of the Plan, the date of termination of such benefit;
6. The date the Employee enters the Uniformed Services of the United States or armed forces of any country or international organization on a full-time active duty basis if active duty is to exceed thirty-one (31) days;
7. The date the Employee requests termination of coverage, unless prohibited by law (i.e., when election changes cannot be made due to Internal Revenue Code Section 125 "change in status" guidelines)." NOTE: The Employer may offer these benefits in conjunction with a cafeteria plan under Section 125 of the Internal Revenue Code and, if so, a voluntary termination must comply with the requirements of the Code and the cafeteria plan;
8. The date the Employee fails to return to Full-time Employment following an approved Leave of Absence. See Coverage During Leave of Absence section;
9. The date the Employee takes an unapproved Leave of Absence from work; or
10. The date the Employee dies.

DEPENDENT COVERAGE TERMINATION

The Dependent coverage of an Employee shall automatically terminate at midnight on the earliest of the following dates:

1. The date the Dependent (other than a Dependent Child age twenty-six (26) or older) ceases to be an Eligible Dependent as defined in the Plan;
2. The date of termination of the Employee's coverage under the Plan;
3. The date the Employee ceases to be in a class of Employees eligible for Dependent coverage;
4. The date the Employee fails to make any required contribution for Dependent coverage;
5. The date the Plan is terminated; or with respect to any Dependent's benefit of the Plan, the date of termination of such benefit;
6. The date the Employee or Dependent enters the Uniformed Services of the United States or armed forces of any country or international organization on a full-time active duty basis if active duty is to exceed thirty-one (31) days;
7. The date the Employee requests termination of Dependent coverage, unless prohibited by law (i.e., when election changes cannot be made due to Internal Revenue Code Section 125 "change in status" guidelines)." NOTE: The Employer may offer these benefits in conjunction with a cafeteria plan under Section 125 of the Internal Revenue Code and, if so, a voluntary termination must comply with the requirements of the Code and the cafeteria plan;
8. The date the Employee fails to return to Full-time Employment following an approved Leave of Absence. See Coverage During Leave of Absence section;
9. The date the Employee takes an unapproved Leave of Absence from work;
10. The last day of the month in which the Dependent Child reaches age twenty-six (26);
11. The date the unmarried adult Dependent Child age twenty-six (26) or older for whom coverage is being continued due to the Child being Physically Handicapped or Intellectually Disabled and incapable of earning his/her own living, upon the earliest to occur of: a. cessation of such inability; b. failure to furnish any required proof of the uninterrupted continuance of such inability or to submit to any required examination; c. the Child no longer being dependent on the Employee for his/her support; or d. the

Child's marriage. However, if such earliest event occurs before the last day of the month in which such Dependent Child reaches age twenty-six (26), then coverage will terminate on the last day of the month in which such Dependent Child reaches age twenty-six (26); or

12. The date the Employee dies.

Coverage may be continued under COBRA, but continuation of coverage is not automatic upon the occurrence of a Qualifying Event. A Covered Employee or a covered Dependent is responsible for notifying the Plan Administrator within sixty (60) days after the date of certain Qualifying Events (including loss of coverage due to divorce, legal separation, or a Dependent Child ceasing to qualify as a Dependent). A change form may be obtained from the Employer. Failure to provide such notice will result in loss of eligibility to elect COBRA coverage. See Continuation of Group Health Coverage (COBRA) section for further information.

A Domestic Partner does not qualify as a spouse under Federal law. Although the Plan will treat a Domestic Partner as a "Qualified Beneficiary," this treatment does not qualify a Domestic Partner as a "Qualified Beneficiary" under IRS 1999 final regulations.

NOTE: The Termination provisions are subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA), Public Law 99-272.

COVERAGE DURING LEAVE OF ABSENCE

If, after depletion of sick leave, vacation time or Paid Time Off (PTO), whichever is appropriate (if any) active work ceases due to an Employer approved non-medical temporary Leave of Absence, lay-off, an Employer approved Medical and Disability Leave, an approved Leave of Absence subject to the Family and Medical Leave Act (FMLA), an approved leave as a reasonable accommodation under the Americans with Disabilities Act (ADA) or approved leave required by applicable State law (Family, Medical, Disability and/or other temporary leave), the Plan Administrator may, while the Plan is in force, continue the Employee's coverage (Employee and Dependent) during the period after cessation of active work due to:

1. Employer approved non-medical temporary personal Leave of Absence, or lay-off but not to exceed a period of one (1) year provided any required Employee contributions are made; or

2. Employer approved Medical and Disability Leave of Absence, but not to exceed a period of one (1) year provided any required Employee contributions are made; or

3. Approved Family and Medical Leave (FMLA), but not to exceed a period of twelve (12) weeks (or twenty-six (26) weeks in the case of a Family service member medical leave) provided any required Employee contributions are made; or

4. Approved leave as a reasonable accommodation under the Americans with Disabilities Act (ADA), as amended, for the timeframe approved by the Employer when leave is the only available accommodation; or

5. Approved leave required by applicable State law (Family, Medical, Disability and/or other temporary leave) for up to the minimum amount of time required by such State law provided any required Employee contributions are made.

The above Employer approved non-medical Leave of Absence and Employer approved Medical and Disability Leave are not concurrent with, and are not in addition to, the twelve (12) week (or twenty-six (26) weeks in the case of a Family service member medical leave) approved Family and Medical Leave (FMLA), an approved leave as a reasonable accommodation under the Americans with Disabilities Act (ADA) or the minimum amount of time required by an approved leave required by applicable State law (Family, Medical, Disability and/or other temporary leave).

NOTE: If applicable State law requires a longer Leave of Absence than FMLA or any other approved Leave of Absence, then State law will prevail.

If the Employee has not returned to Employment that meets the eligibility requirements after completion of an approved Leave of Absence, or if the Employee notifies the Employer that he/she will not be returning to Employment that meets the eligibility requirements following the Leave of Absence, coverage terminates and COBRA continuation becomes available on the basis of reduction in hours. See Continuation of Group Health Coverage (COBRA) section. Failure of the Employee to make any required Employee contributions during an approved Leave of Absence will also result in termination of coverage.

Family and Medical Leave is subject to the requirements of the Family and Medical Leave Act (FMLA).

ACTIVE DUTY IN THE ARMED FORCES

If a Covered Employee and/or his/her covered Dependent(s) would lose Plan coverage as a result of the Employee being called for active duty in the armed forces of the United States, such a reduction in hours (or termination of employment) would be a COBRA Qualifying Event. Any coverage mandated under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended by the Veterans Benefits Improvement Act of 2004, will run concurrently with federally mandated COBRA coverage. For additional information, see the sections entitled Continuation of Group Health Coverage (COBRA) and Continuation of Coverage under USERRA.

REHIRES / REINSTATEMENT OF COVERAGE

A terminated Employee who is rehired will be treated as a new hire and will be required to satisfy all Eligibility and enrollment requirements of the Plan only if the Employee was not credited with an Hour of Service with the Employer (or any member of the controlled or affiliated group) for a period of at least thirteen (13) consecutive weeks immediately preceding the date of rehire or, if less, a period of consecutive weeks that exceeds the greater of (a) four (4) weeks, or (b) the number of weeks of the Employee's immediately preceding Period of Employment.

If a terminated Employee is rehired by the Employer within a thirteen (13) week period immediately following the date of such termination, the Employee shall become eligible for reinstatement of coverage on the first day of the month following the date the Employee resumes employment, and the Employee's Dependents shall also become eligible for reinstatement on that date. However, re-enrollment is not automatic and the Employee must enroll or waive enrollment within thirty (30) days of the rehire employment date.

An Employee who is terminated and rehired will be treated as an Ongoing Employee upon rehire only if the Employee's break in service did not exceed thirteen (13) weeks.

For an approved Leave of Absence, an Employee will remain eligible for coverage under the Plan as long as the Employee is otherwise eligible (and enrolled) under the Plan. Note that for an approved Leave of Absence, an Employee will be treated as an Ongoing Employee, even if the Employee's absence was longer than thirteen (13) weeks.

NOTE: An exception applies for a terminated Employee on COBRA who is rehired and returns to work after expiration of the above reinstatement period. Coverage will be continuous from the date he/she resumes employment.

An Employee whose coverage would terminate due to active duty in the Uniformed Services of the United States, and who qualifies for military leave under the Uniformed Services Employment and Reemployment Rights Act (USERRA), will be reinstated on the date he/she resumes employment with the Employer provided that such resumption of employment is within the time period specified in USERRA.

The reinstatement procedures following a USERRA military leave are subject to the requirements of USERRA.

FAMILY AND MEDICAL LEAVE (FMLA)

All Employers employing at least fifty (50) workers within a seventy-five (75) mile radius of the work place must provide eligible Employees with up to twelve (12) weeks or twenty-six (26) weeks, in the case of #5 below, of job-protected Leave of Absence during a twelve (12) month period, as determined by the Employer, generally for any of the following situations:

1. The birth or adoption of a Child;

2. The serious Illness of the Employee's spouse, Child, or parent;

3. The Employee's own disabling serious Illness;

4. The qualifying exigency (as defined by the Secretary of Labor) of the Employee's spouse, Child or parent service member who is on active duty or has been notified of an impending call or order to active duty; or

5. The serious Illness or Injury of the Employee's spouse, Child, parent or next of kin service member whose Illness or Injury was incurred in the line of duty that may render the member unfit to perform the duties of the service member's office, grade, rank or rating.

ELIGIBLE EMPLOYEES: Employees who have been employed by the Employer for at least twelve (12) months and who have worked at least 1,250 hours for the Employer during the previous twelve (12) months are eligible for Family and Medical Leave.

BENEFIT REQUIREMENT: The Employer must provide the same group health plan during the leave under the same level of contribution required during active employment.

RETURN TO EMPLOYMENT: Although the leave is unpaid, the Employee must be guaranteed return to the same or equivalent position with equivalent Employee benefits, pay, and other terms of employment. (Note: An Employer may deny job restoration under the leave law to Employees who are in the highest paid 10% of Employees.)

Employee benefits may include:

- group life
- educational benefits
- sick leave
- medical
- annual leave
- disability
- dental
- pensions

If an Employee chooses not to retain Plan coverage during Family and Medical Leave, Plan coverage may be restored upon return to active service as an Eligible Employee. Employees must be treated as though no service interruption had occurred. Any period of coverage provided for disability may run concurrently with Family and Medical Leave.

The above listing of Employee benefits may or may not be applicable to every Employer's plan of benefits. This section is intended as a summary of the Family and Medical Leave Act of 1993 (FMLA), effective August 5, 1993, as amended, not as a complete interpretation of the law.

NOTE: An Eligible Employee must refer to the Employer's policy for complete information.

CONTINUATION OF GROUP HEALTH COVERAGE (COBRA)

CONTINUATION OF COVERAGE
(Applies to Medical, Prescription Drug and Dental Coverage)

When Plan coverage terminates due to a Qualifying Event, a Covered Employee or covered Dependent is a Qualified Beneficiary and eligible to elect continued group health coverage ("COBRA coverage"). COBRA coverage is the same health coverage that applies to Covered Employees and covered Dependents under the Plan. However, the individual electing COBRA coverage must pay the full cost of the coverage plus an administrative fee of 2%.

The length of time COBRA coverage can be continued is based upon the date of and the applicable Qualifying Event as described below:

Qualified Beneficiary	Qualifying Event	Maximum Coverage Period
Covered Employee and/or Covered Dependent	Loss of coverage due to termination of employment (other than for gross misconduct) or reduction in hours	18 months
Disabled Covered Employee and/or Disabled Covered Dependent and each Qualified Beneficiary who is not disabled*	Loss of coverage due to termination of employment (other than for gross misconduct) or reduction in hours	29 months*
Covered Dependent	Loss of coverage due to divorce, legal separation or death of Employee	36 months
Covered Dependent	Loss of coverage due to Dependent Child losing eligibility as a Dependent Child	36 months
Covered Dependent	Loss of coverage due to Covered Employee's entitlement to Medicare (See Special Medicare Entitlement Rule section.)	36 months

NOTE: “Qualified Beneficiary” is a term defined under IRS 1999 final regulations to mean a Covered Employee, the spouse of a Covered Employee, or the Dependent Child of a Covered Employee. Continuation coverage for Domestic Partners and their Dependents is offered voluntarily by the Employer and is not required by or subject to COBRA. As this is COBRA-equivalent coverage, a Domestic Partner will be treated as a Qualified Beneficiary to the same extent as if the Domestic Partner were the Employee's spouse and will have independent election rights, including in the event of the Covered Employee’s death. In addition, the Dependent Children of a covered Domestic Partner will be treated as “Qualified Beneficiaries” for these purposes to the same extent that Dependents of a spouse would be so treated and will have independent election rights, including in the event of the Covered Employee’s death. Although the Plan will treat a Domestic Partner as a “Qualified Beneficiary,” this treatment does not qualify a Domestic Partner as a “Qualified Beneficiary” under IRS 1999 final regulations.

QUALIFIED BENEFICIARY

A Qualified Beneficiary also includes a Child born to or placed for adoption with a former Covered Employee/Qualified Beneficiary during the period of COBRA coverage. Newborns and adopted Children of former Covered Employees/Qualified Beneficiaries have independent COBRA rights and can remain on the Plan even if the former Covered Employee/Qualified Beneficiary drops coverage.

***SOCIAL SECURITY DISABILITY**

If a Covered Employee or a covered Dependent is determined to be disabled, as defined in the Social Security Act, on the date of the termination of employment or reduction in hours, or at any time during the first sixty (60) days of COBRA Continuation Coverage, the disabled person may be entitled to continue COBRA coverage for up to twenty-nine (29) months from the date of termination of employment or reduction in hours, provided the Social Security Administration determines, during the initial eighteen (18) month coverage period, that the individual is disabled. To qualify for the eleven (11) month extension of the maximum coverage period, the disabled person must provide the Plan Administrator with a copy of the Social Security Administration determination letter within sixty (60) days of receipt of same, and not later than the expiration of the original eighteen (18) month initial coverage period.

The cost of COBRA coverage for an individual entitled to extended coverage due to Social Security Disability for the period after the end of the eighteen (18) month COBRA coverage period will increase to 150% of the full cost for active participants.

SECONDARY QUALIFYING EVENTS

If COBRA coverage is elected by a covered Dependent based on the Covered Employee's loss of coverage due to termination of employment or reduction in hours and a second Qualifying Event (divorce, legal separation, death or a Dependent Child losing eligibility as a Dependent Child) occurs during the eighteen (18) month COBRA coverage period, the covered Dependent's maximum COBRA coverage period will begin on the date of the first Qualifying Event and continue for a thirty-six (36) month period. For example: If a Covered Employee terminates employment on December 31, 2016, the Employee's covered Dependent elects COBRA coverage, and the former Employee dies before July 1, 2018 (that is prior to the end of the original eighteen (18) month COBRA coverage period), the maximum COBRA coverage period for the Dependent who elected COBRA coverage is extended until December 31, 2019.

SPECIAL MEDICARE ENTITLEMENT RULE

Entitlement to Medicare is not considered a traditional secondary Qualifying Event for a covered Dependent; however, Medicare entitlement does provide potentially longer periods of continuation coverage to certain Qualified Beneficiaries based on the sequence of events. If a Covered Employee becomes entitled to Medicare, but the Employee is still a full-time active Employee, this event is not a COBRA Qualifying Event since Medicare entitlement alone does not cause a loss of coverage. If the Covered Employee voluntarily terminates employment after the Medicare entitlement date, the loss of coverage triggers a potential eighteen (18) month COBRA continuation period for all Qualified Beneficiaries. While the Covered Employee is only entitled to eighteen (18) months of COBRA Continuation Coverage, the other Qualified Beneficiaries (spouse and/or Dependent Children) are entitled to eighteen (18) months or thirty-six (36) months, measured from the date of the Employee's Medicare entitlement, whichever is greater.

EMPLOYEE RESPONSIBILITIES

COBRA coverage <u>is not automatic</u> upon the occurrence of a Qualifying Event. COBRA coverage must be elected as described below. In addition, a Covered Employee or a covered Dependent is responsible for notifying the Plan Administrator within sixty (60) days after the date of the Qualifying Event if the Qualifying Event is the loss of coverage due to divorce, legal separation, or a Dependent Child losing eligibility as a Dependent Child. A change form may be obtained from the Employer. Failure to provide such notice will result in loss of eligibility to elect COBRA coverage.

A Qualified Beneficiary must elect COBRA coverage no later than sixty (60) days after the date the eligible individual is sent an election form describing his/her right to elect continuation coverage (COBRA Election Period). If a Qualified Beneficiary elects coverage during the sixty (60) day COBRA Election Period, coverage is continuous from the time coverage would otherwise have been lost. A properly completed

election form must be returned to the Plan Administrator, signed and dated, by the end of the COBRA Election Period.

If premium payment is not sent with the election form, initial premium payment for COBRA coverage must be received no later than forty-five (45) days after the date COBRA coverage was elected. Initial payment must cover the retroactive monthly coverage period beginning with the date of loss of coverage. **Coverage will not become effective until initial premium payment is received.**

Coverage will remain in effect if subsequent premiums are paid no later than thirty (30) days after the due dates of such payments. **Failure to pay premiums within the time periods specified will result in termination of COBRA coverage. Once continuation is terminated, the coverage cannot be reinstated.** If timely payments of the premium are made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid is deemed to satisfy the Plan's requirement for the amount that must be paid for continuation coverage, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time (30 days) for payment of the deficiency to be made. For purposes of this section an amount not significantly less than the amount the Plan requires to be paid shall be defined as not more than the lesser of $50 or 10% of the required payment amount.

TERMINATION OF COBRA CONTINUATION COVERAGE

COBRA coverage, for a Qualified Beneficiary who elects such coverage, will terminate prior to the completion of the eighteen (18) month, twenty-nine (29) month, or thirty-six (36) month period previously described upon one of the following occurrences:

1. The Qualified Beneficiary becomes covered by another group health plan **after** the date of COBRA election;
2. Required contributions are not paid by or on behalf of the Qualified Beneficiary in a timely manner;
3. The Qualified Beneficiary becomes entitled to benefits under Medicare **after** the date of COBRA election;
4. The Qualified Beneficiary makes a request, in writing, to terminate coverage; or
5. The Plan Sponsor ceases to provide any group health plan to any similarly situated Employee.

NEW DEPENDENTS

If during the eighteen (18) months, twenty-nine (29) months or thirty-six (36) months, if applicable, of COBRA coverage, a Qualified Beneficiary acquires new Dependents (such as through marriage), the new Dependent(s) may be added to the coverage according to the provisions of the Plan. However, the new Dependents do not gain the status of a Qualified Beneficiary and will lose coverage if the Qualified Beneficiary who added them to the Plan loses coverage.

An exception to this is a Child who is born to, or a Child who is placed for adoption with, the Covered Employee Qualified Beneficiary. If the newborn or adopted Child is added to the Covered Employee's COBRA Continuation Coverage, then, unlike a new spouse, the newborn or adopted Child will gain the rights of all other Qualified Beneficiaries. The addition of a newborn or adopted Child does not extend the eighteen (18) or twenty-nine (29) month coverage period. Plan procedures for adding new Dependents can be found in the Eligibility and Effective Date sections of this Plan. Premium rates will be adjusted at that time to the applicable rate.

OPEN ENROLLMENTS

Should an Open Enrollment Period occur during the COBRA continuation period, the Plan Administrator will notify the COBRA Participant of that right as well. If an Open Enrollment Period occurs, the Qualified Beneficiary will have the same rights to select the coverage and any of the options or plans that are available for similarly situated non-COBRA Participants.

TIMING OF THE ELECTION NOTICE

If a Qualifying Event is the Covered Employee's loss of coverage due to termination of employment, reduction in hours, death or Medicare entitlement, the Plan Administrator has forty-four (44) days to notify the Qualified Beneficiary of the right to elect COBRA coverage or, if applicable, the Plan Administrator must notify the COBRA Administrator within thirty (30) days of the Qualifying Event, and the COBRA Administrator has fourteen (14) days to notify the Qualified Beneficiary of the right to elect COBRA coverage.

CONTINUATION OF COVERAGE UNDER USERRA

This section summarizes continuation of coverage under this Plan for Employees absent from work due to military service. The Plan intends to provide benefits as a result of military Leave of Absence as mandated by USERRA, as it may be amended from time to time.

As an Employee you have a right to choose this continuation of coverage if you are absent from work due to service in one of the uniformed services of the United States. "Service" means: active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty and absence from work to determine the Employee's fitness for any of the designated types of duty.

Employees who are dishonorably discharged from the military are not eligible for continuation of coverage under USERRA.

Under the law, the Employee must give the Employer written or verbal advance notice of the military leave, if it is practical to do so, and failure to do so may result in the departing Employee's coverage being cancelled, unless the Employee is excused from giving advance notice of service under USERRA's provisions because it was impossible, unreasonable, or precluded by military necessity. A designated, authorized officer of the branch of the military in which the Employee will be serving may also provide such notice directly to the Employer.

Coverage also may be cancelled if a departing Employee leaves for a period of service that exceeds thirty (30) days and gives advance notice of service, but fails to elect continuation coverage. However, should the Employee pay all unpaid amounts due within sixty (60) days from the date the Employee left for such service, then the Employee will be retroactively reinstated with uninterrupted coverage to the Employee's date of departure.

If the Employee chooses Continuation of Coverage under USERRA, the Employer is required to offer coverage identical to that provided under the Plan prior to the Employee's military leave. If the Employee takes military leave on or after December 10, 2004, and the Employee lost coverage due to that military service, the Employee has the right to elect to extend coverage for the Employee, the Employee's spouse and the Employee's Dependents who are covered by the Plan for up to twenty-four (24) months while the Employee remains on active duty, or during the period that the Employee's reemployment rights are protected. During the first thirty (30) days of leave, the cost of the coverage the Employee elects is the same as the rate that the Employee paid as an Employee. After that time, the rate is the same rate that the Plan charges for COBRA Continuation Coverage. If the Employee or another member of the Employee's Family covered by the Plan becomes disabled during the first sixty (60) days of such coverage, and the Employee provides to the Plan a copy of the Social Security Administration determination of disability before the end of the twenty-four (24) months of coverage, the coverage by the Plan for the Employee, as well as the Employee's spouse and other Family members, can be extended to twenty-nine (29) months. The Employee will have to pay a higher rate for this additional five (5) months of coverage. In addition, if there is an event that would allow the Employee's spouse or Dependent to receive thirty-six (36) months of COBRA coverage, as described above under the COBRA Continuation Coverage provisions, then the Employee's spouse or Dependent will be entitled to elect such coverage if they notify the Plan within sixty (60) days after the event occurs.

If the Employee does not make timely premium payments, then the Plan will provide the Employee with thirty (30) days written notice to pay the premiums. If the Employee fails to pay the requested premium(s) within the thirty (30) days, the Plan has the right to cancel the Employee's continuation of coverage.

If an Employee's or a Dependent of an Employee's health plan coverage was terminated by reason of service in the uniformed services, that coverage must be reinstated upon reemployment, unless the Plan imposes an exclusion or Waiting Period as to illnesses or injuries determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of service.

If you feel you might have continuation rights under USERRA, please contact Human Resources as soon as possible.

DEFINITIONS

Terminology listed below, along with the definition or explanation of the manner in which the term is used, will be recognized for the purpose of this Plan, only if used in this Plan. Terms defined, but not used in this Plan, are to be considered general in nature and are in no way to be used to define or limit benefits or provisions of the Plan. Words or phrases used in this Plan that are capitalized or set forth in bold type but not defined in the Plan are contained in that form as section headings or for ease of review and are intended to have the general meanings associated with such words or phrases based on the context in which they are used.

Masculine pronouns used in this Plan Document shall include masculine or feminine gender unless the context indicates otherwise.

Wherever any words are used herein in the singular or plural, they shall be construed as though they were in the plural or singular, as the case may be, in all cases where they would so apply.

Accident: A sudden and unforeseen event, or a deliberate act resulting in unforeseen consequences.

Accidental Injury: See definition of "Injury".

Actively at Work: As applied to an Employee: the Employee will be considered “Actively at Work” on any day the Employee performs in the customary manner all of the regular duties of employment; an Employee will be deemed “Actively at Work” on each day of a regular paid vacation or on a regular non-working day on which the Covered Employee is not totally disabled, provided the Covered Employee was “Actively at Work” on the last preceding regular work day. An Employee shall be deemed Actively at Work if the Employee is absent from work due to a health factor, subject to the Plan’s Leave of Absence provisions.

ADA: The American Dental Association.

Administrative Period: A period of time selected by the Employer beginning immediately following the end of the Measurement Period and ending immediately before the start of the associated Stability Period. This period of time is used by the Employer to determine if Variable Hour Employees and/or Ongoing Employees are eligible for coverage and, if so, to make an offer of coverage.

Adverse Benefit Determination: Any denial, reduction or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, rescission of coverage, termination or failure to provide or make payment that is based on certain benefit coverage and eligibility determinations.

Adverse Benefit Determination on Appeal: The upholding or affirmation of an appealed Adverse Benefit Determination.

Allowable Claim Limits: The charges for services and supplies, listed and included as Covered Medical Expenses under the Plan, which are Medically Necessary for the care and treatment of Illness or Injury, but only to the extent that such fees are within the Allowable Claim Limits. See Claim Review and Audit Program section.

Allowable Expense: The Usual and Customary charge within Allowable Claim Limits for any Medically Necessary, Reasonable eligible item of expense, at least a portion of which is covered under this Plan. When some other plan provides benefits in the form of services rather than cash payments, the Reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any other plan include the benefits that would have been payable had Claim been duly made.

Alternate Recipient: Any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant’s Eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an Eligible Dependent, but for

purposes of the reporting and disclosure requirements an Alternate Recipient shall have the same status as a Participant.

Alternative Care Plan: In circumstances where there is a reasonable expectation of savings for standard of care medical treatment, medication, or other services and this alternative care can be substituted for more costly care while remaining the treatment of choice, an Alternative Care Plan will be developed to optimize the savings obtained by the services substituted. Example: Substituting Home Health Private Duty Nursing for care in an Inpatient Skilled Nursing Facility.

AMA: The American Medical Association.

Ambulatory Surgery Center: An institution or Facility, either free-standing or as a part of a Hospital with permanent Facilities, equipped and operated for the primary purpose of performing Surgical Procedures and to which a patient is admitted and from which a patient is discharged within a twenty-four (24) hour period. An office maintained by a Physician for the practice of medicine or dentistry, or for the primary purpose of performing terminations of Pregnancy, shall not be considered as an Ambulatory Surgery Center.

Ancillary Services: Incidental services that assist a medical procedure, but are not essential to the accomplishment of the medical procedure (i.e., laboratory testing).

Annual: Yearly; occurring once each Calendar Year.

Traditional Plan:
Annual Out-of-Pocket Maximum: The Maximum dollar amount a Covered Person will pay for Covered Medical Expenses, including the Calendar Year Deductible Medical Copays, but excluding any Covered Charges already paid at 100% in any one Calendar Year period, unless otherwise specified in the Schedule of Benefits. A separate Prescription Drug Annual Out-of-Pocket Maximum applies to Prescription Drug Copays and Expenses.

High Deductible Health Plan:
Annual Out-of-Pocket Maximum: The Maximum dollar amount a Covered Person will pay for Covered Medical and Prescription Drug Expenses including the Calendar Year Deductible, but excluding any Covered Charges already paid at 100% in any one Calendar Year period, unless otherwise specified in the Schedule of Benefits.

Approved Clinical Trial: A phase I, II, III or IV trial that is federally funded by specified Agencies (National Institutes of Health, CDCP, Agency for Health Care Research, CMS, Dept. of Defense or Veterans Affairs, or a non-governmental entity identified by NIH guidelines) or is conducted under an Investigational new Drug application reviewed by the FDA (if such application is required).

Assignment of Benefits: An arrangement whereby the Plan Participant assigns his/her right to seek and receive payment of eligible Plan benefits, in strict accordance with the terms of this Plan Document, to a Provider. If a Provider accepts said arrangement, Provider's rights to receive Plan benefits are equal to those of a Plan Participant, and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an "Assignment of Benefits" as consideration in full for services, supplies, and/or treatment rendered.

Authorized Representative: Person authorized to act on behalf of a Claimant for a benefit Claim or appeal of an Adverse Benefit Determination.

Autism Spectrum Disorder: A disorder that includes autism, Asperger's Syndrome or pervasive development disorder.

Benefit Determination: A determination by the Plan Administrator or Claims Administrator on a Claim for benefits, including an Adverse Benefit Determination.

Benefit Percentage: The portion of Covered Expenses to be paid by the Plan in accordance with the coverage provisions as shown on the Schedule of Benefits. It is the basis used to determine any out-of-pocket expenses including the Calendar Year Deductible, Medical Copays/Expenses and Prescription Drug Copays/Expenses including the Calendar Year Deductible which are to be paid by the Covered Person.

Birthing Center: A Facility, staffed by Physicians, which is licensed as a Birthing Center in the jurisdiction where it is located.

Breach: A Breach is, generally, an impermissible use or disclosure under the Privacy Rule that compromises the security or privacy of the protected health information such that the use or disclosure poses a significant risk of financial, reputational, or other harm to the affected individual.

Calendar Year: A period of time commencing on January 1 and ending on December 31 of the same given year.

Chemical Dependency: The abuse of, or psychological or physical dependency on, or addiction to, alcohol or a controlled substance. A "controlled substance" means a toxic inhalant or a substance designated as a controlled substance as declared by Federal and State law where applicable.

Chemical Dependency Treatment Center: A Facility which provides a program for the treatment of Chemical Dependency pursuant to a written treatment plan approved and monitored by a Physician and is also:

1. Accredited as such a Facility by the Council on Accreditation (COA) or Joint Commission on Accreditation of Health Care Organizations or sponsored by the A.M.A. or A.H.A.;
2. Affiliated with a Hospital under contractual agreement with an established system for patient referral;
3. Licensed as a Chemical Dependency treatment program by the applicable State Commission on Alcohol and Drug Abuse; and
4. Licensed, certified or approved as a Chemical Dependency treatment program or center by any other State agency having legal authority to so license, certify or approve.

Child(ren): In addition to the Employee's own blood descendant of the first degree or lawfully adopted Child, a Child placed with a Covered Employee in anticipation of adoption, a Covered Employee's Child who is an Alternate Recipient under a Qualified Medical Child Support Order as required by the Federal Omnibus Budget Reconciliation Act of 1993, any stepchild, or any other Child for whom the Employee has been legally appointed guardian or conservator. See definition of "Dependent" for any other eligibility provisions for a Child.

CHIP: Refers to the Children's Health Insurance Program or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

CHIPRA: Refers to the Children's Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

Chiropractic Services: The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column.

Claim: A request for a Plan benefit or benefits made by a Claimant in accordance with the Plan's reasonable procedure for filing benefit Claims.

Claim Determination Period: A Calendar Year, a Plan Year or that portion of a Calendar or Plan Year during which the Covered Person, for whom Claim is made, has been covered under this Plan.

Claimant: Individual for whom a Claim is filed.

Claims Administrator: The third party or parties with whom the Plan Administrator has contracted to process the Claims for the benefits under this Plan.

Clean Claim: A Clean Claim is one that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a Claim which has no defect or impropriety. A defect or impropriety shall include a lack of required substantiating documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include Claims under investigation for fraud and abuse or Claims under review for Medical Necessity and Reasonableness, or fees under review for Usual and Customariness, or any other matter that may prevent the charge(s) from being covered expenses in accordance with the terms of this document.

Filing a Clean Claim. A Provider submits a Clean Claim by providing the required data elements on the standard Claim forms, along with any attachments and additional elements or revisions to data elements of which the Provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to Claim submittal) to ensure charges constitute covered expenses as defined by and in accordance with the terms of this document. The paper Claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A Claim will not be considered to be a Clean Claim if the Plan Participant has failed to submit required forms or additional information to the Plan as well.

Close Relative: Includes the spouse, mother, father, sister, brother, Child, or in-laws of the Covered Person.

COBRA: Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COBRA Continuation Coverage: Coverage under this Plan that satisfies an applicable COBRA continuation provision.

COBRA Election Period: The sixty (60) day period during which a COBRA Qualified Beneficiary, who would lose coverage as a result of a Qualifying Event, may elect Continuation Coverage under COBRA. This sixty (60) day period begins the later of:

1. The date of termination of coverage as a result of a Qualifying Event; or
2. The date of the notice of the right to elect COBRA Continuation Coverage under this Plan.

COBRA Qualified Beneficiary: A former Employee or Dependent covered under this Plan on the day before the Qualifying Event who is eligible for continuing coverage under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and its amendments. A COBRA Qualified Beneficiary has independent election rights. A Domestic Partner does not qualify as a spouse under Federal law. If termination of employment occurs, the Plan will treat a Domestic Partner as a “Qualified Beneficiary”; however, this treatment does not qualify a Domestic Partner as a “Qualified Beneficiary” under IRS 1999 final regulations.

Coinsurance: The portion of Covered Expenses that is shared by the Plan and the Covered Person in a specific ratio (i.e., 80%/20%) after the Calendar Year Deductible has been satisfied. The amount of Coinsurance paid by or on behalf of the Covered Person is applied toward the Covered Person’s or Family’s Annual Out-of-Pocket Maximum.

Complications of Pregnancy: A Disease, disorder or condition which is diagnosed as distinct from normal Pregnancy but adversely affected by or caused by Pregnancy. This includes, but is not limited to:

1. Inter-abdominal Surgery, including cesarean section;
2. Excessive vomiting (hyperemesis gravidarum);
3. Toxemia with convulsions (eclampsia);
4. Extra-uterine Pregnancy (ectopic);
5. Postpartum hemorrhage;
6. Rupture or prolapse of the uterus;
7. Spontaneous termination of Pregnancy during a period of gestation in which a viable birth is not possible;
8. Similar medical and surgical condition of comparable severity.

Complications of Pregnancy will not include:

1. Elective abortion;
2. False labor;
3. Occasional spotting;
4. Physician prescribed rest;
5. Morning sickness; or
6. Similar conditions associated with the management of a difficult Pregnancy.

Concurrent Review: The Utilization Review department's review of a Hospital stay, periodically evaluating the need for continued hospitalization.

Congenital Anomaly: A Congenital Anomaly may be viewed as a physical, metabolic or anatomic deviation from the normal pattern of development that is apparent at birth or detected during the first year of life.

Copay: The portion of Covered Expenses which is payable by the Covered Person and which is not applicable to the Calendar Year Deductible unless otherwise stated in this Plan Document.

Corrective Shoes: Shoes with a prescription correction which is a permanent and integral part of the shoe.

Cosmetic Procedure/Cosmetic Surgery: A procedure performed solely for the improvement of a Covered Person's appearance rather than for the improvement or restoration of bodily function.

Covered Dental Expenses: The Usual and Customary fees incurred by the Covered Person for dental services which are provided or rendered by a Dentist and not listed as an exclusion in Dental Plan Limitations and Exclusions.

Covered Employee: An Employee meeting the eligibility requirements for coverage as specified in this Plan and who is properly enrolled in the Plan.

Covered Medical Expenses (Covered Expenses): The Reasonable and Usual and Customary charges, Allowable Claim Limit charges and/or contracted PPO charges incurred by or on behalf of a Covered Person for the Hospital or other medical services listed below which are:

1. Ordered by a Physician or licensed Practitioner;
2. Medically Necessary for the treatment of an Illness or Injury;
3. Not of a luxury or personal nature; and
4. Not excluded under the Major Medical Exclusions and Limitations section of this Plan.

Covered Person: An Employee, a Dependent, a COBRA Qualified Beneficiary or a COBRA Qualified Beneficiary's Dependent meeting the eligibility requirements for coverage as specified in this Plan, and who is properly enrolled in the Plan.

Custodial Care: That type of care or service, wherever furnished and by whatever name called, which is designed primarily to assist a Covered Person, whether or not totally disabled, in the activities of daily living. Such activities include, but are not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in and out of bed, and supervision over medication which can normally be self-administered.

Date of Hire: The Employee's first day of Full-time or Part-time Employment with the Employer.

Deductible: A specified dollar amount of Covered Expenses which must be incurred during a Calendar Year before any other Covered Expenses can be considered for payment according to the applicable Benefit Percentage. The Plan Administrator reserves the right to allocate and apportion the Deductible and benefits to any Covered Persons and assignees.

Dependent:

1. The Covered Employee's legal licensed spouse. Such spouse must have met all the requirements of a valid marriage contract in accordance with the laws of the State in which such parties were married. A common-law marriage recognized by the State in which the Covered Employee resides may be considered a legal marriage for this Plan. **NOTE:** Proof of legal status may be required by the Plan Administrator.

2. A Covered Employee's Domestic Partner who has a single, dedicated relationship with the Employee that contains the following elements:

    a. Both the Employee and Domestic Partner are at least eighteen (18) years of age and mentally competent to consent to contract; and
    b. The relationship is intended to last indefinitely.

3. The Covered Employee's Child who meets all of the following conditions:

    a. Is less than **twenty-six (26) years of age**; and

    b. Is either a:

        i. Natural (biological) Child; or
        ii. Child who has been legally adopted or placed for adoption with the Covered Employee; or
        iii. Stepchild; or
        iv. Foster Child; or
        v. Child who has been placed under the legal guardianship or conservatorship of the Covered Employee or the Employee's covered Dependent spouse; or
        vi. Child of a Domestic Partner.

The age requirement above is waived for any unmarried Child who is Physically Handicapped or Intellectually Disabled and incapable of sustaining his/her own living, who has the same legal residence as the Employee for more than one-half of the Calendar Year, and who does not provide more than one-half of his/her own support for the Calendar Year in which the Child is enrolled for coverage under the Plan. Such Child must have been mentally or physically incapable of earning his/her own living prior to attaining the limiting age stated above. Proof of incapacity must be furnished to the Plan Administrator at the time of initial enrollment or within thirty (30) days of the date such Dependent's coverage would have otherwise terminated due to the age requirement. In addition, the Claims Administrator reserves the right to request proof of continued incapacity at any time.

NOTE: Proof of Dependent eligibility may be required.

Detoxification: The process whereby an alcohol-intoxicated person or person experiencing the symptoms of Substance Abuse is assisted, in a Facility licensed by the Department of Health, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol, alcohol dependency factors or alcohol in combination with Drugs as determined by a licensed Physician, while keeping the physiological risk to the patient at a minimum.

Developmental Delay: A significant variation in normal development as measured by appropriate diagnostic instruments and procedures in one or more of the following: cognitive development, physical development, communication development, social or emotional development or adaptive development.

Direct Agreement: A complete agreement between a Directly Contracted Provider and the DDM or the Plan Sponsor which contains the terms and conditions under which the Covered Person may access discounted fees and/or negotiated or scheduled reimbursement rates which the Plan adopts as Allowable Claims Limits for Claims submitted by directly contracted Providers.

Directly Contracted Provider: A medical Provider which has entered into a Direct Agreement with the DDM or the Plan Sponsor to provide certain medical services to Covered Persons at agreed upon Allowable Claim Limits.

Disease: Any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the Plan is furnished showing that the individual concerned is covered as an Employee under any Workers' Compensation law, occupational Disease law or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the Plan, be regarded as a sickness, Illness or Disease.

Domestic Partners: Applies to two (2) individuals either of the same sex or opposite sex who live together in a long-term relationship of indefinite duration with an exclusive mutual commitment in which the Domestic Partners agree to be jointly responsible for each other's common welfare and share financial obligations.

Donor: One who furnishes blood, tissue, or an organ to be used in another person.

Drug: Insulin and prescription legend Drugs. A prescription legend Drug is a Federal legend Drug (any medicinal substance which bears the legend: "Caution: Federal law prohibits dispensing without a Prescription") or a State restricted Drug (any medicinal substance which may be dispensed only by Prescription, according to State law) and which, in either case, is legally obtained from a licensed Drug dispenser only upon a prescription of a currently licensed Physician.

Durable Medical Equipment: Equipment which is:

1. Able to withstand repeated use;
2. Primarily and customarily used to serve a medical purpose; and
3. Not generally useful to a person in the absence of Illness or Injury.

Elective Surgical Procedure/Elective Surgery: A non-Emergency Surgical Procedure which is scheduled at the Covered Person's convenience without endangering the Covered Person's life or without causing serious impairment to the Covered Person's bodily functions.

Electronic Protected Health Information (ePHI): "Electronic Protected Health Information (ePHI)" has the meaning set forth in 45 C.F.R. Section 160.103, as amended from time to time, and generally means Protected Health Information that is transmitted or maintained in any electronic media.

Eligible Dependent: An Employee's Dependent who meets the Plan's eligibility requirements to enroll for coverage while the Employee is covered under the Plan.

Eligible Employee: An Employee and who is employed by the Employer on a full-time or part-time basis for an average of at least thirty (30) hours per week.

Emergency/Medical Emergency: A situation where necessary treatment is required as the result of a sudden and severe medical event or acute condition. An Emergency includes poisoning, shock, and hemorrhage. Other Emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, that an Emergency did exist. The Plan may, at its own discretion, request satisfactory proof that an Emergency or acute condition did exist. Some examples of an Emergency are: apparent heart attack, severe bleeding, sudden loss of consciousness, severe or multiple Injuries, convulsions, respiratory distress including asthma attacks, apparent poisoning or severe pain from the sudden onset of an Illness. Some examples of conditions that are not generally considered an Emergency are: colds, influenza, ear infections, nausea or headaches.

Emergency Services: With respect to an Emergency medical condition:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the Emergency department of a Hospital, including Ancillary

Services routinely available to the Emergency department to evaluate such Emergency medical condition or within the capability of a Free-standing Emergency Room Facility; and
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and Facilities available at the Hospital or within the capabilities of the staff at a Free-standing Emergency Room Facility, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

Employee: A person who is determined by the Employer to either be employed for Full-time or Part-time Employment or employed as a Variable Hour Employee who has completed the most recent Measurement Period and entered a Stability Period.

Employer: The Employer and any affiliates adopting the Plan with the consent of the Employer by approval of the affiliate entity's governing body.

Enrollment Date: The Enrollment Date in the Plan for an Eligible Employee who enrolls in the Plan during his/her initial eligibility period is the Employee's Date of Hire. The Enrollment Date for a Special Enrollee or a Late Enrollee is the first day of coverage in the Plan.

Essential Health Benefits: "Essential Health Benefits" shall mean, under section 1302(b) of the Patient Protection and Affordable Care Act (PPACA), those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and Substance Abuse disorder services, including behavioral health treatment; Prescription Drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic Disease management; and pediatric services, including oral and vision care.

Experimental/Investigational: Services or treatments that are not widely used or accepted by most Practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments, and that are not the subject of, or in some manner related to, the conduct of an Approved Clinical Trial, as such term is defined herein; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which:

1. Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or
2. Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

Non-approved Phase I and II clinical trials shall be considered Experimental. Non-approved clinical trials include anything that is not listed in the Approved Clinical Trial definition.

A Drug, device, or medical treatment or procedure is Experimental:

1. If the Drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the Drug or device is furnished;
2. If reliable evidence shows that the Drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials (unless identified as a covered service elsewhere) or under study to determine its:

    a. maximum tolerated dose;
    b. toxicity;
    c. safety;
    d. efficacy; and
    e. efficacy as compared with the standard means of treatment or diagnosis; or

3. Reliable evidence shows that the opinion among experts regarding the treatment, procedure, device, Drug, or medicine is that the preponderance of current evidence does not support its efficacy, safety, or its efficacy as compared with the standard means of treatment or with regard to medication, has not determined its maximum tolerated dose.

Reliable evidence shall mean:

1. Only published reports and articles in the authoritative medical and scientific literature;
2. The written protocol or protocols used by the treating Facility or the protocol(s) of another Facility studying substantially the same Drug, device, or medical treatment or procedure; or
3. The written informed consent used by the treating Facility or by another Facility studying substantially the same Drug, device, or medical treatment or procedure.

Subject to a medical opinion, if no other FDA approved treatment is feasible and as a result the Participant faces a life or death medical condition, the Plan Administrator retains discretionary authority to cover the services or treatment.

Medical care and treatment, including prescriptions/diagnostics/labs that are not related directly to a clinical trial are considered for coverage under the Plan for those patients participating in a clinical trial.

Facility/Free-standing Facility: A facility means a Hospital or treatment center that provides medical services on an Inpatient and/or Outpatient basis. A Free-standing Facility is an independent Facility which provides medical services on an Outpatient basis, which may or may not be affiliated with a Hospital (i.e., Ambulatory Surgery Center). See separate definition for “Free-standing Emergency Room Facility.”

Family: A Covered Employee and his/her Eligible Dependents.

Family and Medical Leave: A Leave of Absence pursuant to the provisions of the Family and Medical Leave Act of 1993 (FMLA), as amended.

Fiduciary: The Plan Administrator, but only with respect to the specific responsibilities relating to the administration of the Plan.

Foster Child: A Child for whom an Employee has assumed a legal obligation to support and care, provided:

1. Such Child normally lives with the Employee in a parent-Child relationship; and
2. The Employee has a legal right to claim such Child as a Dependent on his federal income tax return if the Child resides with the Employee for a period of six (6) months or longer.

Free-standing Emergency Room Facility: An independent Facility which provides care for urgent medical conditions and is open twenty-four (24) hours a day, but is not located at a Hospital.

Full-time Employment: A basis whereby an Employee is regularly expected to be employed by the Employer for the minimum number of hours shown in the Employee Eligibility section of this Plan Document. Such work may occur either at the usual place of business of the Employer or at a location to which the business of the Employer requires the Employee to travel, and for which he/she receives regular earnings from the Employer.

Genetic Information: Information about genes, gene products and inherited characteristics that may derive from an individual or a Family member. This includes information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, Family histories and direct analyses of genes or chromosomes.

GINA: The Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies and Employers from discriminating on the basis of Genetic Information.

Habilitation Services: Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community based settings.

Hazardous Pursuit, Hobby or Activity: Services, supplies, care and/or treatment of an Injury or Illness that results from engaging in a Hazardous Pursuit, Hobby or Activity. A pursuit, hobby or activity is hazardous if it involves or exposes an individual to risk of a degree or nature not customarily undertaken in the course of the Covered Person's customary occupation or if it involves leisure time activities commonly considered as involving unusual or exceptional risks, characterized by a constant threat of danger or risk of bodily harm, including but not limited to: hang gliding; skydiving; bungee jumping; parasailing; use of all-terrain vehicles; rock climbing; use of explosives; automobile, motorcycle, aircraft, or speed boat racing; and travel to countries with advisory warnings.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): With regard to health care plans, it should be noted that this Act implemented the portability of health insurance and changed health status eligibility provisions for Employee health plans.

Health Maintenance Organization (HMO): An organized system of health care delivery available to individuals residing in a specific geographic area providing comprehensive medical care to enrollees for a predetermined periodic payment.

HIPAA Privacy Standards: The Privacy Standards of the Health Insurance Portability and Accountability Act of 1996, as they may be amended from time to time.

Home Health Care Agency: A public or private agency or organization that specializes in providing medical care and treatment in the patient's home. Such a Provider must meet all of the following conditions:

1. It is primarily engaged in and duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services;

2. It has policies established by a professional group associated with the agency or organization. This professional group must include at least one (1) Physician and at least one (1) Registered Nurse (RN) to govern the services provided and it must provide for full-time supervision of such services by a Physician or Registered Nurse (RN);

3. It maintains a complete medical record on each individual; and

4. It has a full-time administrator.

Home Health Care Plan: A program for care and treatment of a Homebound Covered Person, established and approved by the Covered Person's attending Physician, which is in lieu of confinement as an Inpatient in a Hospital or other Inpatient Facility in the absence of the services and supplies provided for under the Home Health Care Plan.

Home Infusion Therapy: The administration of fluids, nutrition or medication (including all additives and chemotherapy) by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the home setting. Home Infusion Therapy shall include:

1. Drugs and IV solutions;
2. Pharmacy compounding and dispensing services;
3. All equipment and ancillary supplies necessitated by the defined therapy;
4. Delivery services;
5. Patient and Family education; and
6. Nursing services.

Over-the-counter products which do not require a Physician's or other Provider's prescription, including but not limited to standard nutritional formulations used for enteral nutrition therapy, are not included within this definition.

Home Infusion Therapy Provider: An entity that is duly licensed by the appropriate State agency to provide Home Infusion Therapy.

Homebound: A patient's medical condition is such that it significantly restricts the ability to leave the home, and the patient is unable to drive a motor vehicle by himself/herself.

Hospice: A health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in institutional settings for Covered Persons suffering from a condition that has a terminal diagnosis. A Hospice must have an interdisciplinary group of personnel which includes at least one (1) Physician and one (1) Registered Nurse (RN), and it must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable State licensing requirements.

Hospice Benefit Period: A specified amount of time during which the Covered Person undergoes Hospice care. Such time period begins on the date the attending Physician of a Covered Person certifies a diagnosis of terminally ill, and the Covered Person is accepted into a Hospice program. The period shall end the earlier of six (6) months from this date or at the death of the Covered Person. A new benefit period may begin if the attending Physician certifies that the Covered Person is still terminally ill; however, additional proof may be required by the Claims Administrator before such a new benefit period can begin.

Hospital: An accredited institution which is approved as a Hospital by the Joint Commission on the Accreditation of Health Care Organizations or the American Osteopathic Association, and which meets all of the following criteria:

1. It is primarily engaged in providing, for compensation from its patients and on an Inpatient basis, diagnostic and therapeutic Facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons by or under the supervision of a staff of Physicians;

2. It continuously provides twenty-four (24) hours per day nursing services by registered professional nurses under the supervision of Physicians; and

3. It is not, other than incidentally, a place for rest, the aged, or a nursing home, a hotel or the like.

Hospital Expenses: Charges by a Hospital for room and board (including Private room accommodations) and/or for care in an Intensive Care Unit provided that such care is furnished at the direction of a Physician.

Hospital Miscellaneous Expenses: The actual charges made by a Hospital in its own behalf for services and supplies rendered to the Covered Person which are Medically Necessary for the treatment of such Covered Person. Hospital Miscellaneous Expenses do not include charges for Room and Board or for professional services (including intensive nursing care by whatever name called), regardless of whether the services are rendered under the direction of the Hospital or otherwise.

Hour of Service: Each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the Employer; and each hour for which an Employee is paid, or entitled to payment by the Employer for a period of time during which no duties are performed due to vacation, holiday, Illness, incapacity (including disability), layoff, jury duty, military duty or Leave of Absence.

Illness: A bodily disorder, Disease, physical sickness, mental infirmity, or functional nervous disorder of a Covered Person.

Immunization: The protection of individuals or groups from specific Diseases by vaccination or the injection of immune globulins.

Incurred Date: The date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered.

Individual Treatment Plan: A treatment plan with specific attainable goals and objectives appropriate to both the patient and the treatment modality of the program.

Injury: A condition caused by accidental means which results in damage to the Covered Person's body from an external force.

Inpatient: Refers to a patient admitted as a bed patient to a Hospital, Hospice, Rehabilitation Facility or Skilled Nursing Facility for treatment or observation; charges must be incurred for Room and Board or observation for a period of at least twenty-four (24) hours.

Intensive Care Unit (ICU): A separate, clearly designated service which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has Facilities for special nursing care not available in regular rooms and wards of the Hospital, special life-saving equipment which is immediately available at all times, at least two (2) beds for the accommodation of the critically ill and at least one (1) Registered Nurse (RN) in continuous and constant attendance twenty-four (24) hours a day.

Late Enrollee: An Employee or Dependent who gave up his/her initial opportunity to enroll in the Plan and who enrolls in the Plan more than thirty (30) days after the date of his/her initial eligibility and who is not eligible for a Special Enrollment, or who has failed to enroll by the end of a Special Enrollment Period. Late Enrollees can only enroll once a year during the Annual Open Enrollment Period for the Plan.

Leave of Absence: A Leave of Absence of an Employee that has been approved by his/her Participating Employer, as provided for in the Participating Employer's rules, policies, procedures and practices.

Licensed Practical Nurse/Licensed Vocational Nurse: An individual who has received specialized nursing training and practical nursing experience, and is duly licensed to perform such nursing services by the State or regulatory agency responsible for such licensing in the State in which that individual performs such services.

Material Reduction: Material Reduction in covered services or benefits is any modification to the Plan or change in the information required to be included in the Summary Plan Description (SPD) that, independently or in conjunction with other contemporaneous modifications or changes, would be considered by the average Plan Participant to be an important reduction in covered services or benefits.

Maximum Allowable Charge: The benefit payable for a specific coverage item or benefit under the Plan. The Maximum Allowable Charge will always be a negotiated rate, if one exists; if no negotiated rate exists, the Maximum Allowable Charge will be determined and established by the Plan, at the Plan Administrator's discretion, using normative data and submitted information such as, but not limited to, any one (1) or more of the following, in the Plan Administrator's discretion:

- Medicare reimbursement rates (presently utilized by the Centers for Medicare and Medicaid Services ["CMS"]).
- Prices established by CMS utilizing standard Medicare Payment methods and/or based upon supplemental Medicare pricing data for items Medicare does not cover based on data from CMS.
- Prices established by CMS utilizing standard Medicare payment methods and/or based upon prevailing Medicare rates in the community for non-Medicare Facilities for similar services and/or supplies provided by similarly skilled and trained Providers of care.
- Prices established by CMS utilizing standard Medicare payment methods for items in alternate settings based on Medicare rates provided for similar services and/or supplies paid to similarly skilled and trained Providers of care in traditional settings.
- Medicare cost data as reflected in the applicable individual Provider's cost report(s).
- The fee(s) which the Provider most frequently charges the majority of patients for the service or supply.
- Amounts the Provider specifically agrees to accept as payment in full either through direct negotiation or through a Preferred Provider Organization (PPO) network.
- Average wholesale price (AWP) and/or manufacturer's retail pricing (MRP).

- Medicare cost-to-charge ratios or other information regarding the actual cost to provide the service or supply.
- The allowable charge otherwise specified within the terms of this Plan.
- The prevailing range of fees charged in the same "area" (defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made) by Providers of similar training and experience for the service or supply.
- With respect to Non-Network Emergency Services, the Plan allowance is the greater of:

    - The negotiated amount for In-Network Providers (the median amount if more than one (1) amount to In-Network Providers).
    - One hundred percent (100%) of the Plan's Maximum Allowable Charge payment formula (reduced for cost-sharing).
    - The amount that Medicare Parts A or B would pay (reduced for cost-sharing).

The Plan Administrator may in its discretion, taking into consideration specific circumstances, deem a greater amount to be payable than the lesser of the aforementioned amounts. The Plan Administrator may take any or all of such factors into account but has no obligation to consider any particular factor. The Plan Administrator may also account for unusual circumstances or complications requiring additional, or a lesser, amount of time, skill and experience in connection with a particular service or supply, industry standards and practices as they relate to similar scenarios, and the cause of Injury or Illness necessitating the service(s) and/or charge(s).

In all instances, the Maximum Allowable Charge will be limited to an amount which, in the Plan Administrator's discretion, is charged for services or supplies that are not unreasonably caused by the treating Provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of Provider negligence and/or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

The determination that fees for services are includable in the Maximum Allowable Charge will be made by the Plan Administrator, taking into consideration, but not limited to, the findings and assessments of the following entities: (a) The national medical associations, societies, and organizations; and (b) The Food and Drug Administration (FDA). To be includable in the Maximum Allowable Charge, services and fees must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The Plan Administrator has the discretionary authority to decide if a charge is covered under this Plan. The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

For Claim determinations made in accordance with the Claim Review and Audit Program, the Maximum Allowable Charge will be limited to the Allowable Claim Limits. Please refer to the section, "Claim Review and Audit Program," for the definition of Allowable Claim Limits.

Maximum Amount: Any limit on benefits that are payable under the Plan.

Maximum Benefit: The Maximum Amount that may be payable for each Covered Person for expenses incurred. The applicable Maximum Benefit is shown in the Schedule of Benefits. No further benefits are payable once the Maximum Benefit is reached.

Measurement Period: A period of time selected by the Employer during which Variable Hour Employees' and/or Ongoing Employees' Hours of Service are tracked to determine employment status for benefit purposes. The Initial Measurement Period applies to newly hired Variable Hour Employees. The Standard Measurement Period applies to Ongoing Employees.

Medical Care Benefits: Amounts paid for the diagnosis, cure, mitigation, treatment or prevention of Disease or amounts paid for the purpose of affecting any structure or function of the body.

Medical Child Support Order: Any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for Child support with respect to a Participant's Child or directs the Participant to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law); or
2. Enforces a law relating to Medical Child Support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

Medical Record Review: The process by which the Plan, based upon a review and audit of medical records, determines that a different treatment or different quantity of a Drug or supply was provided which is not supported in the billing. The Plan Administrator may determine the Maximum Allowable Charge according to the Medical Record Review and audit results.

Medical Review Specialist: An organization under contract to the Plan Administrator to provide the services required under the cost containment features of Utilization Review Notification/Concurrent Review/Coordination of Care/Case Management. The Plan Administrator will furnish the name, address and phone number of the Medical Review Specialist.

Medically or Dentally Necessary/Medical or Dental Necessity: Refers to health care services ordered by a Physician or Dentist exercising prudent clinical judgment provided to a Plan Participant for the purposes of evaluation, diagnosis or treatment of that Plan Participant's Illness or Injury. Such services, to be considered Medically/Dentally Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the diagnosis or treatment of the Plan Participant's Illness or Injury. The Medically/Dentally Necessary setting and level of service is that setting and level of service which, considering the Plan Participant's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically/Dentally Necessary must be no more costly than alternative interventions and are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Plan Participant's Illness or Injury without adversely affecting the Plan Participant's medical condition.

1. It must not be maintenance therapy or maintenance treatment;
2. Its purpose must be to restore health;
3. It must not be primarily custodial in nature;
4. It must not be a listed item or treatment not allowed for reimbursement by CMS (Medicare); and
5. The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical or Dental Necessity and/or an Allowable Expense.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Participant is receiving or the severity of the Participant's condition and that safe and adequate care cannot be received as an Outpatient or in a less intensive medical setting. The mere fact that the service is furnished, prescribed or approved by a Physician or Dentist does not mean that it is "Medically or Dentally Necessary." In addition, the fact that certain services are excluded from coverage under this Plan because they are not "Medically or Dentally Necessary" does not mean that any other services are deemed to be "Medically or Dentally Necessary."

To be Medically or Dentally Necessary, all of these criteria must be met. Merely because a Physician or Dentist recommends, approves, or orders certain care does not mean that it is Medically or Dentally Necessary. The determination of whether a service, supply, or treatment is or is not Medically or Dentally Necessary may include findings of the American Medical Association and the Plan Administrator's own medical advisors.

Medicare Benefits: All benefits under Parts A, B and/or D of Title XVIII of the Social Security Act of 1965, as amended from time to time.

Mental Disorder: Any Disease or condition, regardless of whether the cause is organic, that is classified as a Mental or Nervous Disorder in the current edition of *International Classification of Diseases*, published by the U.S. Department of Health and Human Services, or is listed in the current edition of *Diagnostic and*

Statistical Manual of Mental Disorders, published by the American Psychiatric Association or other relevant State guideline or applicable sources.

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA): In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that:

1. The financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage) and that there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan); and

2. The treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage), and that there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage offered in connection with such a plan).

Midwife: A Practitioner who is certified as a Nurse Midwife (CNM) by the American College of Nurse-Midwives and who is authorized to practice as a Nurse Midwife under State regulations.

Morbid Obesity: A diagnosed condition in which the body weight of an individual is the greater of 100 pounds or 100% over the medically recommended weight for a person of the same height, age and mobility and by a BMI (body mass index) greater than 40 (in accordance with Utilization Review's criteria for morbid or severe Obesity).

National Medical Support Notice or NMSN: A notice that contains the following information:

1. Name of an issuing State agency;
2. Name and mailing address (if any) of an Employee who is a Participant under the Plan;
3. Name and mailing address of one or more Alternate Recipients (i.e., the Child or Children of the Participant or the name and address of an official or agency that has been substituted for the mailing address of the Alternate Recipients(s)); and
4. Identity of an underlying Child support order.

Newborns' and Mothers' Health Protection Act of 1996 (NMHPA): A regulation that added a new section restricting the extent to which group health plans may limit Hospital lengths of stays for mothers and newborn Children following delivery. NMHPA regulations apply as of the first day of the first Plan Year beginning on or after January 1, 1998.

No-Fault Automobile Insurance: Automobile insurance that pays for medical expenses for Injuries sustained during the operation of an automobile, regardless of who may have been responsible for causing the Accident.

Non-variable Hour Employee: An Employee reasonably expected at the time of hire to work thirty (30) or more hours per week.

Nurse: An individual who has received specialized nursing training and is authorized to use the designation Registered Nurse (RN), Licensed Vocational Nurse (LVN) or Licensed Practical Nurse (LPN), and who is duly licensed by the State or regulatory agency responsible for such license in the State in which the individual performs the nursing services.

Obesity: A diagnosed condition in which the BMI (body mass index) is at least 30 (ranging from 30-39).

OBRA: The coverage provided under the provisions of the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993), effective August 10, 1993.

Occupational Therapy: Treatment which is rendered for reasons other than restoration of bodily functions and the prevention of disability. Such treatment is usually rendered by the use of work-related skills and leisure tasks for the evaluation of an individual's behavior and/or abilities of self-care, work or play.

Ongoing Employee: An Employee who has been employed by the Employer for at least one (1) complete Measurement Period.

Oral Surgery: Maxillofacial Surgical Procedures include, but are not limited to:

1. Excision of non-dental related neoplasms, including benign tumors and cysts and all malignant and pre-malignant lesions and growths;
2. Incision and drainage of facial abscess;
3. Surgical Procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses; and
4. Surgical and diagnostic treatment of conditions affecting the temporomandibular joint (including the jaw and the craniomandibular joint) as a result of an Accident, a trauma, a congenital defect, a developmental defect or a pathology.

Orthopedic Shoes: Special shoes designed for support of the feet or the prevention or correction of deformities of the feet.

Orthotic Devices: External devices used to support, align, prevent or correct deformities or to improve the function of movable parts of the body. An orthotic insole is a foot supporting device prescribed by a Physician or licensed Practitioner.

Out-of-Area: "Out-of-Area" applies to a Covered Person living or traveling outside of the geographic zip code area serviced by the Preferred Provider Organization (PPO).

Outpatient: A patient who receives medical services at a Hospital but is not admitted as a registered overnight bed patient; this must be for a period of less than twenty-four (24) hours. This term can also be applicable to services rendered in a free-standing independent Facility, such as an Ambulatory Surgery Center.

Outpatient Chemical Dependency/Drug Treatment Facility: An institution which provides a program for a diagnosis, evaluation and effective treatment of Chemical Dependency, and/or Drug use or abuse; provides Detoxification services needed with its effective treatment program; provides infirmary level medical services or arranges at a Hospital in the area for any other medical services that may be required; is at all times supervised by a staff of Physicians; provides at all times skilled nursing care by licensed nurses who are directed by a full-time Registered Nurse (RN); prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs, which is supervised by a Physician; and meets applicable State and Federal, if any, licensing standards.

Outpatient Psychiatric Day Treatment Facility: An administratively distinct governmental, public, private or independent unit or part of such unit that provides for a psychiatrist who has regularly scheduled hours in the Facility, and who assumes the overall responsibility for coordinating the care of all patients.

Part-time Employee: An Employee who is not regularly scheduled to work for the Employer for at least the minimum number of hours shown in the Eligibility section of this Plan Document.

Physical Therapy: Management of the patient's movement system. This includes conducting an examination; alleviating impairments and functional limitation; preventing Injury, impairment, functional limitation and disability; and engaging in consultation, education and research. Direct interventions include the appropriate use of patient education, therapeutic exercise and physical agents such as massage, thermal modalities, hydrotherapy and electricity.

Physically Handicapped or Intellectually Disabled: The inability of a person to be self-sufficient as the result of a condition such as intellectual disability, cerebral palsy, epilepsy or another neurological disorder and diagnosed by a Physician as a permanent and continuing condition.

Physician: A person acting within the scope of his/her license and holding the degree of Doctor of Medicine (MD) or Doctor of Osteopathy (DO) and who is legally entitled to practice medicine in all its branches under the laws of the State or jurisdiction where the services are rendered.

Placement for Adoption: A Child placed with the Covered Employee for adoption, whether or not the adoption has become final, will be considered eligible and will be covered from the date of such adoption or Placement for Adoption. "Placement" means the assumption and retention by the Covered Employee of a legal obligation for total or partial support of such Child in anticipation of adoption of such Child.

Plan: Without qualification, this Plan Document/Summary Plan Description, including any Plan Amendments thereto.

Plan Administrator: Gunnison County, Colorado, who is responsible for the day-to-day functions and arrangements of the Plan. The Plan Administrator may employ persons or firms to process Claims and perform other Plan connected services.

Plan Amendment: A formal document that changes the provisions of the Plan Document, duly signed by the authorized person or persons as designated by the Plan Sponsor.

Plan Participant: Eligible Employee, Eligible Dependent, eligible COBRA Qualified Beneficiary or a COBRA Qualified Beneficiary's Dependent properly enrolled in the Plan.

Plan Sponsor: Gunnison County, Colorado.

Plan Year: The twelve (12) month period beginning on January 1 and ending December 31 of each Calendar Year. The Plan Year is the year on which Plan records are kept.

Practitioner: A Physician or person acting within the scope of applicable State licensure/certification requirements including the following:

1. Advanced Practice Nurse (APN)
2. Audiologist
3. Board Certified Behavior Analyst (BCBA)
4. Certified Diabetic Educator and Dietitian
5. Certified Nurse Midwife (CNM)
6. Certified Operating Room Technician (CORT)
7. Certified Registered Nurse Anesthetist (CRNA)
8. Certified Surgical Technician (CST)
9. Doctor of Chiropractic (DC)
10. Doctor of Dental Medicine (DMD)
11. Doctor of Dental Surgery (DDS)
12. Doctor of Medicine (MD)
13. Doctor of Optometry (OD)
14. Doctor of Osteopathy (DO)
15. Doctor of Podiatric Medicine (DPM)
16. Licensed Acupuncturist (LAC)
17. Licensed Clinical Social Worker (LCSW)
18. Licensed Marriage and Family Therapist (LMFT)
19. Licensed Occupational Therapist
20. Licensed or Registered Physical Therapist
21. Licensed Practical Nurse (LPN)
22. Licensed Professional Counselor (LPC)
23. Licensed Surgical Assistant (LSA)
24. Licensed Vocational Nurse (LVN)

25. Master of Social Work (MSW)
26. Physician Assistant (PA)
27. Psychologist (PhD, EdD, PsyD)
28. Registered Nurse (RN)
29. Registered Nurse First Assistant (RNFA)
30. Registered Nurse Practitioner (RN-NP)
31. Speech Language Pathologist

Preferred Provider Organization (PPO): An alternate health care delivery system with which Plan Administrators may contract to provide comprehensive medical care for Employees. A PPO is a network of individual Physicians and other Providers who accept pre-negotiated, discounted fees for services rendered. Employee participation is encouraged by plan design for improved benefits when network Providers are used. Employees have flexibility under PPO arrangements in which there is a choice of network or non-network Providers.

Pregnancy: The physical state which results in childbirth, life-threatening abortion, or miscarriage, and any medical complications arising out of, or resulting from, such state.

Prescription Drugs: Licensed medicine that is government regulated which must be prescribed by a Qualified Prescriber before it can be obtained.

Preventive Care: This Plan intends to comply with the Patient Protection and Affordable Care Act's (PPACA) requirement to offer in-network coverage for certain preventive services without cost-sharing. To comply with PPACA, and in accordance with the recommendations and guidelines, the Plan will provide in-network coverage for:

- Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations;
- Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention;
- Comprehensive guidelines for infants, Children, and adolescents supported by the Health Resources and Services Administration (HRSA); and
- Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines with services listed by group (all adults, women, children) may be found here: https://www.healthcare.gov/coverage/preventive-care-benefits/. For more information, you may contact the Plan Administrator / Employer at 1-970-641-7623.

Privacy Regulation: The regulations issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended.

Private: A class of accommodations in a Hospital or Skilled Nursing Facility or other Facility providing services on an Inpatient basis in which one (1) patient bed is available per room.

Private Duty Nursing: Continuous skilled care or intermittent care by a Registered Nurse (RN), Licensed Practical Nurse (LPN) or Licensed Vocational Nurse (LVN) while a patient is not confined in a Hospital.

Protected Health Information (PHI): Individually identifiable health information that is created or received by a Covered Entity (the Plan) and relates to: (a) a person's past, present or future physical or mental health or condition; (b) provision of health care to that person; or (c) past, present or future payment for that person's health care. This term shall be construed in accordance with the Privacy Regulation.

Provider: A Physician, Practitioner, health care professional or health care Facility licensed, certified or accredited as required by state law.

Psychiatric Treatment Facility: A mental health Facility which:

1. Provides treatment for individuals who suffer from acute Mental Disorders;
2. Uses a structured psychiatric program with Individual Treatment Plans that have specified goals and appropriate objectives for the patient and treatment modality of the program; and
3. Is clinically supervised by a Physician of medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology.

Qualified Individual: Someone who is eligible to participate in an "Approved Clinical Trial" and either the individual's doctor has concluded that participation is appropriate or the participant provides medical and scientific information establishing that their participation is appropriate.

Qualified Medical Child Support Order (QMCSO): As originally enacted in OBRA 1993, as amended, a Medical Child Support Order that satisfies the following requirements to be a Qualified Medical Child Support Order:

1. The name and last known mailing address of the Plan Participant;
2. The name and address of each Alternate Recipient. "Alternate Recipient" means any Child of a Plan Participant who is recognized under a Medical Child Support Order as having a right to enrollment under a group health plan with respect to such Plan Participant;
3. A reasonable description of the type of coverage to be provided by the group health plan or the manner in which coverage will be determined;
4. The period for which coverage must be provided; and
5. Each plan to which the order applies.

Qualified Medical Child Support Orders include not only court orders, but also administrative processes established under State law.

Reasonable: In the Plan Administrator's discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of Illness or Injury not caused by the treating Provider. Determination that fee(s) or services are Reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of Injury or Illness necessitating the service(s) and/or charge(s).

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be Reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, are not Reasonable. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Administrator. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

Charge(s) and/or services are not considered to be Reasonable, and as such are not eligible for payment (exceed the Maximum Allowable Charge), when they result from Provider error(s) and/or Facility-acquired conditions deemed "reasonably preventable" through the use of evidence-based guidelines, taking into consideration, but not limited to, CMS guidelines.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and, therefore, not eligible for payment by the Plan.

Reconstructive Surgery: A procedure performed to restore the anatomy and/or functions of the body which were lost or impaired due to an Injury or Illness.

Registered Nurse (RN): An individual who has received specialized nursing training and is authorized to use the designation of "RN," and who is duly licensed by the State or regulatory agency responsible for such licensing in the State in which the individual performs such nursing services.

Rehabilitation Facility: A legally operating institution or distinct part of an institution which has a transfer agreement with one or more Hospitals, and which is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post-acute Hospital and rehabilitative Inpatient care, and is duly licensed by the appropriate government agency to provide such services. It does not include institutions which provide only minimal care, Custodial Care, ambulatory, or part-time care services, or an institution which primarily provides treatment of Mental Disorders or Chemical Dependency, except if such Facility is licensed, certified or approved as a Rehabilitation Facility for the treatment of mental conditions or Drug addiction or Chemical Dependency in the jurisdiction where it is located, or it is accredited as such a Facility by the Joint Commission on the Accreditation of Health Care Organizations, or the Commission on the Accreditation of Rehabilitation Facilities.

Residential Treatment Center: Facility that provides twenty-four (24) hour treatment for Chemical Dependency, Drug and Substance Abuse or mental health problems on an Inpatient basis. It must provide at least the following: Room and Board; medical services; nursing and dietary services; patient diagnosis, assessment and treatment; individual, Family and group counseling; and educational and support services. A Residential Treatment Center is recognized if it is accredited for its stated purpose by the Joint Commission on Accreditation of Hospitals and carries out its stated purpose in compliance with all relevant State and local laws.

Retrospective Review: A determination by Utilization Review that medical services performed either Inpatient or Outpatient met criteria for Medical Necessity.

Room and Board: All charges, by whatever name called, which are made by a Hospital, Hospice, Skilled Nursing Facility, Rehabilitation Facility or other covered Facilities as a condition of Inpatient confinement as a bed patient. Such charges do not include the professional services of Physicians nor intensive nursing care, by whatever name called.

Routine Newborn Care: Inpatient charges for a well newborn Child for nursery Room and Board, related expenses following birth, including newborn hearing exams and Physician's pediatric services including circumcision. This term does not apply to a newborn Child's diagnosed Illness.

Routine Patient Cost(s): All items and services consistent with the coverage provided in the Plan that is typically covered for a Qualified Individual who is not enrolled in a clinical trial. Routine Patient Costs do not include: 1) the Investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the Plan's network area unless out-of-network benefits are otherwise provided under the Plan.

Seasonal Employee: An Employee who is hired into a position for which the customary annual employment is six (6) months or less.

Security Incidents: "Security Incidents" has the meaning set forth in 45 C.F.R. Section 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

Semi-Private: A class of accommodations in a Hospital or Skilled Nursing Facility or other Facility providing services on an Inpatient basis in which at least two (2) patient beds are available per room.

Series of Treatments: A Series of Treatments is a planned, structured program which may include Inpatient or Outpatient treatment and is complete when the Covered Person is discharged on medical

advice from Inpatient care, Day Treatment or Outpatient Treatment without a lapse in treatment or when a person fails to materially comply with the treatment program for a period of thirty (30) days.

Serious Mental Illness: Defined as any one of the following eight (8) categories:

1. Schizophrenia
2. Paranoid and other psychotic disorders
3. Bipolar disorders (mixed, manic and depressive);
4. Major depressive disorders (single episode or recurrent);
5. Schizo-affective disorders (bipolar or depressive);
6. Pervasive developmental disorders;
7. Obsessive compulsive disorder; and
8. Depression in childhood and adolescence.

Skilled Nursing Facility/Extended Care Facility: An institution that:

1. Primarily provides skilled, as opposed to custodial, nursing services to patients; and
2. Is approved by the Joint Commission on the Accreditation of Health Care Organizations and/or Medicare.

Sleep Disorder: Medical/psychological condition that disrupts the patient's sleep on a chronic basis.

Special Enrollee: An Eligible Employee and his/her Eligible Dependents who have Special Enrollment rights and who enroll in the Plan during a Special Enrollment Period.

Special Enrollment Period: The period of thirty (30) days in which an Eligible Employee or Dependent who previously declined enrollment in the Plan by signing a waiver of coverage can enroll in the Plan. The Special Enrollment Period for both Employees and Dependents can be activated by:

1. Loss of eligibility for other coverage (except for cause or non-payment of premium);
2. A new Dependent acquired by an Employee through marriage, birth, adoption or Placement for Adoption;
3. Loss of eligibility under Medicaid or a State Children's Health Insurance Program (CHIP) (in which case the Special Enrollment Period is sixty (60) days); or
4. Gain of eligibility for a premium assistance subsidy under Medicaid or CHIP (in which case the Special Enrollment Period is sixty (60) days).

Speech Therapy: A program which evaluates the patient's motor-speech skills, expressive and receptive language skills, writing and reading skills, and determines if the patient requires an extensive hearing evaluation by an audiologist. The therapist also evaluates the patient's cognitive functioning, as well as his/her social interaction skills, such as the ability to maintain eye contact and initiate conversation. Therapy may also involve developing the patient's speech, listening and conversational skills and higher-level cognitive skills, such as understanding abstract thought, making decisions, sequencing, etc. Therapy must be considered medically appropriate even for patients who do not have apparent speech problems, but who do have deficits in higher-level language functioning as a result of trauma or identifiable organic Disease process.

Stability Period: A period selected by the Employer that immediately follows, and is associated with, a Standard Measurement Period or an Initial Measurement Period and, if elected by the Employer, the Administrative Period associated with that Standard Measurement Period or Initial Measurement Period, and is used by the Employer as part of the look back Measurement Method. The Stability Period is a period of time in which the Variable Hour Employee's and/or Ongoing Employee's eligibility status is fixed.

Status Change: Cafeteria plans (under Section 125 of the Internal Revenue Code) permit coverage changes during a Plan Year when a change in status occurs that affects gain or loss of eligibility for coverage for the Employee, the Employee's spouse or Dependent. Some examples of a Status Change are: change in Employee's legal marital status, change in number of Employee's Dependents, change in employment status of Employee, spouse or Dependent and loss of other coverage.

Substance Abuse: The excessive use of a substance, especially alcohol or a Drug. The current edition of *Diagnostic and Statistical Manual* definition is applied as follows:

1. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a twelve (12) month period:

    a. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (i.e., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of Children or household);
    b. Recurrent substance use in situations in which it is physically hazardous (i.e., driving an automobile or operating a machine when impaired by substance use);
    c. Recurrent substance-related legal problems (i.e., arrests for substance-related disorderly conduct); and
    d. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (i.e., arguments with spouse about consequences of intoxication, physical fights).

2. The symptoms have never met the criteria for Substance Dependence for this class of substance.

Substance Abuse Treatment Center: An Institution which provides a program for the treatment of Substance Abuse by means of a written treatment plan approved and monitored by a Physician. This Institution must be:

1. Affiliated with a Hospital under a contractual agreement with an established system for patient referral;
2. Accredited as such a Facility by the Joint Commission on Accreditation of Hospitals; or
3. Licensed, certified or approved as an alcohol or Substance Abuse treatment program or center by a State agency having legal authority to do so.

Substance Dependence: Substance use history which includes the following:

1. Substance abuse (see above);
2. Continuation of use despite related problems;
3. Development of tolerance (more of the Drug is needed to achieve the same effect); and
4. Withdrawal symptoms.

Surgery: Any of the following:

1. The incision, excision, debridement or cauterization of any organ or part of the body, and the suturing of a wound;
2. The manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;
3. The removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body;
4. The induction of artificial pneumothorax and the injection of sclerosing solutions;
5. Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;
6. Obstetrical delivery and dilatation and curettage; or
7. Biopsy.

Surgical Procedure: Surgical Procedures will include all CPT (Current Procedural Terminology) codes from 10000 to 69999.

TEFRA: Tax Equity and Fiscal Responsibility Act of 1982, as amended from time to time.

Temporomandibular Joint (TMJ) Disorders: Disorders that affect the temporomandibular joints at either side of the jaw also known as myofascial pain-dysfunction syndrome.

Total Disability (Totally Disabled): A physical state of a Covered Person resulting from an Illness or Injury which wholly prevents:

1. An Employee from engaging in any and every business or occupation and from performing any and all work for compensation or profit; or
2. A Dependent or a COBRA Qualified Beneficiary from performing the normal activities of a person of that age and sex in good health.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA): A Federal law which applies to persons who have been absent from work because of "service in the uniformed services." "Uniformed services" consists of the United States Army, Navy, Marine Corps, Air Force or Coast Guard; Army Reserve, Naval Reserve, Marine Corps Reserve, Air Force Reserve or Coast Guard Reserve; Army National Guard or Air National Guard; Commissioned Corps of the Public Health Service; any other category of persons designated by the President in time of war or Emergency. "Service" in the uniformed services means: active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty and absence from work for an examination to determine a person's fitness for any of the designated types of duty.

UR Notification: A Plan requirement for a Covered Person to advise Utilization Review of a Hospital admission, health care service, treatment plan, Prescription Drug or Durable Medical Equipment that results in a decision by the Plan that such service is Medically Necessary. The Plan may require notification for certain services as they are received, except in an Emergency. UR Notification is not a guarantee the Plan will cover the cost of such services.

Urgent Care Facility (Minor Emergency Medical Clinic): A Free-standing Facility which is engaged primarily in providing minor Emergency and episodic medical care to a Covered Person. A board-certified Physician, a Registered Nurse (RN), and a registered x-ray technician must be in attendance at all times that the clinic is open. The clinic's Facilities must include x-ray and laboratory equipment and a life support system. For the purposes of this Plan, a clinic meeting these requirements will be considered to be an Urgent Care Facility (Minor Emergency Medical Clinic), by whatever actual name it may be called; however, a clinic located on the premises of, or in conjunction with, or in any way made a part of, a regular Hospital shall be excluded from the terms of this definition.

Usual and Customary: Covered expenses which are identified by the Plan Administrator, taking into consideration the fee(s) which the Provider most frequently charges the majority of patients for the service or supply, the cost to the Provider for providing the services, the prevailing range of fees charged in the same "area" by Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care Facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was incurred.

The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of an individual of the same sex, comparable age and who has received such services or supplies within the same geographic locale.

The term "Usual and Customary" does not necessarily mean the actual charge made nor the specific service or supply furnished to a Plan Participant by a Provider of services or supplies, such as a Physician, therapist, Nurse, Hospital, or pharmacist. The Plan Administrator will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service or supply is customary.

Usual and Customary charges may, at the Plan Administrator's discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

For Claim determinations made in accordance with the Claim Review and Audit Program, the Usual and Customary fee will be the Allowable Claim Limits. Please refer to the section, “Claim Review and Audit Program,” for the definition of Allowable Claim Limits.

Utilization Review (UR): Process by which consistent and measurable standards are applied in which to evaluate and control health care utilization by determining appropriateness of care, setting and Medical Necessity.

Utilization Review (UR) Department: GPA’s HealthWatch department, providing consistent and measurable standards in which to evaluate and control health care utilization by determining appropriateness of care, setting and Medical Necessity. The Utilization Review department's role is to ensure the best use of health care services, eliminating unnecessary costs while maintaining consideration for the patient's best interests.

Variable Hour Employee: An Employee, based on the facts and circumstances at the Employee’s start date, whose reasonable expectation of average hours per week cannot be determined. **This also includes Part-time, Temporary and Seasonal Employees.**

Waiting Period: The period of time that must pass before Plan coverage can become effective for an otherwise Eligible Employee or Dependent. An Employee shall be deemed Actively at Work if the Employee is absent from work due to a health factor.

Well Baby Care or Well Child Care: Medical treatment, services or supplies rendered to a Child, solely for the purpose of health maintenance and not for the treatment of an Illness or Injury, to include medical screenings for vision and hearing.

APPENDIX I

STATES WITH CONSUMER ASSISTANCE PROGRAMS UNDER PHS ACT SECTION 2793

** Current as of January 3, 2018**

(Periodic updates will be posted at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html)

In addition to the State information provided in the chart below, the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) may also be a helpful resource to participants and beneficiaries in need of assistance. Plans and issuers are encouraged to include EBSA's contact information in their notices as well. (EBSA contact information is also included in the Department's model notices.)

EBSA may be contacted at: 1-866-444-EBSA (3272) or www.askebsa.dol.gov.

State	Contact Information
Alabama	No program
Alaska	No program
American Samoa	No program
Arizona	No program
Arkansas	Arkansas Insurance Department, Consumer Services Division 1200 West Third St. Little Rock, AR 72201 (800) 852-5494 http://insurance.arkansas.gov/pages/consumer-services/consumer-services/ (website) Insurance.consumers@arkansas.gov (email)
California	California Consumer Assistance Program Operated by the California Department of Managed Health Care and Department of Insurance 980 9th St, Suite #500 Sacramento, CA 95814 (888) 466-2219 http://www.HealthHelp.ca.gov (website)
Colorado	No program
Commonwealth of Northern Mariana Islands	No program
Connecticut	Connecticut Office of the Healthcare Advocate P.O. Box 1543 Hartford, CT 06144 (866) 466-4446 http://www.ct.gov/oha/site/default.asp (website) healthcare.advocate@ct.gov (email)
Delaware	Delaware Department of Insurance 841 Silver Lake Blvd Dover, DE 19904 (302) 674-7310 http://www.delawareinsurance.gov (website) consumer@state.de.us (email)
District of Columbia	DC Office of the Health Care Ombudsman and Bill of Rights One Judiciary Square 441 4th Street, NW, 900 South Washington, DC 20001 (877) 685-6391 http://healthcareombudsman.dc.gov (website)

State	Contact Information
	healthcareombudsman@dc.gov (email)
Florida	No program
Georgia	Georgia Office of Insurance and Safety Fire Commissioner Consumer Services Division 2 Martin Luther King, Jr. Drive West Tower, Suite 716 Atlanta, Georgia 30334 (800) 656-2298 http://www.oci.ga.gov/ConsumerService/Home.aspx (website)
Guam	Guam Department of Revenue and Taxation 1240 Army Drive Barrigada, Guam 96921 (671) 635-1846
Hawaii	No program
Idaho	No program
Illinois	Illinois Department of Insurance 320 W. Washington St, 4th Floor Springfield, IL 62767 (866) 445-5364 http://insurance.illinois.gov/healthinsurance/consumerHealth.html (website) DOI.Director@illinois.gov (email)
Indiana	No program
Iowa	No program
Kansas	Kansas Insurance Department Consumer Assistance Division 420 SW 9th Street Topeka, KS 66612-1678 (800) 432-2484 (in state) 785-296-7829 (all others) http://www.ksinsurance.org (website) CAP@ksinsurance.org (email)
Kentucky	Kentucky Department of Insurance Division of Consumer Protection P.O. Box 517 Frankfort, KY 40602 (800) 595-6053 http://insurance.ky.gov (website) consumerservices@ky.gov (email)
Louisiana	No program
Maine	Consumers for Affordable Health Care Maine Health Insurance Consumer Assistance Program (MHICAP) 12 Church Street, P.O. Box 2490 Augusta, ME 04338-2490 (800) 965-7476 http://www.mainecahc.org (website) consumerhealth@mainecahc.org (email)
Maryland	Maryland Office of the Attorney General Health Education and Advocacy Unit 200 St. Paul Place, 16th Floor Baltimore, MD 21202 (877) 261-8807 http://marylandattorneygeneral.gov/Pages/Pages/HEAU/default.aspx (website) heau@oag.state.md.us (email)
Massachusetts	Health Policy Commission

State	Contact Information
	Office of Patient Protection (OPP) 50 Milk Street, 8th Floor Boston, MA 02109 (800) 436-7757 http://www.mass.gov/hpc/opp (website) HPC-OPP@state.ma.us (email)
Michigan	Michigan Health Insurance Consumer Assistance Program (HICAP) Michigan Department of Insurance and Financial Services (DIFS) P.O. Box 3020 Lansing, MI 48909-7720 (877) 999-6442 http://www.michigan.gov/difs (website) difs-hicap@michigan.gov (email)
Minnesota	No program
Mississippi	Health Help Mississippi 800 North President Street Jackson, MS 39202 (877) 314-3843 http://www.healthhelpms.org (website) healthhelpms@mhap.org (email)
Missouri	Missouri Department of Insurance Truman State Office Building, Room 530 P.O. Box 690 Jefferson City, MO 65102 (800) 726-7390 http://insurance.mo.gov/consumers/ (website) consumeraffairs@insurance.mo.gov (email)
Montana	Office of the Montana State Auditor Commissioner of Securities and Insurance 840 Helena Ave Helena, MT 59601 (800) 332-6148 (in-state only) (406) 444-2040 http://www.montanahealthanswers.com (website)
Nebraska	No program
Nevada	Nevada Department of Health and Human Services Office of Consumer Health Assistance Governor's Consumer Health Advocate 555 East Washington Ave, Suite 4800 Las Vegas, NV 89101 (702) 486-3587 (888) 333-1597 http://dhhs.nv.gov/Programs/CHA (website) cha@govcha.nv.gov (email)
New Hampshire	New Hampshire Department of Insurance 21 South Fruit Street, Suite 14 Concord, NH 03301 (800) 852-3416 https://nh/gov/insurance/consumers/health.htm (website) consumerservices@ins.nh.gov (email)
New Jersey	New Jersey Department of Banking and Insurance 20 West State Street, P.O. Box 325 Trenton, NJ 08625 (800) 446-7467 (609) 292-7272

State	Contact Information
	http://www.state.nj.us/dobi/consumer.htm (website) ombudsman@dobi.state.nj.us (email)
New Mexico	New Mexico Office of Superintendent of Insurance Managed Health Care Bureau Phone: (855) 427-5674 Fax: (505) 427-5674 Online submission http://osi.state.nm.us/consumer-assistance/forms/managed-healthcare.html
New York	Community Service Society of New York, Community Health Advocates 633 Third Avenue, 10th floor New York, NY 10017 (888) 614-5400 http://www.communityhealthadvocates.org/ (website) cha@cssny.org (email)
North Carolina	North Carolina Department of Insurance Health Insurance Smart NC 430 N. Salisbury Street Suite 1018 Raleigh, NC 27603 (855) 408-1212 http://www.ncdoi.com/Consumers/Health/Smart_NC.aspxh (website) Eastern Regional Office: North Carolina Department of Insurance Health Insurance Smart NC 1316 Unit A Commerce Drive New Bern, NC 28562 Western Regional Office: North Carolina Department of Insurance Health Insurance Smart NC 537 College Street Asheville, NC 28801
North Dakota	No program
Ohio	No program
Oklahoma	Oklahoma Insurance Department Five Corporate Plaza 3625 Northwest 56th Street, Suite 100 Oklahoma City, OK 73112 (800) 522-0071 (in-state only) (405) 521-2828 https://www.ok.gov/oid/Consumers/Consumer_Assistance/ (website)
Oregon	Oregon Health Connect 1435 NE 81st Ave. Suite 500 Portland, OR 97213-6759 (866) 698-6155 http://211info.org/health/ (website) healthconnect@211info.org (email)
Pennsylvania	Pennsylvania Insurance Department 1209 Strawberry Square Harrisburg, PA 17120 (877) 881-6388 http://www.insurance.pa.gov/Consumers/Pages/default.aspx (website)

State	Contact Information
Puerto Rico	Puerto Rico Oficina de la Procuradora del Paciente Calle Recinto Sur #303 San Juan, PR 00910 (787) 979-0909 http://www.pr.gov/ (website) querellas@opp.gobierno.pr (email)
Rhode Island	Rhode Island Consumer Assistance Program Rhode Island Parent Information Network, Inc. 1210 Pontiac Avenue Cranston, RI 02920 (855) 747-3224 http://www.rireach.org/ (website) rireach@ripin.org (email)
South Carolina	South Carolina Department of Insurance Office of Consumer Services P.O. Box 100105 Columbia, SC 29202 (800) 768-3467 (803) 737-6180 http://www.doi.sc.gov/638/Health-Insurance (website) consumers@doi.sc.gov (email)
South Dakota	No program
Tennessee	Tennessee Department of Commerce and Insurance 500 James Robertson Pkwy Davy Crockett Tower, 4th floor Nashville, TN 37243-0565 (615) 741-2241 http://www.tn.gov/commerce/section/consumer-services (website)
Texas	Texas Consumer Health Assistance Program Consumer Protection (111-1A) 333 Guadalupe P.O. Box 149091 Austin, TX 78714-9091 (800) 252-3439 http://www.texashealthoptions.com (website) ConsumerProtection@tdi.texas.gov (email)
Utah	No program
Vermont	Vermont Legal Aid 264 North Winooski Ave. Burlington, VT 05402 (800) 889-2047 http://www.vtlegalaid.org (website)
Virginia	Virginia State Corporation Commission Bureau of Insurance P.O. Box 1157 Richmond, VA 23218 (804) 371-9741 http://www.scc.virginia.gov/boi/cons/index.aspx (website) bureauofinsurance@scc.virginia.gov (email)
Virgin Islands	U.S. Virgin Islands Division of Banking and Insurance 1131 King Street Suite 101 Christiansted St. Croix, VI 00820 (340) 773-6459

State	Contact Information
	http://ltg.gov.vi (website)
Washington	Washington State Office of the Insurance Commissioner 5000 Capitol Blvd, SE Tumwater, WA 98501 (800) 562-6900 https://www.insurance.wa.gov/ (website) cap@oic.wa.gov (email)
West Virginia	West Virginia Office of the Insurance Commissioner Consumer Service Division P.O. Box 50540 Charleston, WV 25305-0540 (888) 879-9842 http://www/wvinsurance.gov/ConsumerServices/ConsumerServices.aspx (website)
Wisconsin	No program
Wyoming	No program

AGENDA ITEM or FINAL CONTRACT REVIEW SUBMITTAL FORM

Agenda Item: Grant Application; MetRec; Gunnison/Hinsdale Early

Action Requested: Other Grant Application Approval

Parties to the Agreement: Met Rec

Term Begins: May 2026 **Term Ends:** **Grant Contract #:**

Summary:

HHS would like to apply to the 2026 Met Rec grant funding for Summer Scholarships for PreK - 5th graders. $15,000

Fiscal Impact: 15,000

Submitted by: Margaret Wacker **Submitter's Email Address:** mwacker@gunnisoncounty.org

Finance Review: (●) Required ( ) Not Required

Comments:

Reviewed by: GUNCOUNTY1\mrozman Discharge Date: 2/25/2026

County Attorney Review: (●) Required ( ) Not Required

Comments:
Legally sufficient. SO 2/24/26

Reveiwed by: GUNCOUNTY1\sobaid Discharge Date: 2/24/2026 Certificate of Insurance Required

Yes ( ) No (●)

County Manager Review:

Comments:

Reveiwed by: GUNCOUNTY1\mbirnie Discharge Date: 2/25/2026

(●) Consent Agenda ( ) Regular Agenda ( ) Worksession Time Allotted: 0

Agenda Date: 3/3/2026

Revised April 2015

Organization Name*

Gunnison County dba Gunnison Hinsdale Early Childhood Council

Organization Address:*

220 N. Spruce Street, Gunnison, CO 81230

Is your organization a municipality, government agency, or nonprofit?*

Government

Will the product of this grant application be available to the public?*

Yes

Where is your organization based?*

South Subdistrict

Contact person name:*

Corrine Jaeger

Contact person phone number:*

970.641.3244

Contact person email address:*

Corrine Jaeger cjaeger@gunnisoncounty.org

Organizational website link*

www.gunnisoncounty.org/ghecc

Your organization's vision:*

Our vision is to ensure the healthy growth and optimal development of all young children so that each child is ready to succeed in school and life.

Your organization's mission:*

Our mission is to expand and improve quality early childhood services and education opportunities for families in Gunnison and Hinsdale Counties.

Who will direct your community project?*

Corrine Jaeger, Early Childhood Services Coordinator

Community project information

Tell us about your project below.

Community grant title:
Universal Summer Scholarship Program PreK – 5th grade

Your answer

Location of your project.*

Gunnison County

Expected start and completion dates for the project/program/service this grant would support:*

The summer programming that we are requesting scholarship support for will run from June 2026-August 2026

Project Description (20 Points): Provide a high-level description of the project you are proposing in this application. (50 words limit) *

Our organization is requesting funding for a summer scholarship program. We plan to offer scholarships to PreK through 5th grade students accessing summer programming. A scholarship application has been created for families to apply for support. Families that demonstrate the greatest financial need will be prioritized.

MetRec Alignment (20 Points): If you were awarded a grant, describe how your project/program/service aligns with MetRec's stated recreation grant funding purpose. (50 words limit) *

The scholarship program will support families with young children who otherwise might not have the financial means to access summer programming offerings. The scholarship program was developed in a collaborative effort between local non-profits and public entities to ensure that all children have access to summer programming and recreation opportunities.

Community Need and Impact (20 Points): How did you engage the community to determine their need? Explain how your project addresses the need and the potential for sustained impact within the community. What specific need or issues does it aim to address? (200 words limit) *

With the school district's Summer Experience program not being offered in summer 2025, a group of family-serving organizations from both the nonprofit and public sectors joined forces to address the gap. This collaborative effort includes Gunnison Valley Mentors, Gunnison County Juvenile Services, Gunnison Recreation Center, Gunnison County Health and Human Services, Western Colorado University, Mountain Roots Food Project, and the Community & Family Coordinator at Crested Butte Community School. Several programs increased enrollment capacity to better meet local demand. This group has continued to meet through out 2025 and 2026 in order to continue this well utilized program.

In 2026, the district's Summer Experience program will return; however, it will be offered at a significantly higher cost than in previous years. What was once a highly affordable $25 enrollment option is now $150, making it no longer financially accessible for many families. While there is now greater availability across multiple summer programs in Gunnison and Crested Butte, affordability

remains a substantial barrier. To ensure equitable access to both the reinstated Summer Experience program and other summer offerings, the coalition agreed that establishing and expanding a centralized scholarship fund is essential to support families with the greatest financial need and prevent cost from limiting participation.

Innovative Impact (20 points) How does your project bring innovative solutions to address community needs? Discuss the project's potential for adaptability and its unique aspects compared to existing solutions. (200 words limit)

Over the past year, partner organizations worked collectively to assess the impact of changes to the Summer Experience program, identify available summer programming across the valley, explore opportunities to expand enrollment capacity, and address workforce needs. As a result, a coordinated scholarship process was developed to ensure that children who would otherwise be unable to access summer programming due to cost could participate.

Through this effort, 71 families received financial assistance, supporting 125 children in attending summer programs in Gunnison and Crested Butte. The centralized scholarship application was intentionally designed to help the review committee prioritize families with the greatest financial need. While scholarships may not cover the full cost of every program, they significantly reduce financial barriers.

Continued investment in this scholarship fund is essential to sustain and expand this impact, particularly as summer programming costs remain elevated. Ongoing funding will ensure equitable access for local children and maintain the strong collaborative model that makes this effort successful.

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Budget (20 points): Provide a comprehensive, itemized budget for your project (see attachment list below). Explain, in narrative form, how MetRec funds will be spent. What percentage of the total project cost is your organization matching in cash? (200 words limit)*

All funds received from MetRec will be used to provide scholarships between $100-$400 / child. The scholarship application was opened 10 days prior to the opening of summer programming registration. All applications are reviewed by the scholarship committee and families demonstrating the greatest financial need will be awarded scholarship funds. The amount of the scholarship funding that will be awarded for each child will be dependent on the family's need and the number of families applying for support. Scholarships funds will be paid directly to the program that the child is enrolled in. No direct payments will go out to families.

At this time we expect to receive $17,000 in matching funds.

What population does your project serve? (50 words limit)*

Families with children in PreK through 5th grade.

Total project cost: (Note, total project cost should be met by the total matching funds amount and MetRec grant request)*

$32,000

Total matching funds amount:*

$17,000

List the sources and amounts of matching funds (Note, the sources and amounts should equal your total matching funds amount):*

- $9,000 – Community Based Child Abuse Prevention Funding
- $8,000 - Child Welfare Family Voice Funding

Are any of your matching funds unsecured at the time of your application submission? If so, how do you plan to raise the unsecured funds.*

NA

Grant award request amount:*

$15,000

AGENDA ITEM or FINAL CONTRACT REVIEW SUBMITTAL FORM

Agenda Item: Teacher Professional Development Services Order Fo

Action Requested: Board of County Commissioners' Signature

Parties to the Agreement: Denver Museum of Nature and Science

Term Begins: April 25, 2026 **Term Ends:** **Grant Contract #:**

Summary:

HHS would like to sign the MOU with Denver Museum of Nature and Science to pay $875 for their presentation and the Early Childhood Conference on 4/25/26.

Fiscal Impact: 875

Submitted by: Margaret Wacker **Submitter's Email Address:** mwacker@gunnisoncounty.org

Finance Review: (●) Required ( ) Not Required

Comments:

Reviewed by: GUNCOUNTY1\mrozman Discharge Date: 2/25/2026

County Attorney Review: (●) Required ( ) Not Required

Comments:
Legally sufficient. SO 2/23/26

Reveiwed by: GUNCOUNTY1\sobaid Discharge Date: 2/23/2026 Certificate of Insurance Required

Yes ( ) No (●)

County Manager Review:

Comments:

Reveiwed by: GUNCOUNTY1\mbirnie Discharge Date: 2/25/2026

(●) Consent Agenda ( ) Regular Agenda ( ) Worksession Time Allotted: 0

Agenda Date: 3/3/2026

Revised April 2015

DENVER MUSEUM OF NATURE & SCIENCE

Teacher Professional Development Services Order Form

This Order Form confirms that Teacher Professional Development (TPD) services will be provided by the Denver Museum of Nature & Science, a nonprofit Colorado corporation, to Gunnison Hinsdale Early Childhood Council ("Participant") as follows:

1. **Description of Services.** TPD services will be provided for the cost and as described in the attached TPD Plan, incorporated by reference.

2. **Ownership.** All intellectual property created by the Museum and provided to the Participant, including without limitation all educational materials, images, and other documentation in any media whether tangible or intangible, shall for all purposes, including patent, trademark or copyright purposes, be the sole and unrestricted property of Museum.

3. **License & Credit & Use**. Upon full payment (unless waived by the Museum) Participant will have a license to use the materials for educational purposes, provided that materials are not sold to others and that attribution is given to DMNS and/or any third parties as set forth herein and in the materials provided by DMNS.

4. **Third Party Material**. DMNS may also provide materials from third parties that are not in the public domain, in which case DMNS has the necessary permissions and licenses in place to convey the materials to the Participant for its use. Participant is responsible for procuring permission from 3 rd parties for any additional use.

5. **Payment**. Payment shall be made to the Museum 21 days prior to the first program date.

DENVER MUSEUM OF NATURE & SCIENCE:

By: _____

PARTICIPANT:

By: _____

Print Name: _____ Print Title: _____

DENVER MUSEUM OF NATURE & SCIENCE

Drafted 2/1/2026

Workshop Series Title:

Simple Routines, BIG Science! (Abbreviated)

Date(s)/Time(s)

Saturday, April 25, 2026
1:00 – 4:00

In-Person Location:

Western Colorado University 1 Western Way, Gunnison, CO 81231)

General Details:

The *Gunnison Hinsdale Early Childhood Council* will host a *Denver Museum of Nature & Science (*DMNS) facilitator to deliver one, ninety-minute workshop on April 25, 2026 for all ECE educators, FFNs and other home care providers in the region. Attendance will range from 40 – 60 people. Participants will be eligible to receive credit for professional learning time though Colorado Shines. The Council will oversee the distribution of accreditation via PDIS. The DMNS facilitator will provide folders with notes and additional resources for each participant to take home with them, as well as an education collection for the group to use during the workshop itself.

DMNS Facilitator:

Tamera Sakotas
Teacher Programs Consultant
Email: Tamera.sakotas@dmns.org
Tamera's Cell Phone: 917-279-4269

Gunnison Hinsdale Early Childhood Council Point of Contact:

Corrine Jaegar
Cjaeger@gunnisoncounty.org
Council Coordinator
970-642-4660

General Workshop Description:

Educators will uncover their own science identities, ensuring their classrooms reflect an accurate and inclusive view of what it means to be a scientist. How do our perceptions shape students' enthusiasm or apathy? How can we enhance our learners' natural desire to explore and make sense of the world? Through research-driven, hands-on activities, participants will experience ways they can engage students in simple thinking routines that build upon their innate skills and curiosities. Educators will walk away with tools that can immediately and simply be applied in the classroom. The original workshop duration is three hours but will be modified into a ninety-minute format to accommodate this conference experience.

Cost Projections:

The Denver Museum of Nature & Science agrees to cover all expenses related to program administration and facilitation costs. The *Gunnison Hinsdale Early Childhood Council* will provide a stipend to cover mileage, food and lodging for the Museum facilitator. The financial breakdown is as follows:

Mileage: 414 x .725 = $300
Hotel: $425 (2 nights plus taxes)
Per Diem: $150 (Average daily meal cost is $50)
Gunnison Hinsdale Early Childhood Council will be invoiced in the amount of $875.

AGENDA ITEM or FINAL CONTRACT REVIEW SUBMITTAL FORM

Agenda Item: Acknowledgment of County Manager's Signature; Prof

Action Requested: County Manager Signature

Parties to the Agreement:

Term Begins: **Term Ends:** **Grant Contract #:**

Summary:

Professional Services Agreement; Little Foot Building

Fiscal Impact: 60,000

Submitted by: Holly Perry **Submitter's Email Address:** hperry@gunnisoncounty.org

Finance Review: (●) Required ( ) Not Required

Comments:

Reviewed by: GUNCOUNTY1\mrozman Discharge Date: 2/25/2026

County Attorney Review: (●) Required ( ) Not Required

Comments:
Legally sufficient. SO 2/25/26

Reveiwed by: GUNCOUNTY1\sobaid Discharge Date: 2/25/2026 Certificate of Insurance Required

Yes (●) No ( )

County Manager Review:

Comments:

Reveiwed by: GUNCOUNTY1\mbirnie Discharge Date: 2/25/2026

(●) Consent Agenda ( ) Regular Agenda ( ) Worksession Time Allotted: 0

Agenda Date: 3/3/2026

Revised April 2015

PROFESSIONAL SERVICES AGREEMENT

THIS PROFESSIONAL SERVICES AGREEMENT ("Agreement") made effective the 1 day of January 2026, by and between the Board of County Commissioners of the County of Gunnison, Colorado, whose address is 200 East Virginia, Gunnison, CO 81230 (herein "Gunnison County") and Little Foot Building LLC, whose address is 103 Floresta St Gunnison CO (herein "Contractor")

RECITALS

The Contractor desires to provide professional services regarding as identified in the Scope of Work attached hereto and incorporated herein by reference as Appendix "A ("Services").

Gunnison County desires to engage Contractor to provide Services according to this Agreement.

AGREEMENT

NOW THEREFORE, in consideration of the Recitals and the mutual covenants and obligations hereinafter set forth, the parties agree as follows:

1. SERVICES.

Contractor shall furnish all materials, labor, supervision, supplies and equipment to commence, diligently pursue, and complete the Services. All Services shall be performed in a timely manner and in accordance with generally accepted standards for Contractor's profession and all applicable federal, state and local laws and regulations affecting the Services or their subject matter. Contractor acknowledges that this is a non-exclusive Agreement, and Gunnison County may contract with additional or other providers able to furnish the same or similar services as it deems appropriate to do so.

2. TERM.

The term of this Agreement shall commence on the date first set forth above and shall terminate on December 31, 2026, unless sooner terminated or replaced as provided herein.

3. STRATEGIC RESULT.

Execution of this Agreement will assist the County with its GV-HEAT implementation strategy, as outlined in the Gunnison County Strategic Plan.

4. COMPENSATION, BONUS AND EXPENSES.

In consideration and exchange for Contractor's performance of the Services, during the Term, Gunnison County shall pay Contractor fees as more specifically not to exceed sixty thousand and No/100 U. S. Dollars ($60,000.00) over the course of the year. Payment shall be made by Gunnison County to Contractor within 45 days of receipt of an invoice.

The Compensation shall compensate Contractor for all charges, expenses, overhead, payroll costs, employee benefits, insurance subsistence, and profits, except as specifically set forth in this Agreement.

5. INSURANCE.

Contractor agrees that at all times during the Term of this Agreement, and for three (3) years after the date the Term of this Agreement expires or the date this Agreement is terminated, or any applicable warranty period, Contractor shall maintain, in full force and effect and at its sole cost and expense, the following insurance policies. Within thirty (30) days of the execution of this Agreement, Contractor will provide insurance certificates to Gunnison County, listing Gunnison County as an additional insured, for the coverages required by this paragraph, which shall state that such policies shall not be materially changed or cancelled without thirty (30) days prior notice to Gunnison County. Written notice shall be sent to the parties identified in the Notices section of this Agreement and sent thirty (30) days prior to any cancellation or non-renewal unless due to non-payment of premiums, in which case, notice shall be sent ten (10) days prior. If written notice is unavailable from the insurer, Contractor shall provide written notice of cancellation, non-renewal and any reduction in coverage to the parties identified in the Notices section by certified mail, return receipt requested within three (3) business days of such notice by its insurer(s).

a. Worker's Compensation Insurance in accordance with Colorado and Federal law which adequately protects all labor employed by Contractor during the term of this Agreement.

b. Comprehensive General Liability Insurance or the equivalent in an amount no less than Four Hundred Twenty-Four Thousand and No/100 U.S. Dollars ($424,000.00) for injury to one person in any single occurrence; and no less than One Million One Hundred Ninety-Five Thousand and No/100 U.S. Dollars ($1,195,000.00) for injur(ies) to two or more persons in any single occurrence (i.e., in the aggregate).

c. Comprehensive automobile liability insurance on all vehicles used in the Services, in an amount no less than Four Hundred Twenty-Four Thousand and No/100 U.S. Dollars ($424,000.00) for injury to one person in any single occurrence; and no less than One Million One Hundred Ninety-Five Thousand and No/100 U.S. Dollars ($1,195,000.00) for injur(ies) to two or more persons in any single occurrence (i.e., in the aggregate).

d. Professional Liability Insurance or the equivalent, such as Errors and Omissions

coverage, in an amount no less than Four Hundred Twenty-Four Thousand and No/100 U.S. Dollars ($424,000.00) for injury to one person in any single occurrence; and no less than One Million One Hundred Ninety-Five Thousand and No/100 U.S. Dollars ($1,195,000.00) for any injur(ies) to two or more persons in any single occurrence (i.e., in the aggregate).

The required insurance shall be underwritten by an insurer licensed or authorized to do business in Colorado. Combinations of primary and excess coverage may be used to achieve minimum coverage limits. Excess/umbrella policy(ies) must follow form of the primary policy(ies) with which they are related to provide the minimum limits and be verified as such on any submitted Certificate of Insurance. The County's acceptance of a certificate of insurance or other proof of insurance that does not comply with all insurance requirements set forth in this Agreement shall not act as a waiver of Contractor's breach of this Agreement or of any of the County's rights or remedies under this Agreement.

If excluded from any policy coverage, this Agreement shall be specifically named an insured contract. If any policy is in excess of a deductible or self-insured retention, the County must be notified by the Contractor. Contractor shall be responsible for the payment of any deductible or self-insured retention. Defense costs shall be in addition to the limits of liability. If this provision is unavailable that limitation must be evidenced on the Certificate of Insurance. A severability of interests or separation of insureds provision (no insured vs. insured exclusion) must be included. A provision that coverage is primary and non-contributory with other coverage or self-insurance maintained by the County, excluding Professional Liability and Workers Compensation policies, if required.

For all coverages required under this Agreement, Contractor's insurer(s) shall waive subrogation rights against the County by policy endorsement. All subcontractors and subconsultants (including independent contractors, suppliers or other entities providing goods or services required by this Agreement) shall be subject to all of the requirements herein and shall procure and maintain the same coverages required of the Contractor. Contractor shall include all such subcontractors as additional insured under its policies (with the exception of Workers' Compensation) or shall ensure that all such subcontractors and subconsultants maintain the required coverages. Contractor agrees to provide proof of insurance for all such subcontractors and subconsultants upon request by the County.

The insurance coverages specified in this Agreement are the minimum requirements, and these requirements do not lessen or limit the liability of the Contractor to the County under this Agreement. The Contractor shall maintain, at its own expense, any additional kinds or amounts

of insurance that it may deem necessary to cover its obligations and liabilities under this Agreement.

The insurance provisions of this Agreement shall survive expiration or termination of this Agreement.

6. INDEPENDENT CONTRACTOR.

In carrying out its obligations and activities under this Agreement, Contractor is acting as an independent contractor and not as an agent, partner, joint venture or employee of Gunnison County. Contractor does not have any authority to bind Gunnison County in any manner whatsoever.

Contractor acknowledges and agrees that Contractor is not entitled to: (i) unemployment insurance benefits; or (ii) Workers Compensation coverage, from Gunnison County. Further, Contractor is obligated to pay all applicable federal, state and local taxes owed in relation to the services.

7. INDEMNIFICATION.

Contractor irrevocably and unconditionally agrees to indemnify, defend and hold harmless Gunnison County, its Commissioners, agents and employees of and from any and all liability, claims, liens, demands, actions and causes of action whatsoever (including reasonable attorney's and expert's fees and costs) arising out of or related to any loss, cost, damage or injury, including death, of any person or damage to property of any kind caused by the misconduct or negligent acts, errors or omissions of Contractor or its employees, subcontractors or agents in connection with this Agreement. Further, the County shall not be liable to Contractor or its affiliates for any loss of anticipated business opportunities, contracts, revenues, profits or savings; damage to goodwill or reputation; or indirect, special or consequential loss or damage, arising out of or in connection with this Agreement, whether for breach of contract, in tort (including negligence), under statute or any other law, and Contractor expressly disclaims any such claims or damages as against the County.

In case of any claim that is subject to indemnification under this Agreement, Contractor will provide the County reasonably prompt notice of the relevant claim. Contractor will defend or settle, at its own expense, any demand, action, or suit on any claim subject to indemnification under this Agreement, through legal counsel selected by Contractor but approved by the County. Each party will cooperate in good faith with the other to facilitate the defense of any such claim and the County will tender the defense and settlement of any action or proceeding covered by this Section to Contractor or upon request. Claims may be settled without the consent of the County, unless the settlement includes an admission of wrongdoing, fault or liability by the County, whether express or implied.

This defense and indemnification obligation shall survive any termination or expiration of this Agreement.

8. DISCRIMINATION.

The Contractor agrees to not discriminate against any person or class of persons by reason of age, race, color, sex, creed, religion, disability, national origin, sexual orientation or political affiliation in providing any services or in the use of any facilities provided for the public in any manner prohibited by Part 21 of the Regulations of the Office of the Secretary of Transportation. Contractor shall further comply with the letter and spirit of the Colorado Anti-Discrimination Act of 1957, as amended, and any other laws and regulations respecting discrimination in unfair employment practices. Additionally, Contractor shall comply with such enforcement procedures as any governmental authority might demand that Gunnison County take for the purpose of complying with any such laws and regulations.

9. AMERICANS WITH DISABILITIES ACT COMPLIANCE.

The Contractor represents and warrants to Gunnison County that at all times during the performance of this Agreement no qualified individual with a disability shall, by reason of such disability, be exclude from participation in, or denied benefits of the service, programs, or activities performed by the Contractor, or be subjected to any discrimination by the Contractor upon which assurance Gunnison County relies.

10. MISCELLANEOUS.

a. SEVERABILITY. If any clause or provision of this Agreement shall be held to be invalid in whole or in part, then the remaining clauses and provisions, or portions thereof, shall nevertheless be and remain in full force and effect.

b. AMENDMENT. No amendment, alteration, modification of or addition to this Agreement shall be valid or binding unless expressed in writing and signed by the parties to be bound thereby.

c. NO WAIVER OF GOVERNMENTAL IMMUNITY. The parties hereto understand and agree that the County is relying upon, and has not waived, the monetary limitations and all other rights, immunities and protection provided by the Colorado Governmental Act, § 24-10-101, et seq., C.R.S. Nothing in this Agreement is, or shall be construed to be, a waiver, in whole or part, by Gunnison County of governmental immunity provided by the Colorado Governmental Immunity Act or otherwise.

d. LEGAL AUTHORITY. Contractor represents and warrants that it possesses the legal authority, pursuant to any proper, appropriate and official motion, resolution or action

passed or taken, to enter into the Agreement. Each person signing and executing the Agreement on behalf of Contractor represents and warrants that he has been fully authorized by Contractor to execute the Agreement on behalf of Contractor and to validly and legally bind Contractor to all the terms, performances and provisions of the Agreement. The County shall have the right, in its sole discretion, to either temporarily suspend or permanently terminate the Agreement if there is a dispute as to the legal authority of either Contractor or the person signing the Agreement to enter into the Agreement.

e. NO CONSTRUCTION AGAINST DRAFTING PARTY. The parties and their respective counsel have had the opportunity to review the Agreement, and the Agreement will not be construed against any party merely because any provisions of the Agreement were prepared by a particular party.

f. ORDER OF PRECEDENCE. In the event of any conflicts between the language of the Agreement and any exhibits to it, the language of the Agreement controls.

g. SURVIVAL OF CERTAIN PROVISIONS. The terms of the Agreement and any exhibits and attachments that by reasonable implication contemplate continued performance, rights, or compliance beyond expiration or termination of the Agreement survive the Agreement and will continue to be enforceable. Without limiting the generality of this provision, the Contractor's obligations to provide insurance and to indemnify the County will survive for a period equal to any and all relevant statutes of limitation, plus the time necessary to fully resolve any claims, matters, or actions begun within that period.

h. INUREMENT. The rights and obligations of the parties herein set forth shall inure to the benefit of and be binding upon the parties hereto and their respective successors and assigns permitted under this Agreement.

i. TIME IS OF THE ESSENCE. The parties agree that in the performance of the terms, conditions, and requirements of this Agreement, time is of the essence.

j. PARAGRAPH HEADINGS. The captions and headings set forth herein are for convenience of reference only and shall not be construed so as to define or limit the terms and provisions hereof.

11. DELEGATION AND ASSIGNMENT.

Contractor shall not delegate or assign its duties under this Agreement without the prior written consent of Gunnison County which consent Gunnison County may withhold in its discretion. Subject to the foregoing, the terms, covenants and conditions of this Agreement shall be binding on the successors and assigns of either party.

12. TERMINATION.

Either party shall have the right to terminate this Agreement at any time, with or without cause, upon thirty (30) days prior written notice to the other. Upon termination, Contractor shall be entitled to compensation for Services performed prior to the date of termination, per the compensation terms provided in this Agreement. Termination shall not affect or prejudice any rights or other remedy that a party may have with respect to the event giving rise to termination or any other rights or other remedy a party may have with respect to breach of this Agreement which existed at or before the date of termination.

13. OWNERSHIP OF PROPERTY.

Any work product, information, materials, goods, or intellectual property generated as a result of the Services shall become the sole and exclusive property of the County, and Contractor agrees to relinquish any rights, implied or otherwise, to such property, including but not limited to any resulting intellectual property rights.

14. WARRANTIES.

Contractor represents and warrants to the County as follows:

a. The Services shall conform to applicable specifications and will be free from deficiencies and defects in materials, workmanship, design or performance, as applicable.

b. All Services shall be performed by qualified personnel in a professional and workmanlike manner, consistent with industry standards.

c. Contractor has the requisite ownership, rights and licenses to perform its obligations under this Agreement and to perform the Services free and clear from all liens, adverse claims, encumbrances and interests of any third party.

d. There are no pending or threatened lawsuits, claims, disputes or actions adversely affecting the Services or Contractor's ability to perform its obligations under this Agreement.

e. Performance of the Services shall not violate, infringe, or misappropriate any patent, copyright, trademark, trade secret, or other intellectual property or proprietary right of any third party.

f. Contractor has the right to and shall assign to County all third-party warranties and indemnities that Contractor receives in connection with any of the Services provided to County. To the extent that Contractor is not permitted to assign any warranties or indemnities to the County, Contractor agrees to specifically identify and enforce those warranties and indemnities on behalf of County to the extent Contractor is permitted to do so under the terms of the applicable third-party agreements.

15. WHEN RIGHTS AND REMEDIES NOT WAIVED.

In no event shall any action by either party constitute or be construed to be a waiver by the other party of any breach of covenant or default which may then exist on the part of the party alleged to be in breach, and the non-breaching party's action or inaction when any such breach or default shall exist shall not impair or prejudice any right or remedy available to that party with respect to such breach or default; and no assent, expressed or implied, to any breach of any one or more covenants, provisions or conditions of the Agreement shall be deemed or taken to be a waiver of any other breach.

16. NO THIRD-PARTY BENEFICIARY.

Enforcement of the terms of the Agreement and all rights of action relating to enforcement are strictly reserved to the parties. Nothing contained in the Agreement gives or allows any claim or right of action to any third person or entity. Any person or entity other than the County or the Contractor receiving services or benefits pursuant to the Agreement is an incidental beneficiary only.

17. CONFLICT OF INTEREST.

The signatories to this Agreement aver to their knowledge, no employee of the County has any personal or beneficial interest whatsoever in the Services. Contractor has no beneficial interest, direct or indirect, that would conflict in any manner or degree with the performance of the Services, and Contractor shall not employ any person having such known interests. The Contractor shall also not engage in any transaction, activity or conduct that would result in a conflict of interest under the Agreement. The Contractor represents that it has disclosed any and all current or potential conflicts of interest. A conflict of interest shall include transactions, activities or conduct that would affect the judgment, actions or work of the Contractor by placing the Contractor's own interests, or the interests of any party with whom the Contractor has a contractual arrangement, in conflict with those of the County. The County, in its sole discretion, will determine the existence of a conflict of interest and may terminate the Agreement in the event it determines a conflict exists, after it has given the Contractor written notice describing the conflict.

18. FORCE MAJEURE.

Neither party shall be responsible for failure to fulfill its obligations hereunder or liable for damages resulting from delay in performance as a result of an unforeseeable event outside the control of such party, and not caused by such party's negligence, including war or armed conflict, fire, flood, strike, riot or insurrection, terrorist attack, nuclear, chemical or biological attack, natural disaster, martial law, unreasonable delay of carriers, governmental order or regulation; PROVIDED, HOWEVER, the any delay caused by the Covid-19 Pandemic (or Endemic), or any other communicable disease pandemic or endemic, shall NOT be considered a force majeure event. If a force majeure event occurs, the time for performance shall be extended by mutual agreement of the parties for a period of time as may be reasonably necessary to compensate for such delay, provided that if such performance still cannot be completed within such extended period of time,

either party may terminate this Agreement and both parties will be released from any further obligation to the other.

19. NOTICES.

Any notice, demand or communication which either party may desire or be required to give to the other party shall be in writing and shall be deemed sufficiently given or rendered if delivered personally or sent by certified first class US mail, postage prepaid, addressed as follows:

Gunnison County: County Manager
Gunnison County
200 E. Virginia
Gunnison, Colorado 81230
Phone: 970-641-0248

With a copy to: Board of County Commissioners of
the County of Gunnison, Colorado 200
E. Virginia
Gunnison, Colorado 81230

Contractor:

Little Foot Building LLC
103 Floresta St.
Gunnison CO 81230

Either party has the right to designate in writing, served as provided above, a different address to which any notice, demand or communication is to be mailed.

20. GOVERNING LAW.

This Agreement shall be governed by and interpreted in accordance with the laws of the State of Colorado. Jurisdiction and venue for any legal proceedings related to this Agreement shall exclusively lie in the State of Colorado District Court located in Gunnison County, Colorado.

21. COUNTERPARTS: FACSIMILE AND ELECTRONIC TRANSMISSION.

This Agreement may be executed by facsimile and/or in any number of counterparts, any or all of which my contain the signatures of less than all the parties, and all of which shall be construed together as but a single instrument and shall be binding on the parties as though originally executed on one originally executed document. All facsimile counterparts shall be promptly followed with delivery of original executed counterparts.

This Agreement may also be executed by electronic means or signatures. Accordingly, the Agreement, and any other documents requiring a signature hereunder, may be signed electronically by the County in the manner specified by the County. The Parties agree not to deny the legal effect

or enforceability of the Agreement solely because it is in electronic form or because an electronic record was used in its formation. The Parties agree not to object to the admissibility of the Agreement in the form of an electronic record, or a paper copy of an electronic document, or a paper copy of a document bearing an electronic signature, on the ground that it is an electronic record or electronic signature or that it is not in its original form or is not an original.

The parties agree that: (i) any notice or communication transmitted by electronic transmission, as defined below, shall be treated in all manner and respects as an original written document; (ii) any such notice or communication shall be considered to have the same binding and legal effect as an original document; and (iii) at the request of either party, any such notice or communication shall be re-delivered or re-executed, as appropriate, by the party in its original form. For purposes of this Agreement, the term "electronic transmission" means any form of communication not directly involving the physical transmission of paper, that creates a record that may be retained, retrieved and reviewed by a recipient thereof, and that may be directly reproduced in paper form by such a recipient through an automated process, but specifically excluding text or instant messages.

22. ENTIRE AGREEMENT.

This Agreement comprises the entire agreement between County and Contractor and supersedes all prior or contemporaneous negotiations, discussions or agreements, whether written or oral, between the parties regarding the subject matter contained herein. No amendment to or modification of this Agreement will be binding unless in writing and signed by an authorized representative of each party.

Notwithstanding anything to the contrary herein, the County shall not be subject to any provision included in any terms, conditions, or agreements appearing on Contractor's or a subcontractor's website or any provision incorporated into any click-through or online agreements related to the work unless that provision is specifically referenced in this Agreement.

23. RECORDS.

Contractor shall maintain for a minimum of three (3) years, adequate financial and other records for reporting to County. Contractor shall be subject to financial audit by federal, state or county auditors or their designees. Contractor authorizes such audits and inspections of records during normal business hours, upon forty-eight (48) hours' notice to Contractor. Contractor shall fully cooperate during such audit or inspections.

24. PUBLIC RECORD.

To the extent not prohibited by state or federal law, this Agreement is potentially subject to public release through the Colorado Open Records Act. The parties further acknowledge and understand that all work product or materials provided or produced under this Agreement,

including items marked Proprietary or Confidential, may be subject to the Colorado Open Records Act., § 24-72-201, *et seq.*, C.R.S.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date above written.

BOARD OF COUNTY COMMISSIONERS
OF THE COUNTY OF GUNNISON, COLORADO

By: _____
Matthew Birnie, County Manager

ATTEST:

_____
Deputy Clerk

GUNNISON COUNTY SEAL COLORADO

CONTRACTOR

By: Andrew J Tocke

Little Foot Building
Andy Tocke
103 Floresta St.
Gunnison CO 81230
(970) 596-6300
littlefootbuilding@gmail.com
January 22, 2026

Little Foot Building 2026 rate sheet
Valid January 1-December 31, 2026

-Hourly rate: $70
-10% mark-up on all materials installed based on after tax price.
Commonly installed material cost plus markup per unit (does not include labor for installations):
-800 lm LED bulb: $2.59
-1100 lm LED bulb: $4.01
-1600 lm LED bulb: $4.46
-LED flood light bulb: 4.26
-Pipe insulation: $4.55
-Low volt thermostat: $83
-Line volt thermostat: $95.20
-CO sensor: $32.13
-Smoke alarm: $24.99
CO/smoke alarm: $59.50
Cost of other materials are available upon request.

-$5 per hour overhead added to all air sealing and insulation work.
-Travel expense:
-$0.725/mile for singular trips greater than 70 miles.
-$150 per diem
-CARE energy assessments will be reimbursed at $400 with a blower door test and $300 without a blower door test.
-Energy Smart Colorado energy assessments will be reimbursed at $500 on houses up to 3000 sqft. Assessments on houses over 3000 sqft will have an addition charge of $0.05 per sqft over 3000 sqft.

Little Foot Building
Andy Tocke
103 Floresta St.
Gunnison CO 81230
(970) 596-6300
littlefootbuilding@gmail.com
January 26, 2026

To whom it may concern,

I, Andy Tocke the sole proprietor of Little Foot Building and its only employ have opted to Waiver Workers Comp. I understand the risks of this a have found it work for me.

Sincerely,
Andy Tocke
Little Foot Building

AGENDA ITEM or FINAL CONTRACT REVIEW SUBMITTAL FORM

Agenda Item: Grant Application; 2026 Gunnison Rotary Community

Action Requested: County Manager Signature

Parties to the Agreement: Gunnison County

Term Begins: **Term Ends:** **Grant Contract #:**

Summary:

Grant application for FAST kids for summer programing and snacks.

Fiscal Impact:

Submitted by: Kari Commerford **Submitter's Email Address:** kcommerford@gunnisoncounty.org

Finance Review: (•) Required ( ) Not Required

Comments:

Reviewed by: GUNCOUNTY1\mlamonica Discharge Date: 2/20/2026

County Attorney Review: (•) Required ( ) Not Required

Comments:
Legally sufficient. SO 2/20/26

Reveiwed by: GUNCOUNTY1\sobaid Discharge Date: 2/20/2026 Certificate of Insurance Required

Yes ( ) No (•)

County Manager Review:

Comments:

Reveiwed by: GUNCOUNTY1\mbirnie Discharge Date: 2/25/2026

(•) Consent Agenda ( ) Regular Agenda ( ) Worksession Time Allotted: 0

Agenda Date: 3/3/2026

Revised April 2015

APPLICATION FOLLOWS ON NEXT PAGE

2026 Gunnison Rotary Community Grant Application

Read the guidelines, download or replicate this form, insert your answers after each question and then scan and email your application and required attachments. You must answer all questions. The application should not exceed three pages plus required attachments. The grant application deadline is close-of-business on Friday March 13. Applications must be in Rotary hands by that time and late applications will not be accepted. Please email your completed applications to maryo@gard-sibley.org. Questions? Call Maryo Ewell at 970-641-4340.

1. Organization's contact information:

§ Organization name: _Gunnison County Family Advocacy and Support Team (FAST) _____

§ Contact Person: Kari Commerford____ Title: Director of Juvenile Services – FAST Manager_____

§ Address: __202 East Georgia Ave.___

§ Phone: 970-642-7393____ Email: _kcommerford@gunnisoncounty.org_____

2. What is your organization's Mission Statement?

FAST is a program for families who are experiencing multiple social determinates of health and are beyond the scope of any one system/service provider. The FAST team collaborates closely with each family to assess needs, identify achievable goals, and build a coordinated team of professionals who are all working together to support the family's success.
FAST can provide direct referrals to prevention support. For families with multi-system involvement FAST can provide short-term wraparound support. The primary goal of FAST is to help stabilize families by helping
them identify, connect, and maintain their natural supports within their community to foster positive youth health-outcome

3. The intent of this award is to assist youth, with a priority to low-income youth. Describe how you would use an award from Rotary.
We currently have 28 youth in the FAST program and 12 of them are under the age of 12. We would like to provide support for families for summer programming costs and weekly lunch/snack pack sent home since lunch isn't provided. We would like to provide $100 per youth for programming and $50 for food/snacks. Total of $1,800.

4.Estimate the number of individuals your proposed grant would serve. 12 youth

5. Please describe the population that you propose to serve, and how you determine "need." Youth who are referred to the FAST program are involved in 2 or more systems. The youth that we are serving under the age of 12 qualify for free or reduced lunch and have multiple system involvement.

8. How will you acknowledge Rotary support? We will have recipients write a thank you note to Rotary.

DOCUMENTS REQUIRED:

_____ Completed and signed application form
__$195,507___ Current year's budget
__Board of County Commissioner's___ List of Board of Directors and Officers
_____ IRS tax-exempt letter, or explanation

Assurance Statement: On behalf of the requesting organization, I hereby certify that the requested grant will be used for the purpose stated on the application form and will not be used in any program that discriminates on the basis of race, sex, religion, color, creed, disability, sexual orientation, gender, national origin, ancestry or age, or any other basis prohibited by applicable law.

_____Date: _____
Signature of Authorized Official

_____
Print Name and Title

AGENDA ITEM or FINAL CONTRACT REVIEW SUBMITTAL FORM

Agenda Item: A Resolution Authorizing ATV, OHV, and UTV Use on

Action Requested: Board of County Commissioners' Signature

Parties to the Agreement:

Term Begins: **Term Ends:** **Grant Contract #:**

Summary:

Resolution Authorizing ATV, OHV, and UTV Use on Certain County Roads in Somerset, Colorado

Fiscal Impact: n/a

Submitted by: Holly Perry **Submitter's Email Address:** hperry@gunnisoncounty.org

Finance Review: ○ Required ◉ Not Required

Comments:

Reviewed by: Discharge Date:

County Attorney Review: ◉ Required ○ Not Required

Comments:
Legally sufficient. SO 2/19/26

Reveiwed by: GUNCOUNTY1\sobaid Discharge Date: 2/19/2026 Certificate of Insurance Required

Yes ○ No ◉

County Manager Review:

Comments:

Reveiwed by: GUNCOUNTY1\mbirnie Discharge Date: 2/25/2026

◉ Consent Agenda ○ Regular Agenda ○ Worksession Time Allotted: 0

Agenda Date: 3/3/2026

Revised April 2015

BOARD OF COUNTY COMMISSIONERS
OF THE COUNTY OF GUNNISON, COLORADO

RESOLUTION NO: 26-_____

A RESOLUTION AUTHORIZING ATV, OHV AND UTV USE ON CERTAIN COUNTY ROADS IN SOMERSET, COLORADO

WHEREAS, Col. Rev. Stat. § 33-14.5-108(1)(f) prohibits the use of all-terrain vehicles ("ATVs"), off-highway vehicles ("OHVs") and utility terrain vehicles ("UTVs") on County roads unless expressly authorized by the County; and

WHEREAS, pursuant to Col. Rev. Stat. §§ 18-9-117(1)(f) and 33-14.5-110, the Board has the authority to adopt rules and regulations for use of ATVs, OHVs and UTVs as to place, time and manner of use; and

WHEREAS, Somerset, Colorado is a United States census-designated place within Gunnison County, Colorado, with its own United States Post Office, and whose population according to the 2020 census was 55 persons; and

WHEREAS, the original plat and built environment in Somerset has resulted in road infrastructure that does not meet current code and presents unique barriers for traditional vehicular use and transportation; and

WHEREAS, the Board finds that use of ATVs, OHVs and UTVs on certain County roads within Somerset, pursuant to the restrictions set forth by applicable law and the provisions of this Resolution, for residential purposes, are in the best interests of the public; and

WHEREAS, the public is reminded to comply with all applicable Federal, state and local laws regarding the registration, licensing, insurance and use of ATVs, OHVs and UTVs in Colorado and particularly in Gunnison County; and

WHEREAS, the public is reminded and encouraged to operate ATVs, OHVs and UTVs in a legal, safe, courteous, and responsible manner, particularly given Somerset's proximity to a heavily traveled State Highway;

NOW, THEREFORE, BE IT RESOLVED by the Board of County Commissioners of the County of Gunnison, Colorado, that:

1. The use of ATVs, OHVs and UTVs is and shall be authorized on those County Roads within the Somerset townsite, as specifically set forth and enumerated as follows:
    a. First Street;
    b. Second Street;
    c. Third Street;
    d. Fourth Street;

e. Fifth Street;
f. Sixth Street;
g. Seventh Street;
h. Eighth Street;
i. Pike Avenue;
j. King Avenue; and
k. River Road.

2. Nothing in this Resolution shall be construed to allow the use of ATVs, OHVs and UTVs on any Federal or State highway, including but not limited to Colorado Highway 133, any Federal or State highway, or any private road, easement, right of way, trail, path, alley or sidewalk without the consent of the landowner.

3. Nothing in this Resolution shall be construed to allow the use of ATVs, OHVs and UTVs on any other County Road in Gunnison County, except where this Board has so expressly authorized by duly adopted ordinance or resolution.

4. Any person who uses an ATV, OHV or UTV on a County Road subject to this Resolution shall be deemed to have consented to the fact that such County Road is a public road or highway under the control of Gunnison County.

5. The foregoing recitals are incorporated herein by reference and adopted as findings and determinations of the Board.

6. Nothing in the resolution shall be construed to afford any person or entity any cause of action against Gunnison County, or any of their respective officials, officers, employees, agents or attorneys, nor create any intended or incident third-party beneficiaries.

7. All orders, instructions, motions and resolutions, or parts thereof, inconsistent with this Resolution are hereby repealed to the extent only of such inconsistency. This paragraph shall not be construed to revive or revise any ordinance, motion, order, or resolution, or part thereof, heretofore repealed. To the extent any ambiguity exists between any ordinance, resolution, motion, order, statement or instruction by the Board, whether existing before or after passage of this Resolution, this Resolution shall control. No statement or writing by any Board member, whether in a meeting of the Board or not, shall purport to amend, alter, supplement or override the express terms of this Resolution, and no such statement or writing may be relied upon by any person in relation to this Resolution.

8. This Resolution shall be in full force and take effect immediately upon its passage and approval, and shall remain in effect unless and until repealed or amended by subsequent Resolution.

INTRODUCED by Commissioner_____, seconded by Commissioner _____, and adopted this _____ day of _____, 2026.

BOARD OF COUNTY COMMISSIONERS
OF THE COUNTY OF GUNNISON, COLORADO

By _____
Laura Puckett Daniels, Chairperson

By _____
Elizabeth Smith, Commissioner

By _____
Jonathan Houck, Commissioner

ATTEST:

_____
Deputy County Clerk

AGENDA ITEM or FINAL CONTRACT REVIEW SUBMITTAL FORM

Agenda Item: Local Landmark Designation for Hartman Castle Nomi

Action Requested: Board of County Commissioners' Signature

Parties to the Agreement:

Term Begins: **Term Ends:** **Grant Contract #:**

Summary:

Designation of Hartman Castle and original ranch house as a local historic landmark.

Fiscal Impact: 0

Submitted by: Mike Pelletier **Submitter's Email Address:** mpelletier@gunnisoncounty.org

Finance Review: ○ Required ◉ Not Required

Comments:

Reviewed by: Discharge Date:

County Attorney Review: ◉ Required ○ Not Required

Comments:
Legally sufficient. SO 2/24/26

Reveiwed by: GUNCOUNTY1\sobaid Discharge Date: 2/24/2026 Certificate of Insurance Required

Yes ○ No ◉

County Manager Review:

Comments:

Reveiwed by: GUNCOUNTY1\mbirnie Discharge Date: 2/25/2026

○ Consent Agenda ◉ Regular Agenda ○ Worksession Time Allotted: 10

Agenda Date: 3/3/2026

Revised April 2015

To: Board of County Commissioners
From: Mike Pelletier, GIS Manager
Date: March 3, 2026
RE: Local Landmark Designation for Hartman Castle

The Hartman Castle, located south of the airport, has been nominated for historic local landmarck designation by the non-profit, Hartman Castle Preservation Corp. The owners of property have agreed to the designation and signed the application form. Staff recommends that the BoCC pass the attached resolution approving the designation.

The designation is for the Hartman Castle (early 1890s) and the original Hartman Ranch House (1880s). Alonzo Hartman was one of the most important pioneers in Gunnison County's history. These buildings help to tell the heritage story of not only the County, but the State of Colorado. Please see the application in your packet for details and photographs of the buildings.

The Gunnison County Historic Preservation Commission considered the application at their meeting on February 25, 2026 and voted to approve the application for landmark status because it meets the following criteria.as written is resolution 2005-35.

> *The proposed landmark must meet one or more of the following criteria for significance:*
>
> - *Must be fifty (50) years or older*
> - *Represents the work of an important builder or architect*
> - *Possesses high artistic values*
> - *Represents a significant type, period or method of construction*
> - *Associated with significant persons or cultural groups*
> - *Associated with significant events or patterns*
> - *Contributes to a historic district*
> - *May possess information important in prehistory or history*

The current owners plan to sell the portion of their property containing the proposed landmarks to the Hartman Castle Preservation Corp (HCPC). The HCPC has been fund raising for the purchase and is planning to submit a grant to the State Historical Fund for acquisition money. That grant application is due April 1st. Once purchased, the Hartman Castle Preservation Corp nonprofit plans to renovate the building for use as a cultural and community center as well as an events center (to include weddings).

BOARD OF COUNTY COMMISSIONERS
OF THE COUNTY OF GUNNISON, COLORADO
RESOLUTION NO. 2026-___

A RESOLUTION DESIGNATING THE HARTMAN CASTLE AND ORIGINAL RANCH HOUSE LOCATED AT 279 COUNTY RD 50, GUNNISON, COLORADO, TO BE EACH INDIVIDUALLY DESIGNATED A GUNNISON COUNTY HISTORIC LANDMARK

WHEREAS, the Board of County Commissioners of the County of Gunnison, Colorado ("Board"), has provided, pursuant to Resolution 93-32, Resolution 05-28 and Resolution 05-35, for the preservation of the cultural, historic, and architectural history within Gunnison County; and

WHEREAS, application has been made for designation as a Gunnison County historical landmark two buildings at 279 County Rd 50, Gunnison, CO, with the extent of each designation being limited to the extent of each building and not including adjacent sheds and other structures; and

WHEREAS, the application included for each building, a Colorado Cultural Resource Survey Architectural Inventory Form, created by a qualified professional, pursuant to the Office of Archaeology & Historic Preservation; and

WHEREAS, the first being a three-story Victorian home known as the Hartman Castle. The second building is known as the original ranch house, which is located approximately forty feet to the southwest of the Hartman Castle. The legal address of the property currently being 5.679 Acres in Section 11, Township 49N, Range 1W. The buildings are located on the southern portion of the above noted Parcel;

WHEREAS. the review process required by Resolution 93-32, Resolution 05-28 and Resolution 05-35 has been conducted and concluded completely and appropriately by the Gunnison County Historic Preservation Commission; and

WHEREAS, the Board has determined, pursuant to Resolution 93-32, Resolution 05-28 and Resolution 05-35, that all of the procedural and substantive prerequisites of designating the Hartman Castle and the original ranch house have been met;

NOW, THEREFORE, BE IT RESOLVED by the Board of County Commissioners of the County of Gunnison, Colorado, that the Hartman Castle and the original ranch house be designated as a Gunnison County Historic Landmark, and further, that this Resolution be recorded in the records of the Gunnison County Clerk and Recorder, as the landmark designation certificate specified by Resolution 93-32, Resolution 05-28 and Resolution 05-35.

INTRODUCED by Commissioner_____, seconded by Commissioner _____, and adopted this ____ day of _____, 2026.

BOARD OF COUNTY COMMISSIONERS
OF GUNNISON COUNTY, COLORADO

By _____
Laura Puckett Daniels, Chairperson

By _____
Elizabeth Smith, Vice-Chairperson

By _____
Jonathan Houck, Board Member

Attest:

_____
Deputy County Clerk

Gunnison County Register of Historic Landmarks Nomination Form

1. **Address and Legal Description of Property**
   a. 594 County Road 50
   b. Two parcels within SE1/4NW1/4NW1/4 of section 11 Township 49 North, Range 1 West

2. **Provide a boundary description, including all lots and blocks within the boundaries**
   a. See Attached Plat

3. **Common Name of Property:** Hartman Castle

4. **SIGNIFICANCE - Check all that apply**

Architectural Significance

a. X Represents work of an important builder in our area
b. X Possesses high artistic values
c. X Represents a significant type, period of construction

Historical Significance

a. X Associated with significant persons
b. X Associated with significant events or patterns
c. ___ Contributes to an historic district

___ Check here if this property is already registered on the State or National register and attach a copy of the nomination form for the state and/or National designation.

This landmark is being nominated for an Historic Landmark designation. I am the owner of the property described above, and hereby request placement of said property on the Gunnison County Register of Historic Properties. I have read Board of County Commissioners Resolutions No. 93-32, 99-39, 05-28, and 05-35 as they may have been amended to date (a copy of which is attached to this nomination form). I agree that if the nominated property is designated as a landmark, the property and I shall be subject to the provisions of Resolution 93-32, 99-39, 05-28, and 05-35, as they exist at the time of this nomination.

David Taylor and Susan Taylor
Print Name of Property Owner (s)

David Taylor 1/30/26
Signature(s) Date

Susan M Taylor 1-30-26

879 Fairway Lane, Gunnison, Co 81230
Mailing Address

303-437-4726
Telephone Number

1130126

Notary Signature Date

TRISTEN KENT COLEMAN
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 20254006010
MY COMMISSION EXPIRES FEBRUARY 12, 2029

(Seal)

Nominating Person if Other Than Owner of Property

PAMELA K WILLIAMS

Print Name

38339 US Hwy 50

Mailing Address

Gunnison, CO 81230

Pamela K Williams

Signature Date

970.641.1442

Telephone Number

NOMINATION JUSTIFICATION

Please state why the property should be listed on the Gunnison County Register of Historic Landmarks. Please address the areas of significance you have identified on the preceding page. Attach additional sheets if necessary.

Without an understanding of the past, a community cannot fully appreciate its present or thoughtfully plan for its future. Hartman Castle stands as a powerful and tangible reminder of Gunnison's origins and of the individuals whose ambition, resilience, creativity, and civic leadership shaped the town and valley we know today. Closely associated with early settler and civic leader Alonzo Hartman and his wife, artist and educator Annie Hartman, the Castle is among the most historically and architecturally significant structures in Gunnison County and is deserving of designation on the Gunnison County Historic Building Register.

Historical Significance: Founders, Civic Leadership, and Early Settlement

Alonzo Hartman's life closely mirrors the broader story of westward expansion and early settlement in Colorado. Born into a pioneer family in Iowa, Hartman was a relative of both Daniel Boone and Abraham Lincoln and grew up following the westward movement of white settlement through Kansas and Colorado. With little formal education, he worked in early Denver businesses and the cattle industry before establishing his own ranching operation in the San Luis Valley. He arrived in the Gunnison Valley on Christmas Day in 1872 as a government employee for the Los Pinos Indian Agency, overseeing a cow camp near present-day Gunnison.

After four years of service, Hartman opened a trading post in 1876, helped establish the area's first post office, and became Gunnison's first postmaster. That original post office building still stands today at the Pioneer Museum. With business partners, Hartman later purchased 120 acres and laid out the townsite of Gunnison, cementing his role as one of the community's founders. In 1885, he returned to ranching and established one of the earliest homesteads in the valley, eventually expanding it to more than 2,000 acres and becoming one of the Gunnison Valley's first major cattlemen.

Annie Hartman: Education, Artistry, and Design Influence

Alonzo married Annie Haigler in 1882. Annie brought her own remarkable story and influence to the Gunnison Valley. Born in 1853 in what is now West Virginia, she descended from American colonists. Like many pioneer families, hers migrated west through Iowa, , and Kansas. Annie spent time in Monticello, Kansas—then an active frontier community—where she and her older sister attended Baker University in Baldwin, Kansas, and studied the sciences. She later worked as a schoolteacher and developed her artistic skills, later becoming part of a small but vibrant artistic community in Gunnison.

Advised to seek a healthier climate due to ongoing health issues, Annie relocated to the valley and worked in the county's first courthouse. Her artistic sensibilities, education, and independence would play a defining role in the design and use of Hartman Castle.

Architectural Significance: Design, Craftsmanship, and Innovation

The Hartmans first lived in cabins near what is now the 13th green of the Dos Rios Golf Course, later building a home on Wisconsin Avenue in downtown Gunnison. In 1890, they returned permanently to their ranch and began construction of what would become Hartman Castle.

As documented in *Dos Rios Memories* by Judy Buffington Sammon, the Hartmans "designed the house which was patterned after the Victorian style of the day and when it was completed it was an elegant structure indeed." Annie Hartman based the design on her own drawings, working closely with a Methodist minister and skilled local craftsmen—believed to include members of the Masonic-affiliated Zuke Elder construction group. Stone was quarried locally, and the building reflects both refined design and frontier ingenuity.

Sammon notes that local residents were hired to execute the Castle's many distinctive features, including "intricate brick work, a three-story winding staircase, and fireplaces in several rooms." These elements underscore the Castle's role not only as a residence, but as a showcase of craftsmanship, community skill, and aspiration at the edge of settlement.

Interior Features: Rare Integrity and Artistic Detail

Upon entering the Castle—then and now—the most striking feature is the magnificent white oak staircase. As described in Dos Rios Memories, the balustrades form an elegant S-shaped design, with the curved staircase descending to the basement kitchen and ascending through the upper floors. Along the stairwell, stained glass windows rise up the wall, gradually decreasing in size. At the top, colored glass panels depict flowers and owls, adding symbolic and artistic detail.

The interior retains remarkable integrity. Wooden arches with filigree and scrollwork frame several downstairs doorways, complemented by parquet floors and elaborate interior fretwork that remains largely intact today. One surviving stained glass window on the stairway continues to illuminate the interior much as it did more than a century ago.

The Basement Kitchen, Dumbwaiter, and Domestic Innovation

An unusual and forward-thinking feature of Hartman Castle was its basement kitchen. Food was prepared below and transported upstairs using a dumbwaiter—an uncommon convenience for rural Colorado at the time. Sammon describes the basement kitchen as having low ceilings and being "dark and gloomy," though originally warmed and brightened by a fireplace.

Despite its utilitarian placement, the kitchen was technologically advanced. The house featured a large modern cooking range equipped with a hot water jacket, providing hot running water—an exceptional amenity in the late 19th century. Water was pumped into the house using a windmill, placing the Hartmans among the earliest residents in the valley to enjoy such conveniences.

Upper Floors, Balcony, and Annie's Studio in the Turret

The second floor contained three bedrooms and a bathroom, which was a rarity at the time. From the landing at the top of the staircase, a door opened onto a second-story balcony, offering expansive views of the surrounding ranch and valley.

Also located on this landing was a pull-down staircase leading to the belvedere, or turret—Annie Hartman's studio. This space was intentionally designed to allow Annie to work uninterrupted. After

pulling up the stairs behind her, she could paint in solitude for hours, surrounded by panoramic views of the Gunnison landscape. According to Sammon, a waterfall scene painted by Annie once adorned the west wall of the turret, clearly demonstrating her skill as a landscape artist and reinforcing the intimate connection between the Castle's architecture and its setting.

Accessibility, Care, and Family Life
The Hartmans' commitment to innovation extended to accessibility and care for family members. An elevator was installed—an extraordinary feature for its time—originally intended for elderly relatives who lived with the Hartmans and later used to assist Annie as her arthritis worsened. While outhouses remained on the property, the Castle itself reflected an unusually modern approach to comfort, health, and domestic life on the frontier.

Contemporary Recognition and Continuing Significance
Today, Hartman Castle's significance continues to grow. It was featured in the 2024 Saving Hartman Castle documentary produced by Rocky Mountain PBS and is slated for inclusion on Colorado's Most Endangered Places list in February 2026, bringing statewide attention and technical assistance from History Colorado.

Designation of Hartman Castle on the Gunnison County Historic Building Register is a critical step in preserving a structure that embodies the County's early settlement, civic leadership, artistic expression, architectural ambition, and technological innovation. More than a residence, Hartman Castle tells a layered story of frontier life elevated by creativity, care, and vision. Its preservation represents not only the safeguarding of an irreplaceable historic landmark, but the opportunity to protect and activate a community asset with enduring educational, cultural, and economic value—ensuring that this extraordinary place remains part of Gunnison County's shared story for generations to come.

1. **Photographs of site and buildings** – See Attached

2. **Address and legal description**
    a. 594 County Road 50
    b. Two parcels within SE1/4NW1/4NW1/4 of section 11 Township 49 North, Range 1 West

3. **Name of builder/architect**
    There is no current builder/architect who is formally associated with the building; however, local architect Jody Reeser specializes in historic preservation and has inspected the building and given the Hartman Castle Preservation organization guidance on its preservation.

Describe architectural style and distinguishing features:
As documented in *Dos Rios Memories* by Judy Buffington Sammon, the Hartmans "designed the [castle] which was patterned after the Victorian style of the day and when it was completed it was an elegant structure indeed." Annie Hartman based the design on her own drawings, working closely with a Methodist minister and skilled local craftsmen—believed to include members of the Masonic-affiliated

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remained on the property, the Castle itself reflected an unusually modern approach to comfort, health, and domestic life on the frontier.

4. **Date of Construction:** 1892-1894

5. **Square footage**
    a. Building #1 (Castle) 3,583 square feet of living space in 3 stories plus 1,519 of unfinished space in the basement
    b. Building #2 (Original ranch house) – 2 stories, 903 square feet

6. **Building materials used**
    a. Building #1 (Castle): Brick first floor, stone base, shingled second floor
    b. Building #2 (Original ranch house): Wood construction

7. **Describe original and present uses**
    a. The Castle was originally used originally as a home for the Hartmans in the 1890s and early 1900s, and during this time it became the became the social center of the County via the couples' entertaining and social events
    b. Over the years the home was sold when the Hartmans moved back to town to their home on Wisconsin Street, but the Castle continued to be a local showplace and social center into the 1920s and beyond. In 1926, the local Cattlemen's Club was trying to attract the Stockgrowers convention to Gunnison, and they used the Castle as an attraction.
    c. Into the mid-20th century the home was sold multiple times and became a restaurant, a private home, and a rental for college students.
    d. The Castle has been vacant since 2015.

8. **Has the structure been moved from its original site? If so, include information on where structure was moved from. Include date of relocation and reason for relocation.**
    No, neither the Castle nor the ranch home have been moved from their original site.

9. **Has the structure been altered? If so, please describe. Include dates if possible.**
    There have been two additions to the Castle:
    a. The back porch and a second stairway to basement were added in the mid-20th century.
    b. A second addition was done in the early 1970s for the restaurant that added a kitchen, and expanded the porch area.

10. **Describe any associated buildings on the property:**
    The original ranch house belonging to the Hartmans from the 1880s exists on the property just behind the Castle; it was remodeled in 1960s with a small addition and has been used as a rental.

11. **Copies of research material used for nomination:**
    a. See attached "Media Examples" pdf document of articles featuring the Hartman Castles.
    b. Other sources include: *Dos Rios Memories* by Judy Buffington Sammon and *The Gunnison Country* by Duane Vandenbusche

12. **Attach a copy of the deed** – See Attached.

13. **Provide a site plan with, at minimum, the following information**
    a. Dimensions of the site/lot
    b. Dimensions of the building (s) and setbacks from property lines
    c. Location(s) of other structures on the site

    See Attached.

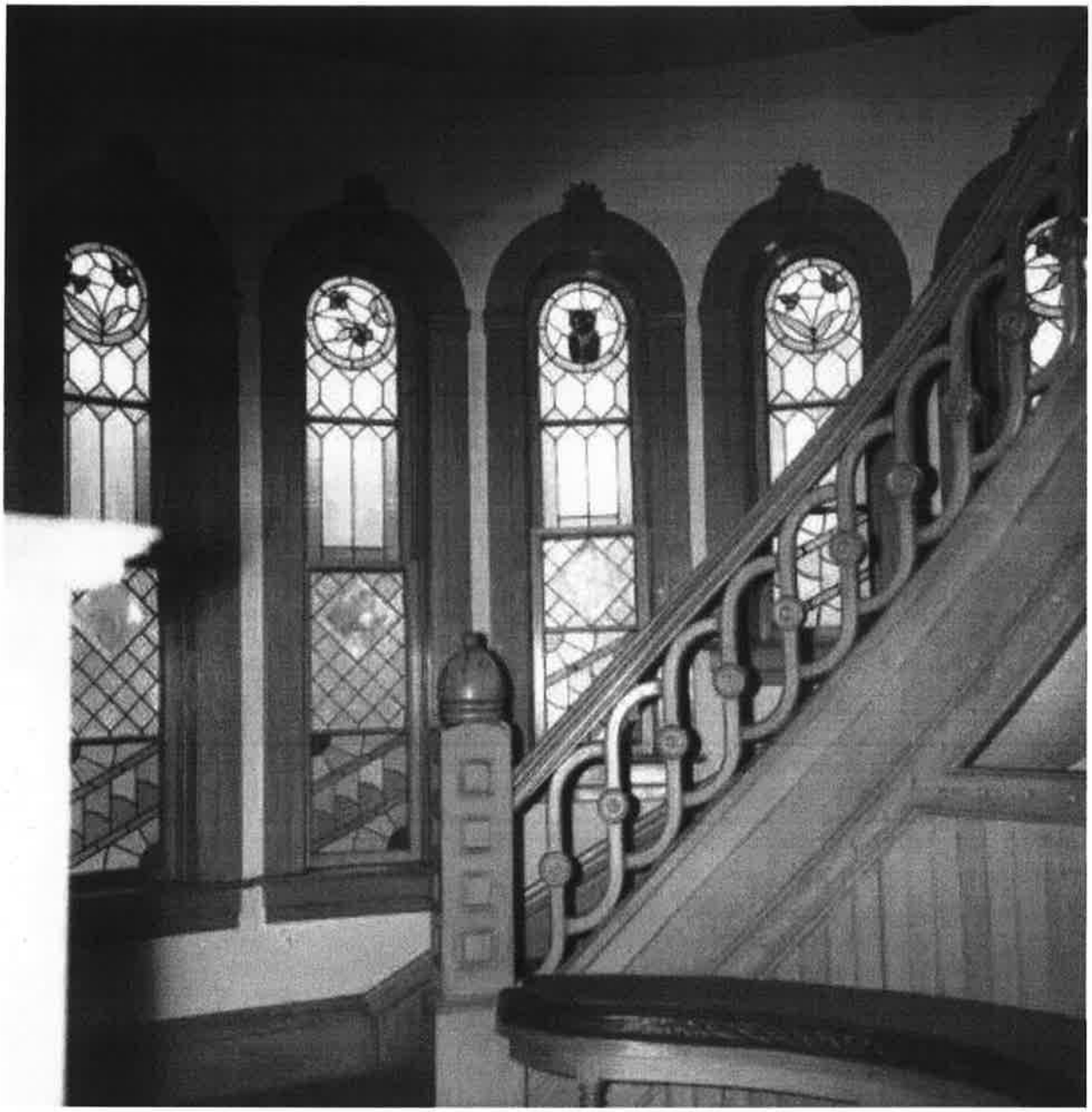
Early photo of Hartman Castle

Early photo of Hartman Castle

Hartman Castle Exterior Detail (Historic Photo)

Hartman Castle Fireplace (Historic Photo), showing tile sourced from Italy and originally shown at 1893 Chicago World's Fair

Hartman Castle Interior Door showing wood detail and craftsmanship (mid-20th century photo)



Hartman Castle: Interior staircase showing stained galss windows and architectural detail (historic photo)

Hartman Castle showing interior window detail (historic photo)

Hartman Castle Interior Painting by Annie Hartman (Historic Photo)

Hartman Women Seated on Stairs at Hartman Castle (Historic Photo)

Original Hartman Ranch House on the Dos Rios Property (Located behind the current Hartman Castle)

BOUNDARY LINE ADJUSTMENT – TAYLOR PROPERTY
TWO PARCELS THE WITHIN SE1/4NW1/4NW1/4 OF SECTION 11, TOWNSHIP 49 NORTH, RANGE 1 WEST, N.M.P.M. GUNNISON COUNTY, COLORADO

LEGEND

- Found rebar with illegible cap
- Found rebar with no cap
- Found rebar with plastic cap stamped "LS 28196"
- Found steel stake with steel cap stamped "LS 11280" or with no cap
- Found rebar with plastic cap stamped "LS 33647"
- Set rebar with plastic cap stamped "LS 34979"
- Utility Pedestal
- Overhead Utility Line
- Fence

N

50 0 50 100
Scale: 1" = 50'

VICINITY MAP

GENERAL NOTES:

1. Property located by field measurements from the northwest corner of Section 11, as marked by a USGLO brass cap. Basis of bearings is astronomic north as determined by solar observations.
2. Parcel No.1 as described does not mathematically close by 1.04 feet. Record bearing and distance are shown in parentheses where they differ from calculated bearing and distance along the closing course of this parcel.
3. Information regarding record easements affecting this parcel was obtained from Title Commitment prepared by First Guardian Title and Escrow, File No.: 12-24-029, dated April 3, 2012, which was provided by client.
4. No certification is intended or this survey or part of is to the location of any adjoining properties.

ATTORNEY'S OPINION

I, _____, an attorney at law duly licensed to practice in the State of Colorado, hereby certify that I have examined title to all lands herein dedicated and subdivided. Such title is held in the name of _____ and is free and clear of all liens, defects, encumbrances, restrictions and reservations except as follows:

☐

This opinion does not address mortgages, deeds of trust or similar instruments wherein the subject property is utilized as security for a promissory note or other written instrument of debt; nor does it address instruments affecting title but not recorded as of the date of this opinion.

Dated this _____day of _____, 20____

_____
Attorney-at-Law

COMMENTS

Plat Notes: ☐

Pursuant to Section 5-209 H. of the Gunnison County Land Use Resolution:

Confinement of Domestic Animals: Each Lot Owner within the subdivision acknowledges and agrees that domestic animals must be controlled by kenneling, leash, fencing, or other physical constraint and that any expenses of enforcement of the domestic animal control restrictions by the County shall be at the expense of the responsible lot owner.

Colorado's Fence Out Requirements: A property owner is required to construct and maintain fencing in order to keep livestock off his/her property in accordance with C.R.S. 35-46-101 et. seq.

Irrigation Ditch Maintenance: An irrigation ditch owner has the right to enter the designated irrigation ditch maintenance easement, maintain the ditch, and may leave natural debris on the bank.

Wildfire Hazard: The owners of this property acknowledge having been informed by Gunnison County of the existence of wildfire hazard areas that may affect the use and occupancy of the property and any improvements thereto. We acknowledge that the County's approval of this subdivision does not guarantee the safety of the property, or in any way imply that areas outside of the designated hazard area will be free from hazards and hereby agree to indemnify, defend, and save harmless the County, its agents, officers, and employees from and against any and all liability, expense including defense costs and legal fees, and claims for damages of any nature whatsoever, including bodily injury, death, personal injury, or property damage, arising from or connected with any activity related to these hazards, including any suits, liability, or expenses.

Geologic Hazard: The owners of this property acknowledge having been informed by Gunnison County of the existence of geologic hazard areas that may affect the use and occupancy of the property and any improvements thereto. We acknowledge that the County's approval of this subdivision does not guarantee the safety of the property, or in any way imply that areas outside of the designated hazard area will be free from hazards and hereby agree to indemnify, defend, and save harmless the County, its agents, officers, and employees from and against any and all liability, expense including defense costs and legal fees, and claims for damages of any nature whatsoever, including bodily injury, death, personal injury, or property damage, arising from or connected with any activity related to these hazards, including any suits, liability, or expenses.

DEDICATION

Know all men by these presents, that the undersigned, being all of the Owner(s), Mortgagee(s) and Lien-holder(s) of certain lands in Gunnison County, Colorado, described as follows:

Township 49 North, Range 1 West, N.M.P.M.

Section 11: Two parcels of land located in the SE1/4NW1/4NW1/4 of said Section 11, more particularly described as follows:

Parcel No.1:

Beginning at a point from whence the NW corner of said Section 11 bears N 89°16' W 1907.0 feet;
thence S 40°16' W 85.0 feet;
thence S 89°21' W 138.0 feet to the true point of beginning;
thence around said tract S 89°21' W 138.4 feet;
thence N 0°29' E 362.71 feet;
thence S 88°07.8' W 51.7 feet;
thence N 18°11.9' W 626.15 feet;
thence N 89°37' E 387.66 feet;
thence S 0°29' E 963.04 feet to the point of beginning,

County of Gunnison,
State of Colorado.

Parcel No.2:

Beginning at a point from whence the NW corner of said Section 11 bears N 89°16' W 1907.0 feet;
thence S 0°29' E 424.85 feet;
thence S 89°30' W 175.83 feet;
thence N 0°29' W 1.5 feet;
thence S 29°30' W 180.77 feet;
thence N 0°29' W 350.70 feet;
thence N 89°37' E 288.4 feet;
thence N 40°16' E 52 feet to the point of beginning,

County of Gunnison,
State of Colorado

In Gunnison County, Colorado, under the name of BOUNDARY LINE ADJUSTMENT – TAYLOR PROPERTY, in Gunnison County, Colorado, have laid out, platted and/or subdivided the same as shown on this plat and do hereby dedicate and convey to the owners of lots, tracts, or parcels within the subdivision and their guests, but not to the public at large, the common right to use streets, alleys, roads and other public areas as shown hereon and hereby dedicate those portions of land labeled as easements for the installation and maintenance of public utilities as shown hereon.

Executed this _____ day of _____, 2024.

☐ OWNERS:

By: _____
David A. Taylor

By: _____
Susan M. Taylor

STATE OF COLORADO }
COUNTY OF GUNNISON } ss.

The foregoing instrument was acknowledged and executed before me this _____ day of _____, 2024, by David A. Taylor and Susan M. Taylor.

Witness my hand and official seal. _____
Notary Public

SURVEYOR'S CERTIFICATE

I, Timothy E. Pearson, a registered land surveyor in the State of Colorado, certify that this plat and the survey referred to herein were made under my direction and control and that both are true and correct to the best of my knowledge.

Dated this _____ day of _____ A.D. 20____

_____
Timothy E. Pearson
Colorado L.S. No. 34979

GUNNISON COUNTY CLERK AND RECORDER'S ACCEPTANCE ☐

This plat was accepted for filing in the office of the Clerk and Recorder of Gunnison County, Colorado on this _____ day of _____ A.D. 20____, Reception Number_____, Time _____

☐ County Clerk and Recorder

By: Deputy

BOUNDARY LINE ADJUSTMENT – TAYLOR PROPERTY
TWO PARCELS THE WITHIN SE1/4NW1/4NW1/4 OF SECTION 11, TOWNSHIP 49 NORTH, RANGE 1 WEST, N.M.P.M.
GUNNISON COUNTY, COLORADO
PROPERTY ADDRESS: 277 S 594 COUNTY ROAD 50

PEARSON SURVEYING
P.O. BOX 852
GUNNISON, CO 81230
970-641-2519

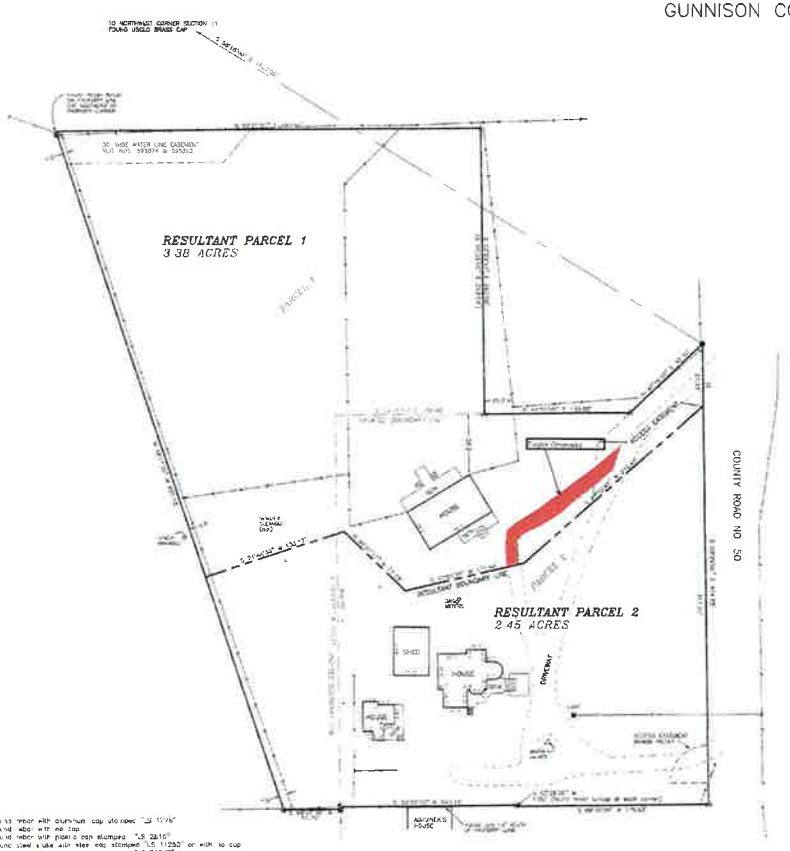
PROJECT # 24-144

DATE : 6/28/24

LATEST REVISION DATE :

SHEET 1 OF 1

BOUNDARY LINE ADJUSTMENT – TAYLOR PROPERTY
TWO PARCELS THE WITHIN SE1/4NW1/4NW1/4 OF SECTION 11, TOWNSHIP 49 NORTH, RANGE 1 WEST, N.M.P.M. GUNNISON COUNTY, COLORADO



VICINITY MAP

DEDICATION

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Section 11: The portions of land included in the SE1/4NW1/4NW1/4 of said Section 11, more particularly described as follows:

Parcel No.1:

Beginning at a point from whence the NW corner of said Section 11 bears N 38°16' W 1801.2 feet;
thence S 48°16' W 98.0 feet;
thence S 89°31' W 133.0 feet to the true point of beginning;
thence continue said East S 89°31' W 330.6 feet;
thence S 0°28' E 262.79 feet;
thence S 89°55' W 51.7 feet;
thence N 16°17'5" W 134.19 feet;
thence N 89°31' E 287.56 feet;
thence N 0°29' E 213.04 feet to the point of beginning.

County of Gunnison
State of Colorado

Parcel No.2:

Beginning at a point from whence the NW corner of said Section 11 bears N 38°16' W 1801.2 feet;
thence S 0°29' E 424.55 feet;
thence S 89°30' W 173.60 feet;
thence N 0°28' W 1.0 feet;
thence S 89°32' W 143.77 feet;
thence N 0°29' W 262.96 feet;
thence N 89°31' E 263.4 feet;
thence N 48°16' E 92 feet to the point of beginning.

County of Gunnison,
State of Colorado

In Gunnison County, Colorado, under the name of BOUNDARY LINE ADJUSTMENT – TAYLOR PROPERTY, in Gunnison County, Colorado, have laid out, platted and/or subdivided the same as shown on this plat and do hereby dedicate and convey to the owners of lots, tracts or parcels within this subdivision and their guests, but not to the public at large, the common right to use streets, alleys, roads and other public areas as shown hereon and hereby dedicate those portions of land labelec as easements for the installation and maintenance of public utilities as shown hereon.

Executed this _____ day of _____ 2024.

OWNERS:

By_____
David A Taylor

By_____
Susan M Taylor

STATE OF COLORADO }
} ss.
COUNTY OF GUNNISON }

The foregoing instrument was acknowledged and executed before me this _____ day of _____ 2024, by David A Taylor and Susan M. Taylor.

Witness my hand and official seal. _____
Notary Public

ATTORNEY'S OPINION

I _____, an attorney at law duly licensed to practice in the State of Colorado, hereby certify that I have examined title to all lands herein dedicated and subdivided. Such title is held in the name of _____ and is free and clear of all liens, defects, encumbrances, restrictions and reservations except as follows:

This opinion does not address mortgages, deeds of trust or similar instruments wherein the subject property is utilized as security for a promissory note or other written instrument of debt; nor does it address instruments affecting title but not recorded as of the date of this opinion.

Dated this _____day of _____ 20__.

_____
Attorney-at-Law

SURVEYOR'S CERTIFICATE

I, Timothy E. Pearson, a registered and surveyor in the State of Colorado, certify that this plat and the survey referred to herein were made under my direction and control and that both are true and correct to the best of my knowledge.

Dated this _____ day of _____ A.D. 20___

_____
Timothy E. Pearson
Colorado L.S. No. 24879

GUNNISON COUNTY CLERK AND RECORDER'S ACCEPTANCE

This plat was accepted for filing in the office of the Clerk and Recorder of Gunnison County, Colorado on this _____ day of _____ A.D. 20____, Receptce Number_____ Time _____

_____
County Clerk and Recorder

_____
By Deputy

COMMENTS

Plat Notes:

Pursuant to Section 5-209 M of the Gunnison County Land Use Resolution:

Containment of Domestic Animals: Each Lot Owner within this subdivision acknowledges and agrees that domestic animals must be controlled by tethering, leash, fencing, or other physical constraint, and that any instance of entanglement of the domestic animal; control restrictions by the County shall be at the expense of the responsible individual.

Colorado's Fence Out Requirements: A property owner is required to construct and maintain fencing in order to keep livestock off his/her property in accordance with C.R.S 35-46-101 et. seq.

Irrigation Ditch Maintenance: An irrigation ditch owner has the right to enter the designated irrigation ditch maintenance easement, maintain the ditch, and may leave natural debris on the bank.

Wildfire Hazard: The owners of this property acknowledge having been informed by Gunnison County of the existence of wildfire hazard areas that may affect the use and occupancy of the property and any improvements thereto. We acknowledge that the County's approval of this subdivision does not guarantee the safety of the property, or in any way imply that areas outside of the designated hazard area will be free from hazards and hereby agree to indemnify, defend, and save harmless the County, its agents, officers, and employees from and against any and all liability, expense including defense costs and legal fees, and claims for damages of any nature whatsoever, including bodily injury, death, personal injury, or property damage, arising from or connected with any activity related to those hazards, including any suits, liability, or expense.

Geologic Hazard: The owners of this property acknowledge having been informed by Gunnison County of the existence of geologic hazard areas that may affect the use and occupancy of the property and any improvements thereto. We acknowledge that the County's approval of this subdivision does not guarantee the safety of the property, or in any way imply that areas outside of the designated hazard area will be free from hazards and hereby agree to indemnify, defend, and save harmless the County, its agents, officers, and employees from and against any and all liability, expense including defense costs and legal fees, and claims for damages of any nature whatsoever, including bodily injury, death, personal injury, or property damage, arising from or connected with any activity related to those hazards, including any suits, liability, or expense.

LEGEND

- Found rebar with aluminum cap stamped "LS 11750"
- Found rebar with no cap
- Found rebar with plastic cap stamped "LS 28161"
- Found steel w/tube with illegible cap stamped "LS 11250" or with no cap
- Found rebar with plastic cap stamped "LS 31847"
- Set rebar with plastic cap stamped "LS 24879"
- Utility pedestal
- Overhead utility lines
- Fence

GENERAL NOTES:

1. Property located by field measurements from the northwest corner of Section 11, as marked by a USGLO brass cap. Basis of bearings is astronomic north as determined by solar observations.
2. Parcel built as described does not mathematically close by 1.04 feet. Record bearing and distance are shown in parentheses, where they differ from calculated bearing and distance along the deed's description of this parcel.
3. Information regarding record easements affecting this parcel was obtained from The Commitment prepared by, First Gunnison Title and Escrow, File No. 12-04-009 dated April 2, 2012 which was provided by client.
4. No certification is provided by this survey or plat as to the location of any adjacent properties.

SCALE: 1" = 50'

BOUNDARY LINE ADJUSTMENT – TAYLOR PROPERTY
TWO PARCELS THE WITHIN SE1/4NW1/4NW1/4 OF SECTION 11, TOWNSHIP 49 NORTH, RANGE 1 WEST, N.M.P.M.
GUNNISON COUNTY, COLORADO
PROPERTY ADDRESS: 277 & 294 COUNTY ROAD 50

PEARSON SURVEYING
P.O. BOX 652
GUNNISON, CO 81230
970-641-2910

PROJECT # 24-1-4

DATE : 8/28/24

LATEST REVISION DATE :

SHEET 1 OF 1

645706 3/31/2017 4:10:47 PM Page 1 of 12
Kathy Simillion Gunnison County, CO
R: $68.00 D: 0.00 eRecorded

RECORDATION REQUESTED BY:
Community Banks of Colorado, a division of NBH Bank
Montrose Facility
330 S 12th Street, Unit B Suite 1
Montrose, CO 81401

WHEN RECORDED MAIL TO:
Community Banks of Colorado, a division of NBH Bank
Attn: Commercial Loan Servicing
1111 Main Street, Suite 2700
Kansas City, MO 64105

FOR RECORDER'S USE ONLY

*0000002016303971-1034003292017^

DEED OF TRUST

MAXIMUM PRINCIPAL AMOUNT SECURED. The Lien of this Deed of Trust shall not exceed at any one time $179,287.00 except as allowed under applicable Colorado law.

THIS DEED OF TRUST is dated March 29, 2017, among Parcel 1: Gunnison Kampground Partners, LLC, a Colorado limited liability company
Parcel 2: David Taylor and Susan Taylor
Parcel 3: David Taylor and Susan Taylor ("Grantor"); Community Banks of Colorado, a division of NBH Bank, whose address is Montrose Facility, 330 S 12th Street, Unit B Suite 1, Montrose, CO 81401 (referred to below sometimes as "Lender" and sometimes as "Beneficiary"); and the Public Trustee of Gunnison County, Colorado (referred to below as "Trustee").

CONVEYANCE AND GRANT. For valuable consideration, Grantor hereby irrevocably grants, transfers and assigns to Trustee for the benefit of Lender as Beneficiary all of Grantor's right, title, and interest in and to the following described real property, together with all existing or subsequently erected or affixed buildings, improvements and fixtures; all easements, rights of way, and appurtenances; all water, water rights and ditch rights (including stock in utilities with ditch or irrigation rights); and all other rights, royalties, and profits relating to the real property, including without limitation all minerals, oil, gas, geothermal and similar matters, **(the "Real Property") located in Gunnison County, State of Colorado:**

Parcel 1:

Tract A:

Township 49 North, Range 1 West, N.M.P.M.

Section 11: A tract of land located in the NW1/4 of said Section 11, more particularly described as follows:

Beginning at the NW corner of said Section 11, U.S.G.L.O.S. Brass cap in place; thence North 89°34' East 659.587 feet to a point of intersect with the centerline of an existing irrigation ditch and the North line of said Section 11, being the NW corner of said tract, the true point of beginning; thence North 89°34' East 700.00 feet to the NE corner of said tract being in common with the NE corner of the NW1/4NW1/4; thence South 00°29'00" East 655.53 feet to the SE corner of said tract being in common with the NE corner of a tract described at Book 399 at page 167; thence South 89°31'00" West 200.00 feet along the North line of said tract described at Book 399 at page 167; thence South 89°31'00" West 387.66 feet to a found Harrison Cap 1776; thence North 71°27'02" West 190.25

feet to the SW corner of said tract being on the E bank of said irrigation ditch; thence North 05°30'20" East 166.77 feet along the east bank of said irrigation ditch; thence North 12°31'44" East 239.71 feet along the E bank of said irrigation ditch; thence N 21°05'01" E 88.95 feet along the E bank of irrigation ditch; thence North 18°33'59" West 117.77 feet to the NW corner of said tract, the true point of
beginning,

EXCEPTING THEREFROM that portion of the above described property described as follows:
Beginning at the Northwest Corner of said Section 11, a U.S.G.L.O.S. Brass Cap in place; thence North 89°34' East 659.587 feet along the North line of the NW1/4NW1/4 of said Section 11 to a point on the centerline of an existing ditch; thence North 89°34' East 464.0 feet along the North line of the NWI/4NW1/4 of said Section 11 to the true point of beginning, being the Northwest corner of said tract; thence south 00°29 1 East 142.0 feet along the West line of said tract to a point being the Southwest corner of said tract; thence North 89°34' East 236.0 feet along the South line of said tract to a point on the East line of the NW1/4NW1/4 of said Section 11, being the Southeast corner of said tract; thence North 00°29' West 142.0 feet along the East line of the NW1/4NW1/4 of said Section 11 to the Northeast corner of the NWI/4NW1/4 of said Section 11, being the Northeast corner of said tract; thence South 89°34' West 236.0 feet along the North line of the NW1/4NW1/4 of said Section 11 to the true point of beginning,

County of Gunnnison,
State of Colorado.

Tract B:

Township 49 North, Range 1 West, N.M.P.M.
Section 11: A tract of land located in the NW1/4NW1/4 of said Section 11, more particularly described as follows: Beginning at the Northwest Corner of said Section 11, a U.S.G.L.O.S. Brass Cap in place; Thence North 89°34' East 659.587 feet along the North line of the NW1/4NW1/4 of said Section 11 to a point on the centerline of an existing ditch; Thence North 89°34' East 464.0 feet along the North line of the NWI/4NWI/4 of said Section 11 to the true point of beginning, being the Northwest corner of said tract; Thence South 00°291 East 142.0 feet along the West line of said tract to a point being the Southwest corner of said tract; thence North 89°34' East 236.0 feet along the South line of said tract to a point on the East line of the NW1/4NW1/4 of said Section 11, being the Southeast corner of said tract; thence North 00°29' West 142.0 feet along the East line of the NWI/4NW1/4 of said Section 11 to the Northeast comer of the
NWI/4NW1/4 of said Section 11, being the Northeast corner of said tract; Thence South 89°34' West 236.0 feet along the North line of the NW1/4NW1/4 of said Section 11 to the true point of beginning,

County of Gunnison,
State of Colorado.

Parcel 2:

Lots 1 through 7, Block 61, FIRST ADDITION to Gunnison,

City of Gunnison,
County of Gunnison,
State of Colorado.

Parcel 3:

Township 49 North, Range 1 West, N.M.P.M.

Section 11: Two tracts of land located in the SE1/4NW1/4NW1/4 of said Section 11, more particularly described as follows:

Tract A:

Beginning at a point from whence the NW corner of said Section 11 bears N 58°16' W 1607.0 feet; thence S 46°16' W 92.0 feet; thence S 89°31' W 133.0 feet to the true point of beginning; thence around said tract S 89°31' W 136.4 feet; thence S 0°29' E 362.71 feet; thence S 89°07.5' W 51.7 feet; thence N 18°11.5' W 656.15 feet; thence N 89°31' E 387.66 feet; thence S 0°29' E 263.04 feet to the point of beginning;

Tract B:
Beginning at a point from whence the NW corner of said Section 11 bears N 58°16' W 1607.0 feet; thence S 0°29' E 424.65 feet; thence S 89°30' W 175.63 feet; thence N 0°29' W 1.0 feet thence S 89°30' W 160.77 feet; thence N 0°29' W 360.70 feet; thence N 89°31' E 269.4 feet; thence N 46°16' E 92 feet to the point of beginning;

County of Gunnison,
State of Colorado.

The Real Property or its address is commonly known as 105 County Road 50, 624 N. Main Street and 594 County Road 50, Gunnison, CO 81230.

CROSS-COLLATERALIZATION. In addition to the Note, this Deed of Trust secures the following described additional indebtedness: In addition to the Note, this Security Instrument (as defined below) also secures all other obligations, debts and liabilities, plus interest thereon, of Borrower or Third Party Obligor (each as defined below), or any one or more of them, to Lender (as defined below), as well as all claims by Lender against Borrower or Third Party Obligor, or any one or more of them, whether now existing or hereafter arising, whether related or unrelated to the purpose of the Note, whether voluntary or otherwise, whether or not due, direct or indirect, determined or undetermined, absolute or contingent, liquidated or unliquidated, whether Borrower or Third Party Obligor, may be liable individually or jointly with others, whether obligated as a guarantor, surety, accommodation party, or otherwise, and whether recovery upon such amounts may be or hereafter may become barred by any statute of limitations, and whether the obligation to repay such amounts may be or hereafter may become otherwise unenforceable; provided, however, that the property described in this Security Instrument shall not secure any other obligation, debt or liability of Borrower or Third Party Obligor, or any one or more of them, to Lender if: (1) this Security Instrument encumbers Borrower's principal residence, a right of rescission would exist as a result of such other obligation, debt or liability being secured by this Security Instrument and Lender has not given any such required notice of the right to rescission with respect to that other obligation, debt or liability, (2) having such obligation, debt or liability secured by this Security Instrument would make the transaction subject to Regulation Z or X (or subject to different disclosure obligations under Regulation Z or X) and Lender fails to fulfill any necessary requirements or conform to any limitations or requirements of Regulation Z or X that are required for loans secured by the property described in this Security Instrument, (3) this cross-collateralization provision would cause Lender to be in violation of any applicable federal or state statute or regulation, including, without limitation, those statutes and regulations governing compliance with federal flood insurance requirements and programs, or (4) such other obligation, debt or liability of Borrower or Third Party Obligor, or any one or more of them, to Lender is a loan by Lender to Borrower or Third Party Obligor, or any one or more of them, that is guaranteed by the United States Small Business Administration, the United States Department of Agriculture Farm Service Agency or any other governmental authority. For purposes of this paragraph: (a) the term "Security Instrument" shall mean the security agreement, pledge agreement, collateral assignment, deed of trust, mortgage or other collateral document in which this paragraph is included, (b) the term "Borrower" shall mean the person or persons who have granted a lien or security interest in favor of Lender pursuant to this Security Instrument, (c) the term "Lender" shall mean the person in whose favor or for whose benefit a lien or security interest is granted pursuant to this Security Instrument, and (d) the term Third Party Obligor shall mean Gunnison Kampground Partners LLC. .

FUTURE ADVANCES. In addition to the Note, this Deed of Trust secures all future advances made by Lender to Borrower or Grantor whether or not the advances are made pursuant to a commitment. Specifically, without limitation, this Deed of Trust secures, in addition to the amounts specified in the Note, all future amounts Lender in its discretion may loan to Borrower or Grantor, together with all interest thereon.

Grantor presently assigns to Lender (also known as Beneficiary in this Deed of Trust) all of Grantor's right, title, and interest in and to all present and future leases of the Property and all Rents from the Property. In addition, Grantor grants to Lender a Uniform Commercial Code security interest in the Personal Property and Rents.

THIS DEED OF TRUST, INCLUDING THE ASSIGNMENT OF RENTS AND THE SECURITY INTEREST IN THE RENTS AND PERSONAL

PROPERTY, IS GIVEN TO SECURE (A) PAYMENT OF THE INDEBTEDNESS AND (B) PERFORMANCE OF ANY AND ALL OBLIGATIONS UNDER THIS DEED OF TRUST. THIS DEED OF TRUST IS GIVEN AND ACCEPTED ON THE FOLLOWING TERMS:

GRANTOR'S REPRESENTATIONS AND WARRANTIES. Grantor warrants that: (a) this Deed of Trust is executed at Borrower's request and not at the request of Lender; (b) Grantor has the full power, right, and authority to enter into this Deed of Trust and to hypothecate the Property; (c) the provisions of this Deed of Trust do not conflict with, or result in a default under any agreement or other instrument binding upon Grantor and do not result in a violation of any law, regulation, court decree or order applicable to Grantor; (d) Grantor has established adequate means of obtaining from Borrower on a continuing basis information about Borrower's financial condition; and (e) Lender has made no representation to Grantor about Borrower (including without limitation the creditworthiness of Borrower).

GRANTOR'S WAIVERS. Grantor waives all rights or defenses arising by reason of any "one action" or "anti-deficiency" law, or any other law which may prevent Lender from bringing any action against Grantor, including a claim for deficiency to the extent Lender is otherwise entitled to a claim for deficiency, before or after Lender's commencement or completion of any foreclosure action, either judicially or by exercise of a power of sale.

PAYMENT AND PERFORMANCE. Except as otherwise provided in this Deed of Trust, Borrower and Grantor shall pay to Lender all Indebtedness secured by this Deed of Trust as it becomes due, and Borrower and Grantor shall strictly perform all their respective obligations under the Note, this Deed of Trust, and the Related Documents.

POSSESSION AND MAINTENANCE OF THE PROPERTY. Borrower and Grantor agree that Borrower's and Grantor's possession and use of the Property shall be governed by the following provisions:

Possession and Use. Until the occurrence of an Event of Default, Grantor may (1) remain in possession and control of the Property; (2) use, operate or manage the Property; and (3) collect the Rents from the Property.

Duty to Maintain. Grantor shall maintain the Property in tenantable condition and promptly perform all repairs, replacements, and maintenance necessary to preserve its value.

Compliance With Environmental Laws. Grantor represents and warrants to Lender that: (1) During the period of Grantor's ownership of the Property, there has been no use, generation, manufacture, storage, treatment, disposal, release or threatened release of any Hazardous Substance by any person on, under, about or from the Property; (2) Grantor has no knowledge of, or reason to believe that there has been, except as previously disclosed to and acknowledged by Lender in writing, (a) any breach or violation of any Environmental Laws, (b) any use, generation, manufacture, storage, treatment, disposal, release or threatened release of any Hazardous Substance on, under, about or from the Property by any prior owners or occupants of the Property, or (c) any actual or threatened litigation or claims of any kind by any person relating to such matters; and (3) Except as previously disclosed to and acknowledged by Lender in writing, (a) neither Grantor nor any tenant, contractor, agent or other authorized user of the Property shall use, generate, manufacture, store, treat, dispose of or release any Hazardous Substance on, under, about or from the Property; and (b) any such activity shall be conducted in compliance with all applicable federal, state, and local laws, regulations and ordinances, including without limitation all Environmental Laws. Grantor authorizes Lender and its agents to enter upon the Property to make such inspections and tests, at Grantor's expense, as Lender may deem appropriate to determine compliance of the Property with this section of the Deed of Trust. Any inspections or tests made by Lender shall be for Lender's purposes only and shall not be construed to create any responsibility or liability on the part of Lender to Grantor or to any other person. The representations and warranties contained herein are based on Grantor's due diligence in investigating the Property for Hazardous Substances. Grantor hereby (1) releases and waives any future claims against Lender for indemnity or contribution in the event Grantor becomes liable for cleanup or other costs under any such laws; and (2) agrees to indemnify, defend, and hold harmless Lender against any and all claims, losses, liabilities, damages, penalties, and expenses which Lender may directly or indirectly sustain or suffer resulting from a breach of this section of the Deed of Trust or as a consequence of any use, generation, manufacture, storage, disposal, release or threatened release occurring prior to Grantor's ownership or interest in the Property, whether or not the same was or should have been known to Grantor. The provisions of this section of the Deed of Trust, including the obligation to indemnify and defend, shall survive the payment of the Indebtedness and the satisfaction and reconveyance of the lien of this Deed of Trust and shall not be affected by Lender's acquisition of any interest in the Property, whether by foreclosure or otherwise.

Nuisance, Waste. Grantor shall not cause, conduct or permit any nuisance nor commit, permit, or suffer any stripping of or waste on or to the Property or any portion of the Property. Without limiting the generality of the foregoing, Grantor will not remove, or grant to any other party the right to remove, any timber, minerals (including oil and gas), coal, clay, scoria, soil, gravel or rock products without Lender's prior written consent.

Removal of Improvements. Grantor shall not demolish or remove any Improvements from the Real Property without Lender's prior written consent. As a condition to the removal of any Improvements, Lender may require Grantor to make arrangements satisfactory to Lender to replace such Improvements with Improvements of at least equal value.

Lender's Right to Enter. Lender and Lender's agents and representatives may enter upon the Real Property at all reasonable times to attend to Lender's interests and to inspect the Real Property for purposes of Grantor's compliance with the terms and conditions of this Deed of Trust.

Compliance with Governmental Requirements. Grantor shall promptly comply with all laws, ordinances, and regulations, now or hereafter in effect, of all governmental authorities applicable to the use or occupancy of the Property, including without limitation, the Americans With Disabilities Act. Grantor may contest in good faith any such law, ordinance, or regulation and withhold

compliance during any proceeding, including appropriate appeals, so long as Grantor has notified Lender in writing prior to doing so and so long as, in Lender's sole opinion, Lender's interests in the Property are not jeopardized. Lender may require Grantor to post adequate security or a surety bond, reasonably satisfactory to Lender, to protect Lender's interest.

Duty to Protect. Grantor agrees neither to abandon or leave unattended the Property. Grantor shall do all other acts, in addition to those acts set forth above in this section, which from the character and use of the Property are reasonably necessary to protect and preserve the Property.

DUE ON SALE - CONSENT BY LENDER. Lender may, at Lender's option, declare immediately due and payable all sums secured by this Deed of Trust upon the sale or transfer, without Lender's prior written consent, of all or any part of the Real Property, or any interest in the Real Property. A "sale or transfer" means the conveyance of Real Property or any right, title or interest in the Real Property; whether legal, beneficial or equitable; whether voluntary or involuntary; whether by outright sale, deed, installment sale contract, land contract, contract for deed, leasehold interest with a term greater than three (3) years, lease-option contract, or by sale, assignment, or transfer of any beneficial interest in or to any land trust holding title to the Real Property, or by any other method of conveyance of an interest in the Real Property. If any Grantor is a corporation, partnership or limited liability company, transfer also includes any change in ownership of more than twenty-five percent (25%) of the voting stock, partnership interests or limited liability company interests, as the case may be, of such Grantor. However, this option shall not be exercised by Lender if such exercise is prohibited by federal law or by Colorado law.

TAXES AND LIENS. The following provisions relating to the taxes and liens on the Property are part of this Deed of Trust:

Payment. Grantor shall pay when due (and in all events prior to delinquency) all taxes, special taxes, assessments, charges (including water and sewer), fines and impositions levied against or on account of the Property, and shall pay when due all claims for work done on or for services rendered or material furnished to the Property. Grantor shall maintain the Property free of all liens having priority over or equal to the interest of Lender under this Deed of Trust, except for the lien of taxes and assessments not due and except as otherwise provided in this Deed of Trust.

Right to Contest. Grantor may withhold payment of any tax, assessment, or claim in connection with a good faith dispute over the obligation to pay, so long as Lender's interest in the Property is not jeopardized. If a lien arises or is filed as a result of nonpayment, Grantor shall within fifteen (15) days after the lien arises or, if a lien is filed, within fifteen (15) days after Grantor has notice of the filing, secure the discharge of the lien, or if requested by Lender, deposit with Lender cash or a sufficient corporate surety bond or other security satisfactory to Lender in an amount sufficient to discharge the lien plus any costs and attorneys' fees, or other charges that could accrue as a result of a foreclosure or sale under the lien. In any contest, Grantor shall defend itself and Lender and shall satisfy any adverse judgment before enforcement against the Property. Grantor shall name Lender as an additional obligee under any surety bond furnished in the contest proceedings.

Evidence of Payment. Grantor shall upon demand furnish to Lender satisfactory evidence of payment of the taxes or assessments and shall authorize the appropriate governmental official to deliver to Lender at any time a written statement of the taxes and assessments against the Property.

Notice of Construction. Grantor shall notify Lender at least fifteen (15) days before any work is commenced, any services are furnished, or any materials are supplied to the Property, if any mechanic's lien, materialmen's lien, or other lien could be asserted on account of the work, services, or materials. Grantor will upon request of Lender furnish to Lender advance assurances satisfactory to Lender that Grantor can and will pay the cost of such improvements.

PROPERTY DAMAGE INSURANCE. The following provisions relating to insuring the Property are a part of this Deed of Trust.

Maintenance of Insurance. Grantor shall procure and maintain policies of fire insurance with standard extended coverage endorsements on a replacement basis for the full insurable value covering all Improvements on the Real Property in an amount sufficient to avoid application of any coinsurance clause, and with a standard mortgagee clause in favor of Lender. Grantor shall also procure and maintain comprehensive general liability insurance in such coverage amounts as Lender may request with Trustee and Lender being named as additional insureds in such liability insurance policies. Additionally, Grantor shall maintain such other insurance, including but not limited to hazard, business interruption, and boiler insurance, as Lender may reasonably require. Policies shall be written in form, amounts, coverages and basis reasonably acceptable to Lender and issued by a company or companies reasonably acceptable to Lender. Grantor, upon request of Lender, will deliver to Lender from time to time the policies or certificates of insurance in form satisfactory to Lender, including stipulations that coverages will not be cancelled or diminished without at least ten (10) days prior written notice to Lender. Each insurance policy also shall include an endorsement providing that coverage in favor of Lender will not be impaired in any way by any act, omission or default of Grantor or any other person. Should the Real Property be located in an area designated by the Administrator of the Federal Emergency Management Agency as a special flood hazard area, Grantor agrees to obtain and maintain Federal Flood Insurance, if available, within 45 days after notice is given by Lender that the Property is located in a special flood hazard area, for the full unpaid principal balance of the loan and any prior liens on the property securing the loan, up to the maximum policy limits set under the National Flood Insurance Program, or as otherwise required by Lender, and to maintain such insurance for the term of the loan.

Application of Proceeds. Grantor shall promptly notify Lender of any loss or damage to the Property. Lender may make proof of loss if Grantor fails to do so within fifteen (15) days of the casualty. Whether or not Lender's security is impaired, Lender may, at Lender's election, receive and retain the proceeds of any insurance and apply the proceeds to the reduction of the Indebtedness, payment of any lien affecting the Property, or the restoration and repair of the Property. If Lender elects to apply the proceeds to restoration and repair, Grantor shall repair or replace the damaged or destroyed Improvements in a manner satisfactory to Lender. Lender shall, upon satisfactory proof of such expenditure, pay or reimburse Grantor from the proceeds for

the reasonable cost of repair or restoration if Grantor is not in default under this Deed of Trust. Any proceeds which have not been disbursed within 180 days after their receipt and which Lender has not committed to the repair or restoration of the Property shall be used first to pay any amount owing to Lender under this Deed of Trust, then to pay accrued interest, and the remainder, if any, shall be applied to the principal balance of the Indebtedness. If Lender holds any proceeds after payment in full of the Indebtedness, such proceeds shall be paid to Grantor as Grantor's interests may appear.

Grantor's Report on Insurance. Upon request of Lender, however not more than once a year, Grantor shall furnish to Lender a report on each existing policy of insurance showing: (1) the name of the insurer; (2) the risks insured; (3) the amount of the policy; (4) the property insured, the then current replacement value of such property, and the manner of determining that value; and (5) the expiration date of the policy. Grantor shall, upon request of Lender, have an independent appraiser satisfactory to Lender determine the cash value replacement cost of the Property.

LENDER'S EXPENDITURES. If any action or proceeding is commenced that would materially affect Lender's interest in the Property or if Grantor fails to comply with any provision of this Deed of Trust or any Related Documents, including but not limited to Grantor's failure to discharge or pay when due any amounts Grantor is required to discharge or pay under this Deed of Trust or any Related Documents, Lender on Grantor's behalf may (but shall not be obligated to) take any action that Lender deems appropriate, including but not limited to discharging or paying all taxes, liens, security interests, encumbrances and other claims, at any time levied or placed on the Property and paying all costs for insuring, maintaining and preserving the Property. All such expenditures incurred or paid by Lender for such purposes will then bear interest at the rate charged under the Note from the date incurred or paid by Lender to the date of repayment by Grantor. All such expenses will become a part of the Indebtedness and, at Lender's option, will (A) be payable on demand; (B) be added to the balance of the Note and be apportioned among and be payable with any installment payments to become due during either (1) the term of any applicable insurance policy; or (2) the remaining term of the Note; or (C) be treated as a balloon payment which will be due and payable at the Note's maturity. The Deed of Trust also will secure payment of these amounts. Such right shall be in addition to all other rights and remedies to which Lender may be entitled upon Default.

WARRANTY; DEFENSE OF TITLE. The following provisions relating to ownership of the Property are a part of this Deed of Trust:

Title. Grantor warrants that: (a) Grantor holds good and marketable title of record to the Property in fee simple, free and clear of all liens and encumbrances other than those set forth in the Real Property description or in any title insurance policy, title report, or final title opinion issued in favor of, and accepted by, Lender in connection with this Deed of Trust, and (b) Grantor has the full right, power, and authority to execute and deliver this Deed of Trust to Lender.

Defense of Title. Subject to the exception in the paragraph above, Grantor warrants and will forever defend the title to the Property against the lawful claims of all persons. In the event any action or proceeding is commenced that questions Grantor's title or the interest of Trustee or Lender under this Deed of Trust, Grantor shall defend the action at Grantor's expense. Grantor may be the nominal party in such proceeding, but Lender shall be entitled to participate in the proceeding and to be represented in the proceeding by counsel of Lender's own choice, and Grantor will deliver, or cause to be delivered, to Lender such instruments as Lender may request from time to time to permit such participation.

Compliance With Laws. Grantor warrants that the Property and Grantor's use of the Property complies with all existing applicable laws, ordinances, and regulations of governmental authorities.

Survival of Representations and Warranties. All representations, warranties, and agreements made by Grantor in this Deed of Trust shall survive the execution and delivery of this Deed of Trust, shall be continuing in nature, and shall remain in full force and effect until such time as Borrower's Indebtedness shall be paid in full.

CONDEMNATION. The following provisions relating to condemnation proceedings are a part of this Deed of Trust:

Proceedings. If any proceeding in condemnation is filed, Grantor shall promptly notify Lender in writing, and Grantor shall promptly take such steps as may be necessary to defend the action and obtain the award. Grantor may be the nominal party in such proceeding, but Lender shall be entitled to participate in the proceeding and to be represented in the proceeding by counsel of its own choice, and Grantor will deliver or cause to be delivered to Lender such instruments and documentation as may be requested by Lender from time to time to permit such participation.

Application of Net Proceeds. If all or any part of the Property is condemned by eminent domain proceedings or by any proceeding or purchase in lieu of condemnation, Lender may at its election require that all or any portion of the net proceeds of the award be applied to the Indebtedness or the repair or restoration of the Property. The net proceeds of the award shall mean the award after payment of all reasonable costs, expenses, and attorneys' fees incurred by Trustee or Lender in connection with the condemnation.

IMPOSITION OF TAXES, FEES AND CHARGES BY GOVERNMENTAL AUTHORITIES. The following provisions relating to governmental taxes, fees and charges are a part of this Deed of Trust:

Current Taxes, Fees and Charges. Upon request by Lender, Grantor shall execute such documents in addition to this Deed of Trust and take whatever other action is requested by Lender to perfect and continue Lender's lien on the Real Property. Grantor shall reimburse Lender for all taxes, as described below, together with all expenses incurred in recording, perfecting or continuing this Deed of Trust, including without limitation all taxes, fees, documentary stamps, and other charges for recording or registering this Deed of Trust.

Taxes. The following shall constitute taxes to which this section applies: (1) a specific tax upon this type of Deed of Trust or upon all or any part of the Indebtedness secured by this Deed of Trust; (2) a specific tax on Borrower which Borrower is

authorized or required to deduct from payments on the Indebtedness secured by this type of Deed of Trust; (3) a tax on this type of Deed of Trust chargeable against the Lender or the holder of the Note; and (4) a specific tax on all or any portion of the Indebtedness or on payments of principal and interest made by Borrower.

Subsequent Taxes. If any tax to which this section applies is enacted subsequent to the date of this Deed of Trust, this event shall have the same effect as an Event of Default, and Lender may exercise any or all of its available remedies for an Event of Default as provided below unless Grantor either (1) pays the tax before it becomes delinquent, or (2) contests the tax as provided above in the Taxes and Liens section and deposits with Lender cash or a sufficient corporate surety bond or other security satisfactory to Lender.

SECURITY AGREEMENT; FINANCING STATEMENTS. The following provisions relating to this Deed of Trust as a security agreement are a part of this Deed of Trust:

Security Agreement. This instrument shall constitute a Security Agreement to the extent any of the Property constitutes fixtures, and Lender shall have all of the rights of a secured party under the Uniform Commercial Code as amended from time to time.

Security Interest. Upon request by Lender, Grantor shall take whatever action is requested by Lender to perfect and continue Lender's security interest in the Rents and Personal Property. In addition to recording this Deed of Trust in the real property records, Lender may, at any time and without further authorization from Grantor, file executed counterparts, copies or reproductions of this Deed of Trust as a financing statement. Grantor shall reimburse Lender for all expenses incurred in perfecting or continuing this security interest. Upon default, Grantor shall not remove, sever or detach the Personal Property from the Property. Upon default, Grantor shall assemble any Personal Property not affixed to the Property in a manner and at a place reasonably convenient to Grantor and Lender and make it available to Lender within three (3) days after receipt of written demand from Lender to the extent permitted by applicable law.

Addresses. The mailing addresses of Grantor (debtor) and Lender (secured party) from which information concerning the security interest granted by this Deed of Trust may be obtained (each as required by the Uniform Commercial Code) are as stated on the first page of this Deed of Trust.

FURTHER ASSURANCES; ATTORNEY-IN-FACT. The following provisions relating to further assurances and attorney-in-fact are a part of this Deed of Trust:

Further Assurances. At any time, and from time to time, upon request of Lender, Grantor will make, execute and deliver, or will cause to be made, executed or delivered, to Lender or to Lender's designee, and when requested by Lender, cause to be filed, recorded, refiled, or rerecorded, as the case may be, at such times and in such offices and places as Lender may deem appropriate, any and all such mortgages, deeds of trust, security deeds, security agreements, financing statements, continuation statements, instruments of further assurance, certificates, and other documents as may, in the sole opinion of Lender, be necessary or desirable in order to effectuate, complete, perfect, continue, or preserve (1) Borrower's and Grantor's obligations under the Note, this Deed of Trust, and the Related Documents, and (2) the liens and security interests created by this Deed of Trust as first and prior liens on the Property, whether now owned or hereafter acquired by Grantor. Unless prohibited by law or Lender agrees to the contrary in writing, Grantor shall reimburse Lender for all costs and expenses incurred in connection with the matters referred to in this paragraph.

Attorney-in-Fact. If Grantor fails to do any of the things referred to in the preceding paragraph, Lender may do so for and in the name of Grantor and at Grantor's expense. For such purposes, Grantor hereby irrevocably appoints Lender as Grantor's attorney-in-fact for the purpose of making, executing, delivering, filing, recording, and doing all other things as may be necessary or desirable, in Lender's sole opinion, to accomplish the matters referred to in the preceding paragraph.

FULL PERFORMANCE. Upon the full performance of all the obligations under the Note and this Deed of Trust, Trustee may, upon production of documents and fees as required under applicable law, release this Deed of Trust, and such release shall constitute a release of the lien for all such additional sums and expenditures made pursuant to this Deed of Trust. Lender agrees to cooperate with Grantor in obtaining such release and releasing the other collateral securing the Indebtedness. Any release fees required by law shall be paid by Grantor, if permitted by applicable law.

EVENTS OF DEFAULT. Each of the following, at Lender's option, shall constitute an Event of Default under this Deed of Trust:

Payment Default. Borrower fails to make any payment when due under the Indebtedness.

Other Defaults. Borrower or Grantor fails to comply with or to perform any other term, obligation, covenant or condition contained in this Deed of Trust or in any of the Related Documents or to comply with or to perform any term, obligation, covenant or condition contained in any other agreement between Lender and Borrower or Grantor.

Compliance Default. Failure to comply with any other term, obligation, covenant or condition contained in this Deed of Trust, the Note or in any of the Related Documents.

Default on Other Payments. Failure of Grantor within the time required by this Deed of Trust to make any payment for taxes or insurance, or any other payment necessary to prevent filing of or to effect discharge of any lien.

Default in Favor of Third Parties. Should Borrower or any Grantor default under any loan, extension of credit, security agreement, purchase or sales agreement, or any other agreement, in favor of any other creditor or person that may materially affect any of Borrower's or any Grantor's property or Borrower's ability to repay the Indebtedness or Borrower's or Grantor's ability to perform their respective obligations under this Deed of Trust or any of the Related Documents.

False Statements. Any warranty, representation or statement made or furnished to Lender by Borrower or Grantor or on Borrower's or Grantor's behalf under this Deed of Trust or the Related Documents is false or misleading in any material respect, either now or at the time made or furnished or becomes false or misleading at any time thereafter.

Defective Collateralization. This Deed of Trust or any of the Related Documents ceases to be in full force and effect (including failure of any collateral document to create a valid and perfected security interest or lien) at any time and for any reason.

Death or Insolvency. The dissolution of Grantor's (regardless of whether election to continue is made), any member withdraws from the limited liability company, or any other termination of Borrower's or Grantor's existence as a going business or the death of any member, the insolvency of Borrower or Grantor, the appointment of a receiver for any part of Borrower's or Grantor's property, any assignment for the benefit of creditors, any type of creditor workout, or the commencement of any proceeding under any bankruptcy or insolvency laws by or against Borrower or Grantor.

Creditor or Forfeiture Proceedings. Commencement of foreclosure or forfeiture proceedings, whether by judicial proceeding, self-help, repossession or any other method, by any creditor of Borrower or Grantor or by any governmental agency against any property securing the Indebtedness. This includes a garnishment of any of Borrower's or Grantor's accounts, including deposit accounts, with Lender. However, this Event of Default shall not apply if there is a good faith dispute by Borrower or Grantor as to the validity or reasonableness of the claim which is the basis of the creditor or forfeiture proceeding and if Borrower or Grantor gives Lender written notice of the creditor or forfeiture proceeding and deposits with Lender monies or a surety bond for the creditor or forfeiture proceeding, in an amount determined by Lender, in its sole discretion, as being an adequate reserve or bond for the dispute.

Breach of Other Agreement. Any breach by Borrower or Grantor under the terms of any other agreement between Borrower or Grantor and Lender that is not remedied within any grace period provided therein, including without limitation any agreement concerning any indebtedness or other obligation of Borrower or Grantor to Lender, whether existing now or later.

Events Affecting Guarantor. Any of the preceding events occurs with respect to any Guarantor of any of the Indebtedness or any Guarantor dies or becomes incompetent, or revokes or disputes the validity of, or liability under, any Guaranty of the Indebtedness.

Adverse Change. A material adverse change occurs in Borrower's or Grantor's financial condition, or Lender believes the prospect of payment or performance of the Indebtedness is impaired.

Insecurity. Lender in good faith believes itself insecure.

RIGHTS AND REMEDIES ON DEFAULT. If an Event of Default occurs under this Deed of Trust, at any time thereafter, Trustee or Lender may exercise any one or more of the following rights and remedies:

Election of Remedies. Election by Lender to pursue any remedy shall not exclude pursuit of any other remedy, and an election to make expenditures or to take action to perform an obligation of Grantor under this Deed of Trust, after Grantor's failure to perform, shall not affect Lender's right to declare a default and exercise its remedies.

Accelerate Indebtedness. Lender shall have the right at its option without notice to Borrower or Grantor to declare the entire Indebtedness immediately due and payable, including any prepayment penalty which Borrower would be required to pay.

Foreclosure. Lender shall have the right to cause all or any part of the Real Property, and Personal Property, if Lender decides to proceed against it as if it were real property, to be sold by the Trustee according to the laws of the State of Colorado as respects foreclosures against real property. The Trustee shall give notice in accordance with the laws of Colorado. The Trustee shall apply the proceeds of the sale in the following order: (a) to all costs and expenses of the sale, including but not limited to Trustee's fees, attorneys' fees, and the cost of title evidence; (b) to all sums secured by this Deed of Trust; and (c) the excess, if any, to the person or persons legally entitled to the excess.

UCC Remedies. With respect to all or any part of the Personal Property, Lender shall have all the rights and remedies of a secured party under the Uniform Commercial Code.

Collect Rents. Lender shall have the right, without notice to Borrower or Grantor to take possession of and manage the Property and collect the Rents, including amounts past due and unpaid, and apply the net proceeds, over and above Lender's costs, against the Indebtedness. In furtherance of this right, Lender may require any tenant or other user of the Property to make payments of rent or use fees directly to Lender. If the Rents are collected by Lender, then Grantor irrevocably designates Lender as Grantor's attorney-in-fact to endorse instruments received in payment thereof in the name of Grantor and to negotiate the same and collect the proceeds. Payments by tenants or other users to Lender in response to Lender's demand shall satisfy the obligations for which the payments are made, whether or not any proper grounds for the demand existed. Lender may exercise its rights under this subparagraph either in person, by agent, or through a receiver.

Appoint Receiver. Lender shall have the right to have a receiver appointed to take possession of all or any part of the Property, with the power to protect and preserve the Property, to operate the Property preceding foreclosure or sale, and to collect the Rents from the Property and apply the proceeds, over and above the cost of the receivership, against the Indebtedness. The receiver may serve without bond if permitted by law. Lender's right to the appointment of a receiver shall exist whether or not the apparent value of the Property exceeds the Indebtedness by a substantial amount. Employment by Lender shall not disqualify a person from serving as a receiver. Receiver may be appointed by a court of competent jurisdiction upon ex parte application and without notice, notice being expressly waived.

Tenancy at Sufferance. If Grantor remains in possession of the Property after the Property is sold as provided above or Lender otherwise becomes entitled to possession of the Property upon default of Borrower or Grantor, Grantor shall become a tenant at sufferance of Lender or the purchaser of the Property and shall, at Lender's option, either (1) pay a reasonable rental for the use of the Property, or (2) vacate the Property immediately upon the demand of Lender.

Other Remedies. Trustee or Lender shall have any other right or remedy provided in this Deed of Trust or the Note or available at law or in equity.

Sale of the Property. In exercising its rights and remedies, Lender shall be free to designate on or before it files a notice of election and demand with the Trustee, that the Trustee sell all or any part of the Property together or separately, in one sale or by separate sales. Lender shall be entitled to bid at any public sale on all or any portion of the Property. Upon any sale of the Property, whether made under a power of sale granted in this Deed of Trust or pursuant to judicial proceedings, if the holder of the Note is a purchaser at such sale, it shall be entitled to use and apply all, or any portion of, the Indebtedness for or in settlement or payment of all, or any portion of, the purchase price of the Property purchased, and, in such case, this Deed of Trust, the Note, and any documents evidencing expenditures secured by this Deed of Trust shall be presented to the person conducting the sale in order that the amount of Indebtedness so used or applied may be credited thereon as having been paid.

Attorneys' Fees; Expenses. If Lender forecloses or institutes any suit or action to enforce any of the terms of this Deed of Trust, Lender shall be entitled to recover such sum as the court may adjudge reasonable as attorneys' fees at trial and upon any appeal. Whether or not any court action is involved, and to the extent not prohibited by law, all reasonable expenses Lender incurs that in Lender's opinion are necessary at any time for the protection of its interest or the enforcement of its rights shall become a part of the Indebtedness payable on demand and shall bear interest at the Note rate from the date of the expenditure until repaid. Expenses covered by this paragraph include, without limitation, however subject to any limits under applicable law, Lender's attorneys' fees whether or not there is a lawsuit, including attorneys' fees and expenses for bankruptcy proceedings (including efforts to modify or vacate any automatic stay or injunction), appeals, and any anticipated post-judgment collection services, the cost of searching records, obtaining title reports (including foreclosure reports), surveyors' reports, and appraisal fees, title insurance, and fees for the Trustee, to the extent permitted by applicable law. Grantor also will pay any court costs, in addition to all other sums provided by law.

Rights of Trustee. To the extent permitted by applicable law, Trustee shall have all of the rights and duties of Lender as set forth in this section.

NOTICES. Any notice required to be given under this Deed of Trust, including without limitation any notice of default and any notice of sale shall be given in writing, and shall be effective when actually delivered, when actually received by telefacsimile (unless otherwise required by law), when deposited with a nationally recognized overnight courier, or, if mailed, when deposited in the United States mail, as first class, certified or registered mail postage prepaid, directed to the addresses shown near the beginning of this Deed of Trust. All copies of notices of foreclosure from the holder of any lien which has priority over this Deed of Trust shall be sent to Lender's address, as shown near the beginning of this Deed of Trust. Any party may change its address for notices under this Deed of Trust by giving formal written notice to the other parties, specifying that the purpose of the notice is to change the party's address. For notice purposes, Grantor agrees to keep Lender informed at all times of Grantor's current address. Unless otherwise provided or required by law, if there is more than one Grantor, any notice given by Lender to any Grantor is deemed to be notice given to all Grantors.

MISCELLANEOUS PROVISIONS. The following miscellaneous provisions are a part of this Deed of Trust:

Amendments. This Deed of Trust, together with any Related Documents, constitutes the entire understanding and agreement of the parties as to the matters set forth in this Deed of Trust. No alteration of or amendment to this Deed of Trust shall be effective unless given in writing and signed by the party or parties sought to be charged or bound by the alteration or amendment.

Annual Reports. If the Property is used for purposes other than Grantor's residence, Grantor shall furnish to Lender, upon request, a certified statement of net operating income received from the Property during Grantor's previous fiscal year in such form and detail as Lender shall require. "Net operating income" shall mean all cash receipts from the Property less all cash expenditures made in connection with the operation of the Property.

Caption Headings. Caption headings in this Deed of Trust are for convenience purposes only and are not to be used to interpret or define the provisions of this Deed of Trust.

Merger. There shall be no merger of the interest or estate created by this Deed of Trust with any other interest or estate in the Property at any time held by or for the benefit of Lender in any capacity, without the written consent of Lender.

Governing Law. This Deed of Trust will be governed by federal law applicable to Lender and, to the extent not preempted by federal law, the laws of the State of Colorado without regard to its conflicts of law provisions. This Deed of Trust has been accepted by Lender in the State of Colorado.

Choice of Venue. If there is a lawsuit, Grantor agrees upon Lender's request to submit to the jurisdiction of the courts of Montrose County, State of Colorado.

Joint and Several Liability. All obligations of Borrower and Grantor under this Deed of Trust shall be joint and several, and all references to Grantor shall mean each and every Grantor, and all references to Borrower shall mean each and every Borrower. This means that each Grantor signing below is responsible for all obligations in this Deed of Trust. Where any one or more of the

parties is a corporation, partnership, limited liability company or similar entity, it is not necessary for Lender to inquire into the powers of any of the officers, directors, partners, members, or other agents acting or purporting to act on the entity's behalf, and any obligations made or created in reliance upon the professed exercise of such powers shall be guaranteed under this Deed of Trust.

No Waiver by Lender. Lender shall not be deemed to have waived any rights under this Deed of Trust unless such waiver is given in writing and signed by Lender. No delay or omission on the part of Lender in exercising any right shall operate as a waiver of such right or any other right. A waiver by Lender of a provision of this Deed of Trust shall not prejudice or constitute a waiver of Lender's right otherwise to demand strict compliance with that provision or any other provision of this Deed of Trust. No prior waiver by Lender, nor any course of dealing between Lender and Grantor, shall constitute a waiver of any of Lender's rights or of any of Grantor's obligations as to any future transactions. Whenever the consent of Lender is required under this Deed of Trust, the granting of such consent by Lender in any instance shall not constitute continuing consent to subsequent instances where such consent is required and in all cases such consent may be granted or withheld in the sole discretion of Lender.

Severability. If a court of competent jurisdiction finds any provision of this Deed of Trust to be illegal, invalid, or unenforceable as to any person or circumstance, that finding shall not make the offending provision illegal, invalid, or unenforceable as to any other person or circumstance. If feasible, the offending provision shall be considered modified so that it becomes legal, valid and enforceable. If the offending provision cannot be so modified, it shall be considered deleted from this Deed of Trust. Unless otherwise required by law, the illegality, invalidity, or unenforceability of any provision of this Deed of Trust shall not affect the legality, validity or enforceability of any other provision of this Deed of Trust.

Successors and Assigns. Subject to any limitations stated in this Deed of Trust on transfer of Grantor's interest, this Deed of Trust shall be binding upon and inure to the benefit of the parties, their successors and assigns. If ownership of the Property becomes vested in a person other than Grantor, Lender, without notice to Grantor, may deal with Grantor's successors with reference to this Deed of Trust and the Indebtedness by way of forbearance or extension without releasing Grantor from the obligations of this Deed of Trust or liability under the Indebtedness.

Time is of the Essence. Time is of the essence in the performance of this Deed of Trust.

Waive Jury. All parties to this Deed of Trust hereby waive the right to any jury trial in any action, proceeding, or counterclaim brought by any party against any other party.

Waiver of Homestead Exemption. Grantor hereby releases and waives all rights and benefits of the homestead exemption laws of the State of Colorado as to all Indebtedness secured by this Deed of Trust.

DEFINITIONS. The following capitalized words and terms shall have the following meanings when used in this Deed of Trust. Unless specifically stated to the contrary, all references to dollar amounts shall mean amounts in lawful money of the United States of America. Words and terms used in the singular shall include the plural, and the plural shall include the singular, as the context may require. Words and terms not otherwise defined in this Deed of Trust shall have the meanings attributed to such terms in the Uniform Commercial Code:

Beneficiary. The word "Beneficiary" means Community Banks of Colorado, a division of NBH Bank, and its successors and assigns.

Borrower. The word "Borrower" means David Allen Taylor and Susan Marie Taylor and includes all co-signers and co-makers signing the Note and all their successors and assigns.

Deed of Trust. The words "Deed of Trust" mean this Deed of Trust among Grantor, Lender, and Trustee, and includes without limitation all assignment and security interest provisions relating to the Personal Property and Rents.

Default. The word "Default" means the Default set forth in this Deed of Trust in the section titled "Default".

Environmental Laws. The words "Environmental Laws" mean any and all state, federal and local statutes, regulations and ordinances relating to the protection of human health or the environment, including without limitation the Comprehensive Environmental Response, Compensation, and Liability Act of 1980, as amended, 42 U.S.C. Section 9601, et seq. ("CERCLA"), the Superfund Amendments and Reauthorization Act of 1986, Pub. L. No. 99-499 ("SARA"), the Hazardous Materials Transportation Act, 49 U.S.C. Section 1801, et seq., the Resource Conservation and Recovery Act, 42 U.S.C. Section 6901, et seq., or other applicable state or federal laws, rules, or regulations adopted pursuant thereto.

Event of Default. The words "Event of Default" mean any of the events of default set forth in this Deed of Trust in the events of default section of this Deed of Trust.

Grantor. The word "Grantor" means David Taylor, Susan Taylor and Gunnison Kampground Partners LLC.

Guarantor. The word "Guarantor" means any guarantor, surety, or accommodation party of any or all of the Indebtedness.

Guaranty. The word "Guaranty" means the guaranty from Guarantor to Lender, including without limitation a guaranty of all or part of the Note.

Hazardous Substances. The words "Hazardous Substances" mean materials that, because of their quantity, concentration or physical, chemical or infectious characteristics, may cause or pose a present or potential hazard to human health or the environment when improperly used, treated, stored, disposed of, generated, manufactured, transported or otherwise handled.

The words "Hazardous Substances" are used in their very broadest sense and include without limitation any and all hazardous or toxic substances, materials or waste as defined by or listed under the Environmental Laws. The term "Hazardous Substances" also includes, without limitation, petroleum and petroleum by-products or any fraction thereof and asbestos.

Improvements. The word "Improvements" means all existing and future improvements, buildings, structures, mobile homes affixed on the Real Property, facilities, additions, replacements and other construction on the Real Property.

Indebtedness. The word "Indebtedness" means all principal, interest, and other amounts, costs and expenses payable under the Note or Related Documents, together with all renewals of, extensions of, modifications of, consolidations of and substitutions for the Note or Related Documents and any amounts expended or advanced by Lender to discharge Grantor's obligations or expenses incurred by Trustee or Lender to enforce Grantor's obligations under this Deed of Trust, together with interest on such amounts as provided in this Deed of Trust. Specifically, without limitation, Indebtedness includes the future advances set forth in the Future Advances provision, together with all interest thereon and all amounts that may be indirectly secured by the Cross-Collateralization provision of this Deed of Trust.

Lender. The word "Lender" means Community Banks of Colorado, a division of NBH Bank, its successors and assigns.

Note. The word "Note" means the promissory note dated March 29, 2017, **in the original principal amount of $179,287.00** from Borrower to Lender, together with all renewals of, extensions of, modifications of, refinancings of, consolidations of, and substitutions for the promissory note or agreement. The maturity date of the Note is March 29, 2024.

Personal Property. The words "Personal Property" mean all equipment, fixtures, and other articles of personal property now or hereafter owned by Grantor, and now or hereafter attached or affixed to the Real Property; together with all accessions, parts, and additions to, all replacements of, and all substitutions for, any of such property; and together with all proceeds (including without limitation all insurance proceeds and refunds of premiums) from any sale or other disposition of the Property.

Property. The word "Property" means collectively the Real Property and the Personal Property.

Real Property. The words "Real Property" mean the real property, interests and rights, as further described in this Deed of Trust.

Related Documents. The words "Related Documents" mean all promissory notes, credit agreements, loan agreements, environmental agreements, guaranties, security agreements, mortgages, deeds of trust, security deeds, collateral mortgages, and all other instruments, agreements and documents, whether now or hereafter existing, executed in connection with the Indebtedness.

Rents. The word "Rents" means all present and future rents, revenues, income, issues, royalties, profits, and other benefits derived from the Property.

Trustee. The word "Trustee" means the Public Trustee of Gunnison County, Colorado.

EACH GRANTOR ACKNOWLEDGES HAVING READ ALL THE PROVISIONS OF THIS DEED OF TRUST, AND EACH GRANTOR AGREES TO ITS TERMS.

GRANTOR:

X _____
David Taylor, Individually

X _____
Susan Taylor, Individually

GUNNISON KAMPGROUND PARTNERS LLC

By: _____
David A. Taylor, Manager of Gunnison Kampground Partners LLC

By: _____
Susan M. Taylor, Manager of Gunnison Kampground Partners LLC

INDIVIDUAL ACKNOWLEDGMENT

STATE OF Colorado)
) SS
COUNTY OF douglas)

RIHANA SULEIMAN
Notary Public
State of Colorado
Notary ID 20144015691
My Commission Expires Apr 11, 2018

On this day before me, the undersigned Notary Public, personally appeared **David Taylor and Susan Taylor**, to me known to be the individuals described in and who executed the Deed of Trust, and acknowledged that they signed the Deed of Trust as their free and voluntary act and deed, for the uses and purposes therein mentioned.

Given under my hand and official seal this 29 day of March, 20 17.

By Rihana Suleiman Residing at Parker Colorado

Notary Public in and for the State of Colorado My commission expires 4-11-18

LIMITED LIABILITY COMPANY ACKNOWLEDGMENT

STATE OF Colorado)
) SS
COUNTY OF douglas)

RIHANA SULEIMAN
Notary Public
State of Colorado
Notary ID 20144015691
My Commission Expires Apr 11, 2018

On this 29 day of March, 20 17, before me, the undersigned Notary Public, personally appeared **David A. Taylor, Manager of Gunnison Kampground Partners LLC and Susan M. Taylor, Manager of Gunnison Kampground Partners LLC**, and known to me to be members or designated agents of the limited liability company that executed the Deed of Trust and acknowledged the Deed of Trust to be the free and voluntary act and deed of the limited liability company, by authority of statute, its articles of organization or its operating agreement, for the uses and purposes therein mentioned, and on oath stated that they are authorized to execute this Deed of Trust and in fact executed the Deed of Trust on behalf of the limited liability company.

By Rihana Suleiman Residing at Parker Colorado

Notary Public in and for the State of Colorado My commission expires 4-11-18

694335 12/6/2023 10:16:23 AM Page 1 of 1
Kathy Simillion Gunnison County, CO
R: $13.00 D: 0.00 eRecorded

Original Note and Deed of Trust Returned to:	Community Banks of Colorado, a division of NBH Bank
WHEN RECORDED RETURN TO:	1111Main, Ste. 2700, Kansas City, MO 64105
Prepared/Received by: Stacie Orr	Loan #XXXXXX3971-1

REQUEST FOR FULL [X] / PARTIAL [ ]
RELEASE OF DEED OF TRUST AND RELEASE BY HOLDER OF THE EVIDENCE OF DEBT WITHOUT PRODUCTION OF EVIDENCE OF DEBT PURSUANT TO § 38-39-102 (1) (a) and (3), COLORADO REVISED STATUTES

December 5, 2023 — Date

Parcel 1: Gunnison Kampground, LLC, a Colorado limited liability company, Parcel 2: David Taylor and Susan Taylor, Parcel 3: David Taylor and Susan Taylor — Original Grantor (Borrower)

105 County Rd 50, Gunnison, CO 81230-9233 — Current Address of Original Grantor, Assuming Party, or Current Owner

[ ] Check here if current address is unknown

Community Banks of Colorado, a division of NBH Bank — Original Beneficiary (Lender)

March 29, 2017 — Date of Deed of Trust

March 31, 2017 — Date of Recording and/or Re-Recording of Deed of Trust

Gunnison County, Reception No. 645706
County Rcpt. No. and/or Film No. and/or Book/Page No. and/or Torrens Reg. No.

TO THE PUBLIC TRUSTEE OF Gunnison COUNTY (The County of the Public Trustee who is the appropriate grantee to whom the above Deed of Trust should grant an interest in the property described in the Deed of Trust.)

PLEASE EXECUTE AND RECORD A RELEASE OF THE DEED OF TRUST DESCRIBED ABOVE. The indebtedness secured by the Deed of Trust has been fully or partially paid and/or the purpose of the Deed of Trust has been fully or partially satisfied in regard to the property encumbered by the Deed of Trust as described in the Deed of Trust as to a full release or, in the event of a partial release, only that portion of the real property described as:

(IF NO LEGAL DESCRIPTION IS LISTED THIS WILL BE DEEMED A FULL RELEASE.)

Pursuant to § 38-39-102 (3), Colorado Revised Statutes, in support of this Request for Release of Deed of Trust, the undersigned, as the holder of the evidence of debt secured by the Deed of Trust described above, or as a Title Insurance Company authorized to request the release of a Deed of Trust pursuant to § 38-39-102(3)(c), Colorado Revised Statutes, in lieu of the production or exhibition of the original evidence of debt with this Request for Release, certifies as follows:

1. The purpose of the Deed of Trust has been fully or partially satisfied.
2. The original evidence of debt is not being exhibited or produced with this request for release of Deed of Trust.
3. It is one of the following entities (check applicable box):

a. [X] The holder of the original evidence of debt that is a qualified holder, as specified in § 38-39-102(3)(a), Colorado Revised Statutes, that agrees that it is obligated to indemnify the Public Trustee for any and all damages, costs, liabilities, and reasonable attorney fees incurred as a result of the action of the Public Trustee taken in accordance with this request for release;

b. ☐ The holder of the evidence of debt requesting the release of a Deed of Trust without producing or exhibiting the original evidence of debt that delivers to the Public Trustee a corporate surety bond as specified in § 38-39-102(3)(b), Colorado Revised Statutes;

c. ☐ A title insurance company licensed in Colorado, as specified in § 38-39-102(3)(c), Colorado Revised Statutes, that agrees that it is obligated to indemnify the Public Trustee pursuant to statute as a result of the action of the Public Trustee taken in accordance with this request for release and that has caused the indebtedness secured by the deed of trust to be satisfied in full, or in the case of a partial release, to the extent required by the holder of the indebtedness; or

d. ☐ A holder, as specified in § 38-39-102 (3)(d)(I), Colorado Revised Statutes, that agrees that it is obligated to indemnify the Public Trustee pursuant to statute as a result of the action of the Public Trustee in accordance with this Request for Release and that has caused the indebtedness secured by the Deed of Trust to be satisfied in full, or in the case of a partial release, to the extent required by the holder of the indebtedness. **E-FILE ONLY**

Community Banks of Colorado, a division of NBH Bank; 1111 Main, Ste. 2700, Kansas City, MO 64105
Name and address of the holder of the evidence of debt secured by Deed of Trust (lender) or name and address of the Title Insurance Company authorized to request the release or a Deed of Trust

Christina Becerra, Vice President Community Banks of Colorado, a division of NBH Bank
Name, title, and address of officer, agent, or attorney of the holder of the evidence of debt secured by Deed of Trust (lender)

Christina Becerra
Signature

Signature

State of Missouri, County of Jackson
The foregoing Request for Release was acknowledged before me on December 5, 2023 (Date) by* Christina Becerra - Vice President Community Banks of Colorado, a division of NBH Bank
*If applicable, insert title of officer and name of current holder

CARLOS D. NORIEGA
Notary Public-Notary Seal
STATE OF MISSOURI-Jackson County
My Commission Expires: Mar. 28, 2024
Commission # 16301364

Witness my hand and official seal

Notary Public

3-28-2024
Date Commission Expires

RELEASE OF DEED OF TRUST

WHEREAS, the Grantor(s) named above, by Deed of Trust, granted certain real property described in the Deed of Trust to the Public Trustee of the County referenced above, in the State of Colorado, to be held in trust to secure the payment of the indebtedness referred to in the Deed of Trust; and
WHEREAS, the indebtedness secured by the Deed of Trust has been fully or partially paid and/or the purpose of the Deed of Trust has been fully or partially satisfied according to the written request of the holder of the evidence of debt or Title Insurance Company authorized to request the release of the Deed of Trust;
NOW THEREFORE, in consideration of the premises and the payment of the statutory sum, receipt of which is hereby acknowledged, I, as the Public Trustee in the County named above, do hereby fully and absolutely release, cancel and forever discharge the Deed of Trust or that portion of the real property described above in the Deed of Trust, together with all privileges and appurtenances belonging to the real property.

(Public Trustee use only; use appropriate label)

(Public Trustee's seal) GUNNISON COUNTY PUBLIC TRUSTEE SEAL

Public Trustee

Teresa Brown
Deputy Public Trustee

12/6/2023

(If applicable: Notary Seal)

(If applicable, name and address of person creating new legal description as required by § 38-35-106.5, Colorado Revised Statutes.)

AGENDA ITEM or FINAL CONTRACT REVIEW SUBMITTAL FORM

Agenda Item: Local Landmark Designation for Crystal Townsite Bu

Action Requested: Board of County Commissioners' Signature

Parties to the Agreement:

Term Begins: **Term Ends:** **Grant Contract #:**

Summary:

Historic local landmark designation of six cabins in the Crystal townsite

Fiscal Impact: 0

Submitted by: Mike Pelletier **Submitter's Email Address:** mpelletier@gunnisoncounty.org

Finance Review: ○ Required ◉ Not Required

Comments:

Reviewed by: Discharge Date:

County Attorney Review: ◉ Required ○ Not Required

Comments:
Legally sufficient. SO 2/24/26

Reveiwed by: GUNCOUNTY1\sobaid Discharge Date: 2/24/2026 Certificate of Insurance Required

Yes ○ No ◉

County Manager Review:

Comments:

Reveiwed by: GUNCOUNTY1\mbirnie Discharge Date: 2/25/2026

○ Consent Agenda ◉ Regular Agenda ○ Worksession Time Allotted: 10

Agenda Date: 3/3/2026

Revised April 2015

To: Board of County Commissioners
From: Mike Pelletier, GIS Manager
Date: March 3, 2026
RE: Local Landmark Designation for Crystal Townsite Buildings

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The Crystal Townsite is located between Marble and Schofield on Forest Service Road 314. The owners of much of the land in the old townsite have nominated six buildings for historic local landmarck designation. Staff recommends that the BoCC pass the attached resolution approving the designation.

The Crystal area was known for good silver mines and the town was incorporated in 1881. The peak population of 600 in 1883 was down to 4 by 1910. The town had over seventy buildings and even 12 streetlights. However, the most famous structure is the Crystal Mill, which is located to the northwest of the town and is a very popular tourist draw. Fortunately, a number of relatively well preserved structures exist within the old town. The nominated buildings are as follows:

1. The Crystal Club – 1899 saloon/dance hall, 1,840 sqft, 3862 FS 314
2. The A.A. Johnson General Store –1881 store/post office, 1,450 sqft, 3880 FS 314
3. The Clayton Cabin – 1895 owner ran a jack train, 570 sqft, 3901 FS 314
4. The Melton Cabin – 1880s, prominent mine owner, 1,099 sqft, 3925 FS 314
5. The Rosetta Cabin – 1895-ish miner cabin, 1050 sqft, 3930 FS 314
6. The Edgerton Cabin – 1885-ish miner cabin, 285 sqft, 3940 FS 314 (the Edgerton family kept a detailed journal of life in Crystal)

These buildings help to tell the heritage story of this fasicinating and beautiful corner of Gunnison County and Colorado. Please see the application in your packet for details and photographs of the buildings.

The Gunnison County Historic Preservation Commission considered the application at their meeting on February 25, 2026 and voted to approve the application for landmark status because it meets the following criteria.as written is resolution 2005-35.

> *The proposed landmark must meet one or more of the following criteria for significance:*
> - *Must be fifty (50) years or older*
> - *Represents the work of an important builder or architect*
> - *Possesses high artistic values*
> - *Represents a significant type, period or method of construction*
> - *Associated with significant persons or cultural groups*
> - *Associated with significant events or patterns*
> - *Contributes to a historic district*
> - *May possess information important in prehistory or history*

BOARD OF COUNTY COMMISSIONERS
OF THE COUNTY OF GUNNISON, COLORADO
RESOLUTION NO. 2026-__

A RESOLUTION DESIGNATING THE FOLLOWING BUILDINGS LOCATED IN THE FORMER TOWNSITE OF CRYSTAL, WHICH IS LOCATED BETWEEN MARBLE AND SCHOFIELD ALONG FOREST SERVICE ROAD 314, GUNNISON COUNTY, COLORADO, TO BE INDIVIDUALLY A GUNNISON COUNTY HISTORIC LANDMARK

1. THE CRYSTAL CLUB - 3862 FS 314
2. THE A.A. JOHNSON GENERAL STORE - 3880 FS 314
3. THE CLAYTON CABIN - 3901 FS 314
4. THE MELTON CABIN - 3925 FS 314
5. THE ROSETTA CABIN - 3930 FS 314
6. THE EDGERTON CABIN - 3940 FS 314

WHEREAS, the Board of County Commissioners of the County of Gunnison, Colorado ("Board"), has provided, pursuant to Resolution 93-32, Resolution 05-28 and Resolution 05-35, for the preservation of the cultural, historic, and architectural history within Gunnison County; and

WHEREAS, application has been made for individually designating as a Gunnison County historical landmarks six buildings with the former townsite of Crystal. Located between Marble and Schofield along Forest Service Road 314, with the extent of each designation being limited to the extent of each building and not including adjacent sheds and other structures; and

WHEREAS, the application included for each building, a Colorado Cultural Resource Survey Architectural Inventory Form, created by a qualified professional, pursuant to the Office of Archaeology & Historic Preservation; and

WHEREAS, the six buildings are known as and are addressed as follows: Crystal Club (3862 FS 314), A.A. Johnson General Store (3880 FS 314), Clayton Cabin (3901 FS 314), Melton Cabin (3925 FS 314), Rosetta Cabin (3930 FS 314), and Edgerton Cabin (3940 FS 314). The legal address of the property currently being 345.35 acres in sections 3, 27, 33 & 34, township 11S, range 87W including mining claims in Rock Creek Mining District; and

WHEREAS. the review process required by Resolution 93-32, Resolution 05-28 and Resolution 05-35 have been conducted and concluded completely and appropriately by the Gunnison County Historic Preservation Commission; and

WHEREAS, the Board has determined, pursuant to Resolution 93-32, Resolution 05-28 and Resolution 05-35, that all of the procedural and substantive prerequisites of designating these buildings have been met;

NOW, THEREFORE, BE IT RESOLVED by the Board of County Commissioners of the County of Gunnison, Colorado, that the Crystal Club, A.A. Johnson General Store,

Clayton Cabin, Melton Cabin, Rosetta Cabin, and Edgerton Cabin be individually designated as a Gunnison County Historic Landmarks, and further, that this Resolution be recorded in the records of the Gunnison County Clerk and Recorder, as the landmark designation certificate specified by Resolution 93-32, Resolution 05-28 and Resolution 05-35.

INTRODUCED by Commissioner_____, seconded by Commissioner _____, and adopted this ____ day of _____, 2026.

BOARD OF COUNTY COMMISSIONERS
OF GUNNISON COUNTY, COLORADO

By _____
Laura Puckett Daniels, Chairperson

By _____
Elizabeth Smith, Vice-Chairperson

By _____
Jonathan Houck, Board Member

Attest:

_____
Deputy County Clerk

Crystal River North Fk
FS 314
CLAYTON CABIN
CRYSTAL CLUB
A.A. Johnson General Store
MELTON CABIN
Crystal River
CRYSTAL MILL
ROSSETA CABIN
EDGERTON CABIN
Crystal River South Fk
190 ft US

OAHP1403
Rev. 9/98

COLORADO CULTURAL RESOURCE SURVEY

Architectural Inventory Form

Official eligibility determination
(OAHP use only)
Date _____ Initials _____
_____ Determined Eligible- NR
_____ Determined Not Eligible- NR
_____ Determined Eligible- SR
_____ Determined Not Eligible- SR
_____ Need Data
_____ Contributes to eligible NR District
_____ Noncontributing to eligible NR District

I. IDENTIFICATION

1. Resource number: 5GN6527
2. Temporary resource number: Feature 2
3. County: Gunnison
4. City: Crystal
5. Historic building name: Crystal Club
6. Current building name: Crystal Club
7. Building address: 3881 Forest Service Road 314, Crystal Townsite Vicinity (per Gunnison County Assessor 2019d)
8. Owner name and address: Christopher Cox/Treasure Mountain Ranch, Inc/Crystal Mountain Ranch: 1203 Colorado Avenue, Glenwood Springs, Colorado 81601

II. GEOGRAPHIC INFORMATION

9. P.M.: 6th Township: 11 S Range: 87 W
   SW ¼ of SE ¼ of SE ¼ of SE ¼ of section 28
10. UTM reference:
    Zone: 13 N ; 318106 mE 4325444 mN
11. USGS quad name: Snowmass Mountain
    Year: 1960 (PR 1987) Map scale: 7.5' ☒ 15' ☐ (Attach photocopy of appropriate map section)
12. Lot(s): _____ Block: _____
    Addition: Yes Year of addition: Unknown specifically, though circa 1899
13. Boundary description and justification:
    Boundary of the Crystal Club (5GN6527) is defined by the physical extent of the primary building and its associated building on the north, east, and south, and by the east boundary of neighboring parcel on the west. Today, the Crystal Club is part of the greater, undivided ~400 Treasure Mountain Ranch/Crystal Mountain Ranch (Parcel # 2915-340-00-004) (Gunnison County Assessor 2019d).

III. Architectural Description

14. Building plan (footprint, shape): Rectangular
15. Dimensions in feet: Length: 46' 7" X Width: 19' 11"
16. Number of stories: 2
17. Primary external wall material(s): Wood- log; Wood- horizontal siding
18. Roof configuration: Gable- front
19. Primary external roof material(s): Metal
20. Special features: Remnants of a painted canvas sign are still present on the north elevation; the painting on the canvas sign has not been updated for at least 60 years (Christopher Cox, personal communication September 25, 2019)
21. General architectural description:

The Crystal Club building (Feature 1) is generally oriented north/south. It is a hewn-log building, with corner notching visible in some places. The building was historically clad in a combination of horizontal wood siding, seen on the primary (north) façade and vertical-board siding. Evidence of a stone foundation is present. With the exception of the new roof and foundation work, the construction materials in this building are original, including interior floorboards, ceilings, and other finishes (Christopher Cox, personal communication September 25, 2019).

The north façade is a gable end and includes the entrance doors, located toward the east side of the elevation. The entrance consists of two side-hung wooden doors that may have been swinging doors. Both doors had a fixed lite at one point, but the glass is gone; one of the window openings is boarded over while the other is filled in with a Plexiglas-like sheet. A large wood-framed window with closed wood shutters is located west of the doors. A tall wood-framed door is present at the center of the elevation , in the upper half story, in the gable. This opening has been boarded up from the inside. Remnants of the "CRYSTAL CLUB" canvas sign are still hanging on the elevation above the ground floor entrance doors and window. An advertisement/announcement board is attached to the exterior of this elevation east of the entrance door. "E BARONI / MAY 22, 1922" is carved into the exterior siding at the east end of the elevation.

The east elevation includes the original building and an historic addition. No siding is present on this elevation, rather the hewn, square notched logs are visible, as are the rounded logs that make up the later addition at the south end. One boarded-over, rectangular window is present on the original building elevation. South of that window is the obvious end of the original building, demarcated by square notches in the logs. A boarded-over, rectangular window is present in the addition just south of the junction. A boarded-over doorway is present south of the window, and yet another window with wood shutters is south of the boarded-over doorway. The ends of dimensional lumber floor joists can be seen along the elevation where the second floor is present on the interior. Pieces of dimensional lumber are intermittently nailed on, vertically, along the entire elevation. While it is possible that an addition, such as a lean-to, was added and later removed, it is also possible that these are furring strips used to prepare the elevation for the application of milled siding (note, however, that no historic records revealed that siding was ever applied to this elevation).

The south elevation consists of the "back" of the addition. It is clad in vertical board siding. A vertical-board door is present toward the east end of the elevation and has a porcelain doorknob. The siding in the gable is vertical board-and-batten and includes two small square windows with wood shutters. Some sheet metal is nailed below the gable and above the vertical boards that cover the log structure. A shed-like addition protrudes out from the elevation at its east end. The shed is 3' 11" x 7' 4" and has a dimensional lumber post-in-hole frame with horizontal wood board siding. Wood doors are present on its north and west sides. A small, boarded-over window is also present on its east side. Most of the roofing material over the shed is gone, but what remains appears to be wood boards covered with asphalt roll.

The west elevation mimics the east elevation, with exposed log exterior. Like the east elevation, the original building and addition can easily be differentiated by the obvious square notching in the logs demarcating the "back" of the original building. A tall rectangular window with wood shutters is present toward the south end of the addition, and a smaller, long rectangular window is present just north of the shuttered window toward the north end of the addition. The location of the small rectangular window corresponds to an interior stairway. Another boarded-over, tall rectangular window is present toward the south end of the original building. Dimensional lumber boards are intermittently nailed on vertically along the original building elevation with the possibility of being furring strips used to prepare the elevation for the application of milled siding, like the east elevation (note, again, that no historic records revealed that siding was ever applied to this elevation). The ends of dimensional lumber floor joists can be seen along the elevation where the second floor is present on the interior.

The interior of the original building consists of one large room on the ground floor and an attic-like space in the upper half story. The original siding, floorboards, and ceiling are still present. A decorative wood board that may have once hung over the now-absent bar is lying on the floor along the east wall. Inside the ground floor room, the log walls are lined with vertical bead board wainscoting. The floorboards are wood. The ceiling is also made of wood boards, and the original joists can be seen in the attic above. The roof, including framing and exterior materials, was entirely rebuilt in 1992. The new roofing material is clearly visible in the upper half-story space.

The interior of the addition to the back of the building consists of two separate rooms on the ground floor and two separate rooms on the upper half story. The "back"/south room on the ground floor served as a kitchen area. The original floor is wood boards, and the ceiling displays the original wood joists. The exterior door on the south elevation of the building provides entrance into this back room. Wall finishes on the east, south,

and west walls consist of bead board wainscoting, painted tan or white, with horizontal wood boards above the wainscoting to the ceiling. A window is present in the west wall, and some built-in wood shelving is present on the south wall. The north wall has white painted bead board extending from floor to ceiling. The north wall also includes built-in wood shelving and a porcelain sink. A door made of wood boards is present in the north wall and leads into the north room on the ground floor of the addition. The north room abuts the south wall of the original building and includes a stairwell leading to the upper half story. The floor is of original wood boards, and a door/hatch is present in the floor which leads to a subterranean cellar space. The stairs are located on the west wall and consist of two flights with one landing. The tread on the stairs is well worn. The wall finish on the south wall is horizontal wood siding. The west and north walls are unfinished and the east wall is covered in vertical wood boards. A paneled wood door, which leads outside (though is currently boarded-over), is located in the east wall of this room. Another paneled wood door is present in the north wall of this room toward its east end, and this door leads into the main ground floor room of the original building. The upper half story of the addition is divided into two similar rooms- east and west. The east room has original wood floorboards with a rectangular hole in the floor toward the room's south end; this hole opens down into the kitchen area below. The south, west, and north walls are finished in vertical wood boards; the east wall is horizontal wood boards. A boarded-up window is present in the south wall. The west room is more-or-less a mirror image of the east room. Original floorboards are wood, and a rectangular hole in the floor toward the south end of the room also opens up into the kitchen area below. There is another boarded-up window in the south wall. An opening with no door immediately at the top of the stairs on the dividing wall connects the two rooms. The new roof rafters, boards, and covering can be seen in these rooms.

22. Architectural style/building type: Pioneer Log

23. Landscaping or special setting features: None

24. Associated buildings, features, or objects:

Outhouse (Feature 2) – the outhouse is located southeast of the primary building (Feature 1) and measures approximately 5' x 5'. It has a gable roof, framed with dimensional lumber and covered with wood shingles on the north slope and seamed metal on the south slope. A strip of metal sheet has been placed over the peak. The structure is framed with dimensional lumber, and exterior siding consists of rounded log planks. The door, which is made of vertical dimensional lumber boards and is detached, is located on the east elevation.

IV. ARCHITECTURAL HISTORY

25. Date of construction: Estimate: _____ Actual: 1899

Source of information: Neal 2002:173; Silver Lance 1899d, 1899f

26 Architect: Unknown

Source of information: n/a

27. Builder/contractor: Unknown

Source of information: n/a

28. Original owner: Likely W.B. Wright

Source of information: Silver Lance 1899a

29. Construction history (including description and dates of major additions, alterations, or demolitions):

The Crystal Club was originally built in May/June/July of 1899 (Silver Lance 1899d, 1899f); the addition on the back of the building was constructed soon after the original summer 1899 construction episode, possibly even later that year (Christopher Cox, personal communication September 25, 2019). The roof, including original shake shingles, boards, and rafters, was replaced in 1992 to preserve the building from the elements. The top logs on the building were also replaced as they were rotting (Neal 2002:173-175). The foundation of the building has also been worked on, including the addition of railroad ties, lumber, and rock to provide extra support (Christopher Cox, personal communication September 25, 2019; Roger Neal, personal communication September 26, 2019).

30. Original location: ☒ Moved: ☐ Date of move: _____

V. HISTORICAL ASSOCIATIONS

31. Original use(s): Social- Clubhouse

32. Intermediate use(s): Domestic-Camp

33. Current use(s): Vacant

34. Site type(s): Former "gentleman's" club during the late 19th/early 20th centuries; partial seasonal residence mid-20th century; currently unoccupied

35. Historical background:

Based on few and brief newspaper mentions, it appears that the Crystal Club as an establishment may have been present in a different building in Crystal prior to its installment in the building documented here.

On Friday, April 14th, 1899, the *Silver Lance* relayed a rumor that the "Crystal Club Saloon" would open its doors the upcoming Saturday (Silver Lance 1899g). On Friday, April 21st, 1899, The "Crystal Club Saloon" was reported as having opened at an unidentified location the prior Wednesday (Silver Lance 1899c).

The property upon which this building is located was purchased around early May of 1899 by R.B. Wright. Mr. Wright purchased the property from Geo. W. Melton and Geo. C. Eaton to serve as a "new home" for the Crystal Club. At the time of purchase, a "stage barn" was present on the property (Silver Lance 1899a, 1899b). On May 19, 1899, the *Silver Lance* reported that ground had been broken for the new Crystal Club building, the development attributed to the men "Hodges and Wright". The paper noted that the "heavy timbers for the sills and supports" had been hewn and would be installed that week. The building was predicted to be 24' x 30' with an "annex" of 16' x 24' at the back. The "annex" is presumed to be the historic addition described above. The building was also predicted to be "substantial" with hardwood floors and to be "tastily furnished". The building was also described as being located at the "extreme west end of the lots [in town]", which corresponds with the location of the building documented here (Silver Lance 1899d).

The newspaper announced that on June17th, 1899, a dance would be held in the "new Crystal Club Building"; everyone was invited (Silver Lance 1899e). On July 7th, 1899, it was noted that the "papering and inside work on the Crystal Club" had been completed within the last week and that the club had a "handsome new painted sign over the front door" (Silver Lance 1899f). The remnants of that sign are still present on the building, having last been repainted more than 60 years ago (Christopher Cox, personal communication September 25, 2019). Remnants of the original wallpaper are also still present in the building (see photo 256, roll 19-262).

The Crystal Club was strictly for men only. The Club allowed men to "gamble, drink, conduct business, and shoot pool under club authority" (Vandenbusche 1980:245). Archival research did not reveal how long the Crystal Club was in operation as a social establishment.

Owner Christopher Cox remembers that an ornate wooden bar was once present inside the building along the west wall. The bar was stolen out of the building in the 1940s, likely between 1948 and 1949 as local resident Roger Neal remembers seeing the bar in the building the first summer he came to Crystal with his family, which was 1948. The bar was gone when Mr. Neal returned the summer of 1949. Mr. Cox later found pieces of the bar in local pawn shops. Additionally, the now salvaged wallpaper was located above the bar on the west wall (Christopher Cox, personal communication September 25, 2019; Roger Neal, personal communication September 26, 2019).

Although the Crystal Club was known strictly as a "gentleman's club" with no women allowed, while replacing the roof in 1992, Mr. Neal found a turn-of-the-century lady's compact tucked into the original rafters that were being replaced (Roger Neal, personal communication September 26, 2019).

Crystal Townsite History

Before the mining boom of the late 19th century, the Crystal Valley, located between Sheep Mountain, Little Bear Mountain, and Mineral Point, was occupied by the Ute Indians. The Utes were forcibly removed from the area and placed on reservations by the federal government around 1879, and infiltration of the former Ute lands by prospecting miners was quick to follow. Euroamerican prospectors began arriving in the Crystal Valley predominantly by way of Crested Butte, Gothic, and Schofield in the late spring and early summer of 1880 (Neal 2002:7; Vandenbusche 1980:245,). Prospectors set up camp near the confluence of the north and south forks of the Crystal River where they located outcroppings of clear quartz crystals which became the settlement's namesake (Vandenbusche 1980:245).

Although lead, copper, zinc, and some gold were present in the quartz formations around Crystal, silver was the main ore attracting miners to the valley. The silver in the area was high in quantity, quality, and, of course, value (Neal 2002:9). The town of Crystal was officially incorporated on August 26, 1881 (Neal 2002:10). Crystal was granted a post office in 1882, with Albert A. Johnson leading that effort and being designated as the first postmaster (Neal 2002:15; Vandenbusche 1980:246).

Other nearby silver mining camps were established during the same time period as Crystal. Located south

of Crystal toward Crested Butte was Schofield, the earliest iteration of which was present as early as 1873. Schofield, however, was already in its final decline by late 1883. By that time, most of its residents had moved on, many of them to Crystal (Vandenbusche 1980:249, 252). Several of the original structures in the Crystal mining camp were moved there from Schofield (Neal 2002:7). The Schofield post office was discontinued in 1885, and the town was emptied. A brief revival of Schofield took place in 1899, but it was abandoned for good by 1900 (Neal 2002:134; Vandenbusche 1980:252). Similarly, the once booming mining town of Gothic, located between Schofield and Crested Butte and which was incorporated in 1879, began its sharp decline soon after it had reached its peak in 1881. Like Schofield, by 1883, Gothic was more-or-less abandoned (Vandenbusche 1980:258). Another nearby mining camp included Snowmass City, founded in 1880 and located a mere mile north of Crystal. By 1881, Snowmass City was starting to grow, and in 1883, a road was blasted between Snowmass City and Crystal, connecting Snowmass City with the route over Schofield Pass and into Crested Butte. Snowmass City reached its peak in 1884 but could not overcome its access difficulties and competition from Crystal. It succumbed in 1886 (Vandenbusche 1980:249).

By 1881, there are said to have been 21 or 22 cabins present at Crystal (Neal 2002:8; Vandenbusche 1980:245, Neal 2002:8). Citing the Colorado State Business Directory, Neal relays that the population of Crystal was reported as 600 in 1883; 300 in 1884 and1885; 400 in 1886 and 1888; 200 in 1889; and 101 in 1900 (2002:8). By 1910, however, the Census lists Crystal's population as four (Neal 2002:8). Notably, the 1910 Census was taken mid-May, so the count of four may have represented only year-round residents; only hardy souls over-wintered in Crystal which was, and continues to be, notoriously snowed-in during the cold months of the year (Callihan 2017; Neal 2002:8)

In its heyday, Crystal had a newspaper, a post office, saloons, a stage line, two general stores, a pool hall, a hotel, a "gentleman's club" (5GN6527), a two-story town hall, an assayer and chemist, a livery, a barber shop, over seventy houses, and more (Neal 2002:12-13; Vandenbusche 1980:245). Twelve streetlights were present in Crystal: large metal kerosene lamps hung from poles that were lit at dusk and extinguished at 10:00 pm (Neal 2002:119). A telegraph line ran from Marble through Crystal and on to Crested Butte, and a telephone line was developed from Marble to Crystal in 1904 (Neal 2002:108). The residents of Crystal procured their water from ditches that ran through town on each side of the main road through town, fed by a natural spring located east of town (Neal 2002:10). A blacksmith shop, no longer extant, was located just west of town, opposite the Sheep Mountain Tunnel Mill/Crystal Mill (5GN1627) (Roger Neal, personal communication September 27, 2019).

Additionally, Crystal also had its own cemetery, located southwest of the town and the Sheep Mountain Tunnel Mill/Crystal Mill (5GN1627) along what is now Gunnison County Road 3. Numerous Crystal residents are interred at the now overgrown cemetery, which is located within an avalanche chute. As such, the cemetery has been subjected to countless avalanches which have pummeled the little graveyard over the years. Burials are obscured by vegetation and avalanche debris. Some wrought iron fencing is still visible along with a single, roughly made headstone- that of Judge Tom O'Bryan, a prominent resident of Crystal from its inception until his death in 1904 (Christopher Cox and Heather Leigh, personal communication September 25, 2019; Roger Neal, personal communication September 26-27, 2019; Neal 2002:23-24).

From the beginning, Albert A. Johnson was Crystal's "leading citizen" (Vandenbusche 1980:247). Johnson operated the general store (5GN6528) and a hotel; edited and printed the town's first newspaper, the *Crystal River Current*; and owned several mining properties including the famed Lead King for a time. Johnson was responsible for securing a post office for Crystal and, as mentioned above, served as the first postmaster (Vandenbusche 1980:247). In addition to his prominent role in development of the Crystal community, Johnson became known regionally as a "legendary postman" who bravely and unfailingly carried mail between Crystal and Crested Butte on skis during the snowy months. His route, through the "feared Crystal Canyon," was extremely perilous due to the terrain and avalanche danger (Vandenbusche et al. 2008:55, 58). Al Johnson was regionally recognized as the "top snowshoer of the Rocky Mountains" for his speed and technique at completing his treacherous mail-carrying route in addition to winning many ski races across Colorado's western slope (Vandenbusche 1980:247, 423, 426-428).

Snowshoeing [skiing] was extremely popular, and necessary, in the broader Gunnison country around the turn of the century (Vandenbusche 1980:247). "Every man, woman, and child had to learn to ski if they wished to get anywhere in the winter in the early mining days" (Vandenbusche et al. 2008:75). Crystal was no exception in its love of skiing. The "Crystal Snowshoe Club" became "legendary in the rocky mountains" and featured the "famed" Al Johnson (Vandenbusche et al. 2008:120). In 1886, the Gunnison Country Snow-Shoe Club was formed with Al Johnson serving on the Executive Committee. The Club organized competitive races in Gunnison, Crested Butte, Irwin, Gothic, and Schofield in February and March of that year, all of which were met with great enthusiasm and support from the local communities (Vandenbusche

1980:426-428).

Since its inception, access to Crystal has been a challenge and a hindrance to the town's development. Until 1883, Crystal was extremely isolated from the rest of the region with only "jack" trails (the period term for mule trails) connecting the town with Crested Butte to the south and Carbondale to the north (Vandenbusche 1980:245). Along the route to Crested Butte, a toll road was completed between the mining settlements of Gothic and Schofield in 1881, and the old jack trail between Schofield and Crystal was finally also converted into a wagon road in 1883 (Neal 2002:11-12, Vandenbusche 1980:245). After the completion of the wagon road from Schofield, Crystal's population rose (Vandenbusche 1980:245-246). Still, the Crystal Canyon Road between Crystal and Schofield and beyond to Crested Butte was extremely dangerous and one of the "most treacherous in Colorado;" in winter, the canyon "vomited avalanches" (Vandenbusche et al. 2008:54).

Silver mines surrounding Crystal included the "Belle of Titusville, Catalpa, Eureka, Jack Whacker, Inez, Bear Mountain, and Daisy," with the most reputable mines in the area being "the Lead King, Black Queen, and Sheep Mountain Tunnel" (Vandenbusche 1980:245). The Sheep Mountain Tunnel is the mine that was most related to the iconic mill located on the Crystal River just west of town- the Sheep Mountain Tunnel Mill /Crystal Mill (5GN1627). The "Mill," which was actually a powerhouse, has become the most photographed site in Colorado, its only competition being the Maroon Bells near Aspen (Vandenbusche 1980:247, Vandenbusche et al. 2008:58). Built in 1892, the Mill contained a water wheel that generated the power to operate a compressor that in turn powered air drills at the Sheep Mountain Tunnel. The water power used to operate the system was created by damming the Crystal River at the entrance to the Sheep Mountain Tunnel, the confluence of the north and south forks of the river. The Mill eventually also provided power to the nearby Inez, Bear Mountain, and Black Queen mines. The presence of the Mill facilitated continued silver mining in the Crystal vicinity during the difficult years of the silver crash; "the community of Crystal owes much of its existence to this power generating facility" (Daily 1985).

Shipping ore from these mines was a constant struggle. The lack of a railroad line at Crystal meant that ore had to be hauled by wagon or jack train along the dangerous rockslide- and snowslide-prone canyon roads to the nearest railroad stations. Between 1886 and 1909, the residents of Crystal were promised several times that a railroad branch would reach the little town, alleviating their transport woes and providing the mines (and the town) a much needed boost with the ability to easily ship more ore, but the railroad never came (Vandenbusche 1980:245, 248).

Leading up to the Silver Panic of 1893, the declining price of silver resulted in a stark decrease in Crystal's population by 1892. Despite the presence of the advantageous Sheep Mountain Tunnel Mill/Crystal Mill (5GN1627), the town never fully recovered from the decline, with its population cut in half at that time. The *Crystal River Current* ceased operations in 1892, with the *Silver Lance* courageously appearing in 1893 to take its place. Crystal's population continued to dwindle, however, and the *Silver Lance* merged with the *Marble City Times* in 1899 (Vandenbusche 1980:245, 248). The Crystal post office closed in 1909 (Neal 2002:16).

Crystal was practically deserted by 1915. In 1916, a minor revitalization took place when the Black Queen, Lead King, and Sheep Mountain tunnels began operating and shipping ore once again. By 1917, however, the revival had already died, and the Sheep Mountain Tunnel closed for good, rendering Crystal a veritable ghost town (Vandenbusche 1980:248). Never-ending access difficulties coupled with the decline of the profitability of silver led to the town's final denouement (Neal 2002:138). Still, Crystal can be commemorated as a mountain mining town that persevered through staggering adversity during a time when its neighbors had already folded, notably Gothic, Schofield, and Snowmass City (Vandenbusche 1980:249, 252). Indeed, "Crystal [is] perhaps the best example of a north country town which stood amidst too much adversity" (Vandenbusche 1980:249).

After the mining days ended, a few people continued to seasonally occupy the town. Emmet S. Gould arrived in Crystal from Aspen in 1938 in search of ore. He ended up buying several mining claims, the Sheep Mountain Tunnel Mill/Crystal Mill (5GN1627), and several lots and cabins. Emmet's descendents continue to have a presence in the area as the Crystal Mountain Ranch (Neal 2002:151-152). Several other families called Crystal a summer home during the mid-20th century (and still do today), keeping the sleepy town partially occupied in the summer months (Neal 2002:140-197, 251-253).

By the 1950s, outdoors excursions were being led by individuals residing seasonally in Crystal. Beginning in 1954, Richard "Dick" Car-Skaden guided tourists on hiking trips in the mountains, deeming his operation the Snowmass Wilderness Guide Service. Dick lived seasonally in the back of the Crystal Club (5GN6527), the building that housed the "gentleman's club" in the mining days, from the 1950s into the early 1970s. The Crystal Club also served as the base for his excursions (Neal 2002:141, 175-176). Also beginning in 1954,

Theodore "Sarge" Jackson, who lived in various cabins during his time in Crystal, began taking tourists and hunters on guided horseback trips into the surrounding mountains. Eventually, he moved his base of operations up the pass south into Schofield (Neal 2002:142). Area artist John Toly also lived in the back of the Crystal Club seasonally during the 1970s (Neal 2002:176). The Colorado Outward Bound School, established in 1962, created a base camp in the area for teaching life skills through outdoor activities. The school's students have performed service days in Crystal which consist of general maintenance tasks around town (Neal 2002:152-154).

Today, seasonal tourist visitation to Crystal has skyrocketed. People making the trek between Marble and Crested Butte over the infamous Schofield Pass and through Crystal Canyon, in capable 4x4 or other off-highway vehicles, pass through the once booming town. Visitation numbers to the famous Sheep Mountain Tunnel Mill /Crystal Mill (5GN1627) have increased exponentially in recent years to as many as 300 vehicles per day (Heather Leigh, personal communication September 25, 2019). The Mill and most of the townsite is owned by the Crystal Mountain Ranch. The Ranch manages public access to the iconic Mill, again, the most photographed location in all of Colorado, allowing tourists to walk down to the river bank opposite the building for a small fee. Five of the historic cabins belonging to the Crystal Mountain Ranch are available for rent seasonally to tourists. The Ranch also offers a designated camping area and a gift shop in the original A.A. Johnson General Store (5GN6528). Other cabins in the town are owned by private individuals and are used as seasonal homes; Crystal has no year-round occupants.

36. Sources of information:

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2019d Public records for 3881 Forest Service Road 314 , Crystal Townsite Vicinity. Electronic document, https://www.gunnisoncounty.org/327/Property-Record-Search, accessed December 2, 2019.

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1886b "Report on Al Johnson's role in the Schofield avalanche recovery." 30 January. Gunnison, Colorado.
1887 "Al Johnson listed as vice president of Gunnison Country Snow-Shoe Club." 22 January. Gunnison, Colorado.

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2008 Field Guide to Colorado's Historic Architecture and Engineering. Colorado Historical Society,

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Vandenbusche, Duane
1980 *The Gunnison Country*. B & B Printers, Gunnison, Colorado.

Vandenbusche, Duane, the Gunnison Pioneer Museum, and the Crested Butte Mountain Heritage Museum
2008 *Images of America: Around Gunnison and Crested Butte*. Arcadia Publishing, Charleston, South Carolina.

VI. SIGNIFICANCE

37. Local landmark designation: Yes ☐ No ☒ Date of designation: n/a
Designating authority: n/a

38. Applicable National Register Criteria:

- ☒ A. Associated with events that have made a significant contribution to the broad pattern of our history;
- ☐ B. Associated with the lives of persons significant in our past;
- ☒ C. Embodies the distinctive characteristics of a type, period, or method of construction, or represents the work of a master, or that possess high artistic values, or represents a significant and distinguishable entity whose components may lack individual distinction; or
- ☒ D. Has yielded, or may be likely to yield, information important in history or prehistory.
- ☐ Qualifies under Criteria Considerations A through G (see Manual)
- ☐ Does not meet any of the above National Register criteria

39. Area(s) of significance: Exploration/Settlement; Industry-mining

40. Period of significance: 1899-1917

41. Level of significance: National ☐ State ☒ Local ☒

42. Statement of significance:

5GN6527, the Crystal Club, meets the requirements of NRHP Criteria A, C, and D in the areas of Exploration/Settlement and Industry-Mining.

Regarding **Criterion A**, the Crystal Club is an element of the late 19th/early 20th century regionally noteworthy mining town of Crystal (5GN1332), the development of which was a part of and directly associated with the historically significant mining boom of that time period in Colorado. Having been built in 1899 and operated as a focal point of the community thereafter, the Crystal Club clearly falls within the full Crystal Townsite's suggested period of significance of 1880-1917.

Regarding **Criterion C**, as a Pioneer Log building (History Colorado 2008), the Crystal Club embodies distinctive characteristics of a type, period, and method of construction. Initially chosen as an expedient and durable form of shelter (especially in the forested mountain areas of the state), Pioneer Log buildings have become an iconic part of Colorado's built heritage. This particular example has a distinct form marked by the entry on the gable end—a trait that evolved in the West as a unique response to snow accumulation in the Rocky Mountains (Bomberger 1991). Its construction and materials reflect the skills and abilities of individuals working with what resources were available in this community at the time it was built. It was originally a 1.5-story single-pen structure composed of square-notched hewn logs. As is very common to this building type, additions are difficult to incorporate, and it was expanded by way of a single-pen log addition to the rear, the most common evolution of Pioneer Log buildings. Other modifications, such as the possible application of milled siding (or at least the possible preparation for such), reflect what may have been changes in the lives of those who lived and worked here. The presence of likely furring strips on the secondary elevations, for example, suggests siding might once have been applied to (or intended for) all sides of the building and not just the façade. Such a change may have coincided with a prosperous period for the owner in which he would have been able to access imported materials that would have conveyed a sense of the establishment's permanence.

Regarding **Criterion D**, passing observations of surface-exposed cultural material and earthen depressions

in addition to the presence of at least one extant outhouse near the Crystal Club suggest archaeological potential associated with the building. The extant outhouse and other likely previous privy locations, at a minimum, could yield information significant to our understanding of the site, the full town, and the larger area, beyond that already available in written or oral documentation.

The Crystal Club was not found to be directly associated with any significant persons in history, therefore it is not recommended as eligible under Criterion B.

While some modern repairs/replacements have been made to the Crystal Club building, especially its roof, the building overall retains a vast majority of its original materials and construction, which remain in impressively decent shape. Alterations made to the building have not overwhelmed its original design. Furthermore, beyond retaining physical integrity, the building also retains intangible integrity (see Item 43 below). In sum, the building continues to convey its relationship with the areas of significance and can be recommended as eligible to the NRHP under Criteria A, C, and D.

43. Assessment of historic physical integrity related to significance:

Regarding the aspects of integrity, the Crystal Club retains location as it remains in its original location. Although some modern improvements/repairs have been made to the building, notably to the roof, materials, workmanship, and design are overall retained as the original materials, methods of construction, and layout of the building are still present and can be discerned. Association is retained as the Crystal Club is an early element of the historically significant mining town of Crystal, with its date of construction, 1899, falling within the town's suggested period of significance. Setting and feeling are also retained as little has changed in the surrounding landscape to alter the environment from what it would have been during the period of significance, with the exception of some modern tourist traffic in the area.

VII. NATIONAL REGISTER ELIGIBILITY ASSESSMENT

44. National Register eligibility field assessment:

Eligible ☒ Not Eligible ☐ Needs Data ☐

45. Is there National Register district potential? Yes ☒ No ☐

Discuss:

Given the historical continuity and good condition of the extant buildings, the full Crystal Townsite (5GN1332) holds the potential to be considered eligible for inclusion on the NRHP as a District under Criteria A, B, C, and D for a suggested period of significance of 1880-1917. Crystal fulfills the requirements of **Criterion A**, association with significant events, as the town is inextricably associated with the historically significant late 19th/early 20th century mining boom in Colorado, having been developed, incorporated, and occupied as a direct result of that momentous event in Colorado history.

The town fulfills the requirements of **Criterion B** for its association with prominent figure Albert A. Johnson, a Crystal resident who was a "legendary" figure in the Gunnison country during the late 19th century (Professor Duane Vandenbusche, personal communication March 25, 2020). He is significant for his role in helping the town of Crystal develop and thrive between 1881 and 1893 and in popularizing recreational skiing in the region prior to the turn of the century. Born near Montreal in the Laurentain mountain area of Canada in 1851, Al Johnson came to Crystal in 1880 as a silver prospector with his brother Fred (Callihan 2017; Vandenbusche et al. 2008:58). Rather than working directly in mining operations, Al Johnson decided to supply miners with essential goods and opened the "A.A. Johnson General Store" (5GN6528) in Crystal in 1881. Over the years, in addition to the general store, he operated a hotel in Crystal and owned several nearby mining properties, including the famed and lucrative Lead King for a time (Vandenbusche 1980:247).

Johnson has been called Crystal's "leading citizen" for his contributions between 1881 and his death in 1893 (Vandenbusche 1980:247). As a "merchant, miner, post master, mail carrier, man and maid of all work, and boss of good fellows generally" (Gunnison Review Press 1886a), he was "widely respected for his business acumen and outgoing personality" within Crystal and beyond (Callihan 2020). He initiated and perpetuated the town's growth by, first, opening and operating the general store, and, second, by securing the postal contract for Crystal in 1882. Notably, merchandise provided in Johnson's general store allowed stalwart Crystal locals to remain in town year-round. The town of Crystal was, and continues to be, snowbound every winter, with no easy access to supplies. By keeping his store well-stocked, Johnson provided a continuous and reliable inventory to the hardy folks who over-wintered in Crystal, offering products necessary for personal use but also for continuing nearby mining

work through the challenging winter months (Callihan 2017; Neal 2002:14).

Importantly, Johnson also housed the Crystal Post Office at his general store, reliably carried the mail between Crystal and Crested Butte on a year-round basis, and served as the town's postmaster until his death in 1893 (Neal 2002:15-16; Vandenbusche 1980:247). In 1885, Johnson was recommended as a potential Gunnison County Commissioner to represent the Crystal area by virtue of his efforts as a "faithful worker for that section of the country…[for while working] for himself he [worked] for others by his pen and otherwise in order to promote the interest of that rich mining region" (Gunnison Review Press 1885). In 1886, Johnson launched Crystal's first newspaper, the *Crystal River Current,* which he edited and published through 1892 in a building (no longer extant) behind his store (Neal 2002:195; Vandenbusche 1980:245). In 1890, Johnson served as Crystal City Council Clerk (Neal 2002:15). That same year, Johnson married Kate Usher, sister of prominent Crystal resident Jim Usher. A baby girl, Crystal Rose, was born to the Johnsons on May 1, 1891 but died on October 29, 1891 (Callihan 2017). By that time, Al Johnson was suffering from a bad cough that was likely due to tuberculosis. In an effort to combat his illness, Johnson spent the winters of at least 1891 through 1893 in Arizona, returning to Crystal during the summers to run his store and the post office, but he died in Phoenix on January 19, 1893, at the age of 42 (Callihan 2017).

Beyond his pivotal role in building and supporting the local Crystal community, Johnson is remembered regionally for his impressive "snowshoeing," the period term for skiing, and for expanding Gunnison country ski culture. Skiing was extremely popular, and vital, in the broader Gunnison country in the late 19th and early 20th centuries (Vandenbusche 1980:247). "Every man, woman, and child had to learn to ski if they wished to get anywhere in the winter in the early mining days" (Vandenbusche et al. 2008:75). Ski groups flourished throughout the area at various mining camps, and the town of Crystal was no exception in its love of (and need for) skiing. The Crystal Snowshoe [ski] Club became "legendary in the rocky mountains" and featured the "famed" Al Johnson (Vandenbusche et al. 2008:120).

Johnson primarily gained skiing notoriety as one of the few in the Gunnison country who unfailingly carried mail on skis across high elevation, extremely dangerous, snow-covered terrain. Johnson became known regionally as a "legendary postman" who bravely and dependably executed his "anointed task" of carrying mail between Crystal and Crested Butte on what became known as the "Snowshoe Express" (Vandenbusche 1980:247, 423; Vandenbusche et al. 2008:55). His route, which included a stretch through the "feared Crystal Canyon," was extremely perilous, likely the most perilous in the region, due to the terrain and avalanche danger in snowy conditions (Vandenbusche 1980:78; Vandenbusche et al. 2008:58). Johnson became recognized as the "top snowshoer [skier] of the Rocky Mountains" for his speed and technique in completing this treacherous, avalanche-prone mail-carrying route (Vandenbusche 1980:423). Weekly, Johnson donned 11-foot wooden skis to travel the 18 miles from Crystal to Crested Butte, traversing the dreaded Crystal Canyon, with as much as 40 pounds of mail on his back each way (Callihan 2020). Adding to his acclaim, an avalanche one January night in 1886 hit the mining camp at Schofield, located at the top of Crystal Canyon. Upon hearing the news, Johnson skied up the canyon during the continuing blizzard in total darkness to aid the devastated camp. Johnson is noted to have dug victims out of the snow-slide and led people to safety amidst the storm that dumped six feet of snow at Schofield and four feet at Crystal. Following the rescue, he continued on to Crested Butte to deliver news of the avalanche and assembled a rescue party to return to Schofield to carry on with the recovery (Callihan 2020; Gunnison Review Press 1886b).

Beyond his courageous mail delivery on skis, Johnson's fame was bolstered by numerous ski race victories across Colorado's western slope (Vandenbusche 1980:247, 423, 426-428). His fame helped popularize skiing as recreation in Colorado. In 1886, he fostered the extensive ski culture of the region by serving on the Executive Committee of the newly formed Gunnison Country Snow-Shoe (ski) Club, developed to encourage competitive regional ski racing and winter sports, and he was vice-president of the club the following year (Gunnison Review Press 1887) . At Johnson's suggestion and primarily through his efforts, the Club organized wildly popular races in the towns of Gunnison, Crested Butte, Irwin, Gothic, and Schofield during February and March of 1886 (Vandenbusche 1980:426-428). Inspired by similar "snowshoe carnivals" he had experienced back home near Montreal, Johnson led the organization of the races in Crested Butte, Gunnison, Irwin, and Gothic that would cumulatively become known as the "Great Race of 1886" (Callihan 2020). Those four races were met with great enthusiasm and support from the local communities, with excited

spectators gathering along the race routes to cheer on contestants from their respective mining camps. An estimated 1,000 people gathered to watch the Crested Butte race, for which a special Denver and Rio Grande Excursion train was chartered (Callihan 2020; Vandenbusche 1980:426-428). The Great Race of 1886, conceived and implemented by Al Johnson, introduced competitive ski racing to the Gunnison country (Vandenbusche 1980:428-429).

Al Johnson was described as "without a doubt, the most graceful snowshoer the Rocky Mountains [had] ever produced…a daring adventurer on shoes [skis]" (Vandenbusche 1980:427). In 1974, the telemark ski community in Crested Butte began the Al Johnson Memorial Uphill/Downhill Telemark Race. The race, honoring Al Johnson, his exceptional skiing abilities, and his devoted public service as a mail carrier through unthinkably hostile weather and terrain, continues to be held annually at Crested Butte Mountain Resort. As a further tribute, "Let 'em Run!: Al Johnson and the Great Races of 1886," a play by Michael Callihan documenting aspects of Johnson's remarkable life, has been produced in Gunnison and Crested Butte annually since 2017, playing to sold out crowds (Michael Callihan, personal communication March 29, 2020).

The townsite fulfills the requirements of **Criterion C** as its buildings retain sufficient integrity to cumulatively convey the historic built character of a late 19th/early 20th century Colorado mountain mining community. Characteristics of the extant buildings, primarily of the dominant Pioneer Log style, reflect vernacular approaches to building and reveal methods, techniques, and materials known and available to the occupants of Crystal at the time of their construction. The Pioneer Log buildings, primarily consisting of common notched log construction with various chinking materials and gabled roofs, represent residences, a commercial building, a social building, and a barn, all of which had important, individualized roles in community life, reflecting the day-today on goings in an isolated mountain mining town. Additionally, the previously recorded and SRHP-listed Tays/Anderson House (5GN2432), a wood frame Victorian building believed to have been a kit home, provides a contrast to the dominant vernacular building methods, exemplifying more formalized building techniques and imported wood building materials available to affluent members of the community (Anderson 1995). Also of particular note among the buildings in the town is the newly recorded Schoolhouse (5GN6532), which is an excellent and well-preserved example of a rural one-room schoolhouse—an increasingly rare property type in the region. Along with its extant ancillary building, the Schoolhouse has a very recognizable design and construction materials that meet specific eligibility criteria laid out in the NRHP Multiple Property Documentation Form for Rural School Buildings in Colorado, including being a single-story with a front gabled roof, having typical fenestration, and being built with wood framing and shiplap siding (Doggett and Wilson 1999).

Finally, the town fulfills the requirements of **Criterion D**, potential to yield information important in history, due to its archaeological promise. Passing observations during the 2019 architectural inventory of surface-exposed cultural material; artifacts partially buried around building foundations, present inside buildings, and fallen through floors; numerous abandoned privy pits; and the presence of many standing outhouses across the entire townsite suggest that Crystal possesses great archaeological potential; archaeological investigations, both surface survey and subsurface testing, are highly likely to yield further information not already available in written or oral documentation that could significantly contribute to our understanding of the history of the site and the region.

Beyond the townsite itself (5GN1332), a District boundary could be expanded to incorporate other contemporaneous and related features, including the previously recorded and NRHP-listed Sheep Mountain Tunnel Mill/Crystal Mill (5GN1627), the still unrecorded Crystal Cemetery, the unrecorded spring and ditch water supply system, and nearby mine-related features, if found to be extant at a later date.

The Crystal Club (5GN6527) Contribution to District Potential

As the Crystal Club (5GN6527) is an element of and directly associated with the full townsite (5GN1332), and given that the Crystal Club retains sufficient integrity to convey its association with the full townsite's suggested period of significance (1880-1917), it can be considered contributing toward District potential.

If there is National Register district potential, is this building: Contributing ☒ Non-contributing ☐

46. If the building is in existing National Register district, it: Contributing ☐ Non-contributing ☐

VIII. RECORDING INFORMATION

47. Photograph numbers: Roll 19-258, images 61-79, 110-112
Roll 19-260, images 742-745
Roll 19-261, images 135-149
Roll 19-262, images 255-298

Negatives filed at: Metcalf Archaeological Consultants, Inc. (digitally)

48. Report title: Architectural Inventory of the Crystal Townsite for the Gunnison County Historical Commission, Gunnison County, Colorado.

49. Date(s): 09/25/2019 – 09/27/2019

50. Recorder(s): Natasha E Krasnow and Kelly J Pool

51. Organization: Metcalf Archaeological Consultants, Inc.

52. Address: PO Box 899, Eagle, Colorado 81631

53. Phone number(s): 970-328-6244

NOTE: Please include a sketch map, a photocopy of the USGS quad map indicating resource location, and photographs.

History Colorado - Office of Archaeology & Historic Preservation
1200 Broadway, Denver, CO 80203 (303) 866-3395

5GN6527 – Crystal Club.
View of north elevation. View south. (Roll 19-258, image 65, 09/25/2019)

5GN6527 – Crystal Club.
Oblique view of northwest corner. View southeast. (Roll 19-258, image 64, 09/25/2019)

5GN6527 – Crystal Club.
View of west elevation including north end. View east. (Roll 19-258, image 61, 09/25/2019)

5GN6527 – Crystal Club.
View of west elevation including south end. View east. (Roll 19-258, image 62, 09/25/2019)

5GN6527 – Crystal Club.
Oblique view of southwest corner. View northeast. (Roll 19-258, image 77, 09/25/2019)

5GN6527 – Crystal Club.
View of south elevation. View north. (Roll 19-258, image 76, 09/25/2019)

5GN6527 – Crystal Club.
Oblique view of southeast corner. View northwest. (Roll 19-258, image 72, 09/25/2019)

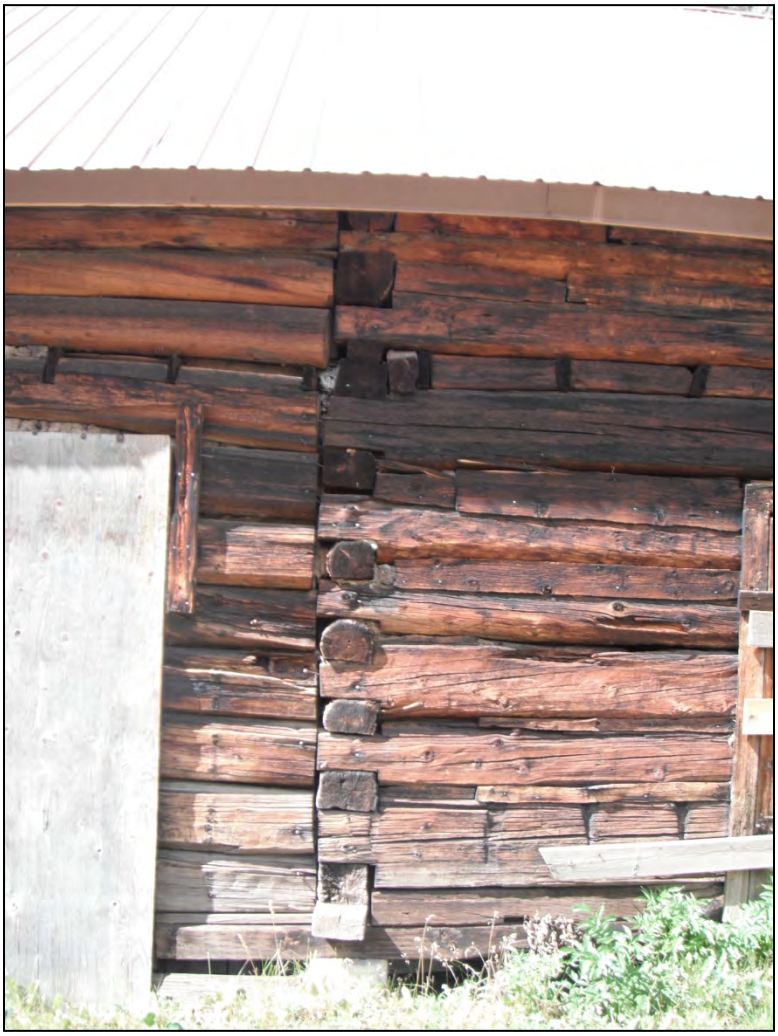
5GN6527 – Crystal Club.
View of east elevation. View west. (Roll 19-260, image 742, 09/27/2019)

5GN6527 – Crystal Club.
Oblique view of the northeast corner. (Roll 19-260, image 744, 09/27/2019)

5GN6527 – Crystal Club.
Detail of front doors on the north elevation. (Roll 19-261, image 135, 09/27/2019)

5GN6527– Crystal Club. Detail of poster board and part of the canvas sign on the north elevation at its east end. View south. (Roll 19-258, image 111, 09/25/2019)

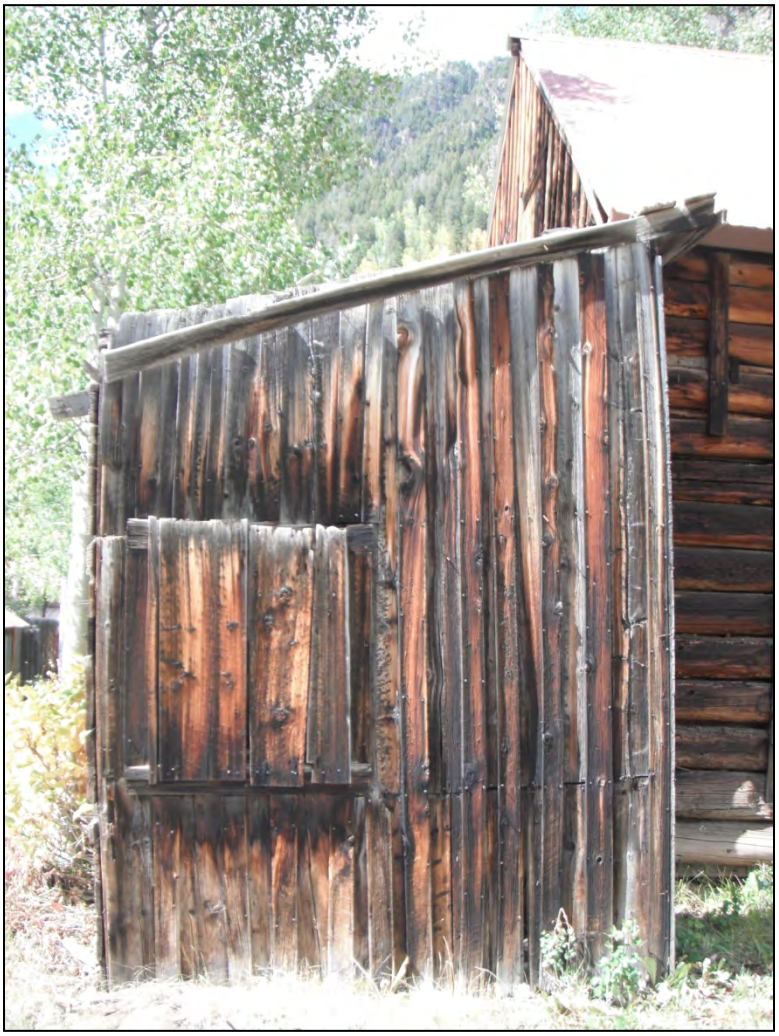
5GN6527 – Crystal Club. Detail of square log notching on the west elevation at the junction of the original building (photo left) and the historic addition (photo right). View east.
(Roll 19-258, image 112, 09/25/2019)



5GN6527 – Crystal Club. Detail of square log notching on the east elevation at the junction of the original building (photo right) and the historic addition (photo left). View west.
(Roll 19-261, image 147, 09/27/2019)

5GN6527 – Crystal Club. Detail of east elevation showing the ends of the interior floor joists exposed on the exterior. View west. (Roll 19-261, image 147, 09/27/2019)

5GN6527 – Crystal Club. Detail of shed addition on the southeast corner of the building. View south-southwest. (Roll 19-261, image 146, 09/27/2019)



5GN6527 – Crystal Club. Detail of shed addition on the southeast corner of the building. View west. (Roll 19-261, image 144, 09/27/2019)

5GN6527 – Crystal Club. Detail of shed addition on the southeast corner of the building. View northwest. (Roll 19-261, image 143, 09/27/2019)

5GN6527 – Crystal Club. Detail of graffiti on the north elevation toward its east end- "E BARONI / MAY 22, 1922". View south. (Roll 19-258, image 110, 09/25/2019)

5GN6527 – Crystal Club. Oblique view of northwest corner of the outhouse (Feature 2). View southeast. (Roll 19-258, image 73, 09/25/2019)

5GN6527 – Crystal Club. Oblique view of southeast corner of the outhouse (Feature 2). View northwest. (Roll 19-258, image 74, 09/25/2019)

5GN6527 – Crystal Club. Interior, view of the west wall inside the back room of the addition. View west. (Roll 19-262, image 255, 09/27/2019)

5GN6527 – Crystal Club. Interior, detail of the original wallpaper salvaged from throughout the building. Plan view. (Roll 19-262, image 256, 09/27/2019)

5GN6527 – Crystal Club. Interior, view of the northeast corner of the back room in the addition. View northeast. (Roll 19-262, image 258, 09/27/2019)

5GN6527 – Crystal Club. Interior, view of the north wall of the back room in the addition. View north. (Roll 19-262, image 259, 09/27/2019)

5GN6527 – Crystal Club. Interior, view of the stairs on the west wall in the "front room" of the addition. View west. (Roll 19-262, image 269, 09/27/2019)

5GN6527 – Crystal Club. Interior, view of the door in the east wall of the "front room" of the addition. View east. (Roll 19-262, image 265, 09/27/2019)

5GN6527 – Crystal Club. Interior, view of the door in the south wall of the original building which leads into the "front room" of the addition. The log wall photo left would have originally been exterior. View northeast. (Roll 19-262, image 266, 09/27/2019)

5GN6527 – Crystal Club. Interior, view of the northwest corner of the main ground floor room in the original building. View northwest. (Roll 19-262, image 272, 09/27/2019)

5GN6527 – Crystal Club. Interior, view of the northeast corner of the main ground floor room in the original building. View northeast. (Roll 19-262, image 274, 09/27/2019)

5GN6527 – Crystal Club. Interior, view of the southwest corner of the main ground floor room in the original building. View southwest. (Roll 19-262, image 277, 09/27/2019)

5GN6527 – Crystal Club. Interior, view of the southeast corner of the main ground floor room in the original building. View southeast. (Roll 19-262, image 278, 09/27/2019)

5GN6527 – Crystal Club. Interior, view of the ceiling of the main ground floor room in the original building. View east/up. (Roll 19-262, image 279, 09/27/2019)

5GN6527 – Crystal Club. Interior, view of the west wall of the main ground floor room in the original building. View west. (Roll 19-262, image 280, 09/27/2019)

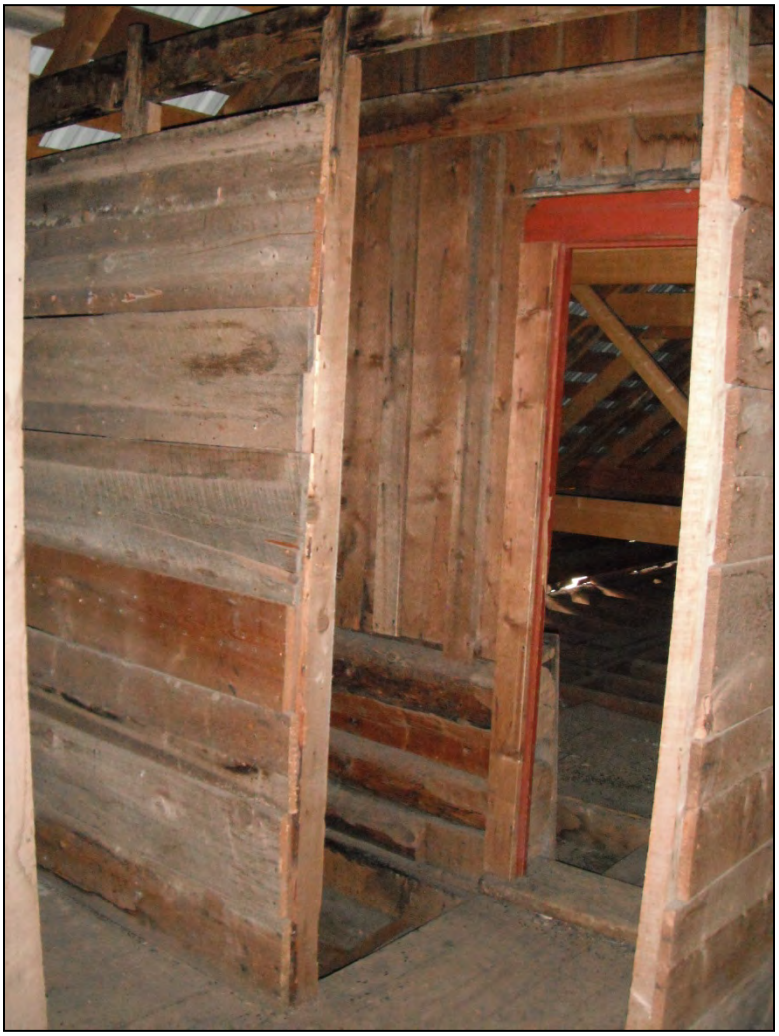
5GN6527 – Crystal Club. Interior, view of the decorative wood piece that used to hang over the bar, now laying along the east wall of the main ground floor room in the original building. View southeast. (Roll 19-262, image 281, 09/27/2019)

5GN6527 – Crystal Club. Interior, view of the new roof trusses above the main room of the original building. View north. (Roll 19-262, image 285, 09/27/2019)

5GN6527 – Crystal Club. Interior, view of the new roof trusses above the main room of the original building, also showing original floor joists and current residents. View north.
(Roll 19-262, image 286, 09/27/2019)

5GN6527 – Crystal Club. Interior, view of the southeast corner of the east second floor room above the addition, also showing the new roof framing. View southeast.
(Roll 19-262, image 287, 09/27/2019)

5GN6527 – Crystal Club. Interior, view of the northeast corner of the east second floor room above the addition, also showing the new roof framing. View northeast.
(Roll 19-262, image 293, 09/27/2019)

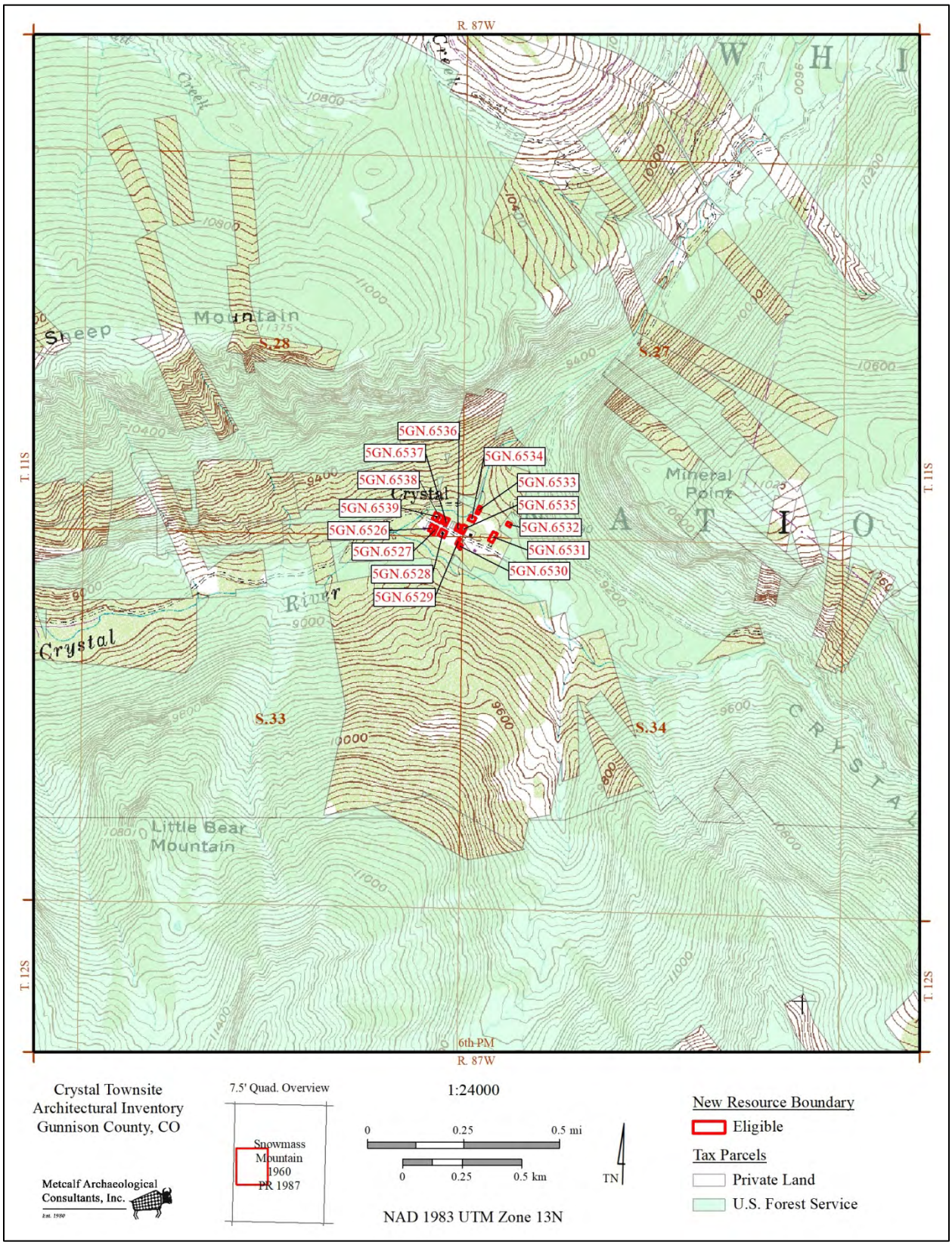


5GN6527 – Crystal Club. Interior, view of the head of the stairs in the addition from the east second floor room. View northwest. (Roll 19-262, image 290, 09/27/2019)

5GN6527 – Crystal Club. Interior, view down the stairs in the addition from the second floor. Note use wear on the stairs. View west/down. (Roll 19-262, image 295, 09/27/2019)

SITE SKETCH MAP

SITE LOCATION MAP



CLG 76112

G/ES

OAHP1403
Rev. 9/98

COLORADO CULTURAL RESOURCE SURVEY

Architectural Inventory Form

Official eligibility determination
(OAHP use only)
Date _____ Initials _____
_____ Determined Eligible- NR
_____ Determined Not Eligible- NR
_____ Determined Eligible- SR
_____ Determined Not Eligible- SR
_____ Need Data
_____ Contributes to eligible NR District
_____ Noncontributing to eligible NR District

I. IDENTIFICATION

1. Resource number: 5GN6528
2. Temporary resource number: Feature 3
3. County: Gunnison
4. City: Crystal
5. Historic building name: A.A. Johnson General Store
6. Current building name: General Store
7. Building address: 3881 Forest Service Road 314, Crystal Townsite Vicinity (per Gunnison County Assessor 2019d)
8. Owner name and address: Christopher Cox/Treasure Mountain Ranch, Inc/Crystal Mountain Ranch: 1203 Colorado Avenue, Glenwood Springs, Colorado 81601

II. GEOGRAPHIC INFORMATION

9. P.M.: 6th Township: 11 S Range: 87 W
   SE ¼ of SE ¼ of SE ¼ of SE ¼ of section 28 projected
   NE ¼ of NE ¼ of NE ¼ of NE ¼ of section 33 projected
10. UTM reference:
    Zone: 13 ~~N~~ ; 37 318141 mE 26 4325433 mN NAD 83 elev 8950ft
11. USGS quad name: Snowmass Mountain
    Year: 1960 (PR 1987) Map scale: 7.5' ☒ 15' ☐ (Attach photocopy of appropriate map section)
12. Lot(s): _____ Block: _____
    Addition: Yes Year of addition: Unknown exactly, but likely late 19th/ early 20th century
13. Boundary description and justification:
    Boundary of the General Store (5GN6528) is defined by the physical extent of the primary building and its associated building and modern amenities/landscaping features to the east and west and by the 100ft that would have been the length of the original lot to the north and south. Today, the General Store is part of the greater, undivided ~400 Treasure Mountain Ranch/Crystal Mountain Ranch (Parcel # 2915-340-00-004). (Gunnison County Assessor 2019d).

III. Architectural Description

14. Building plan (footprint, shape): L-shaped
15. Dimensions in feet: Length: 25'10" X Width: 17'6" (dimensions reflect the maximum full building footprint)
16. Number of stories: 1.5
17. Primary external wall material(s): Wood- log
18. Roof configuration: Gable- front
19. Primary external roof material(s): Metal
20. Special features: ~~None~~ dovetail notching, stovepipe

21. General architectural description:

The General Store (Feature 1) consists of the original log building and an historic wood-framed shed addition. The full building generally faces north. The roof of the main building is front gabled, framed in dimensional lumber, and is covered in new seamed metal with metal flashing around the eaves. A stovepipe projects out of the peak toward the south end of the building. Intermittent stone foundation is visible around the main building. The original building measures approximately 26' north/south x 18' east/west. The shed addition on the west elevation of the main building measures 12' 5" north/south x 18' east/west.

The primary façade is the north façade, with the main door centered and flanked by two four-over-four-lite double-hung windows. All are wood framed. Siding consists of the exposed hewn, steeple-notched logs, with wood and mud chinking. The door is original, made of wood, and the original mail slot is still present under the four pane window in the door. A moderately ornate metal doorknob with keyhole is present. A wood framed screen door covers the main door. The gable apex is sided with vertical board-and-batten, and one window is centered in the upper half story. A plywood shutter is present on the window, which is also screened. Nails in the window and door framing are both wire and square. While the secondary elevations to be described below are of round logs, the logs of this primary façade are hewn, and marks of the axe blade are still visible. The seemingly special attention paid to what is the storefront likely has two possible explanations that would be in-keeping with the building's function: either the hand-hewn surface, rather than a rounded-log finish, was considered preferable for the primary façade of a commercial building; or hewing was done as a means of preparing the façade for possible subsequent application of siding no longer present or that was never applied (note that there are no known historic records indicating siding was ever applied to the front façade). If siding was meant to be applied to the front façade, the absence of furring strips would suggest that vertical board-and-batten would have been the intended siding, more easily nailed to the finished surface of the hand-hewn logs than clapboards.

The east elevation is of round, steeple notched logs with mud and wood chinking. The mud is very friable. The ends of the dimensional lumber interior floor joists are visible. Both square and wire nails are present in the construction. This elevation appears slightly burned.

The south elevation also shows the round, steeple-notched logs with minimal wood and mud chinking remaining. One wood-framed four-over-four-lite double-hung window is present on the ground floor toward the east end. To the west of the window, three logs have been replaced with new aspen logs. The gable apex is sided with vertical board-and-batten. One fixed two-lite window, screened over, is present in the gable above the ground floor window. A door, made of vertical dimensional lumber with a porcelain doorknob, is present west of the window, indicating the location of the top plate between the lower and upper stories. Two dimensional lumber boards are nailed horizontally across the base of the door. The presence of this door suggests that a balcony or an exterior stair case may have been present at one point in time. All windows and the door are wood framed. Like the east elevation, this elevation also appears slightly burned. Both wire and square nails are present.

The west elevation of the main building mimics the east, consisting of the round, steeple notched logs with wood and mud chinking. The ends of the dimensional lumber interior second floor joists are also visible on this elevation. Again, both square and wire nails are used throughout.

The historic shed addition abuts the west elevation of the main building at its south end. The addition has a shed roof that slopes south and east. The roof is of dimensional lumber framing with metal flashing around the eaves and covered in seamed metal. There is asphalt roll visible under the seamed metal. A skylight is cut out of the roof toward the west side. Stone foundation supports the addition.

The north elevation of the addition is sided with vertical board-and-batten siding with two wood framed doors – one each toward the east and west ends. The doors are paneled wood and appear original. The east door has a porcelain doorknob. Both have wood framed screen doors. Both square and wire nails are used in the construction.

The west elevation of the addition also has vertical board-and-batten siding with one wood framed window centered. It is boarded over with plywood. Both square and wire nails are present.

The south elevation of the addition is also vertical board-and-batten siding. A window is present toward the west end, and it is boarded over with plywood. The dimensional lumber along the eave on this elevation is highly degraded.

The interior of the main building consists of one room on the ground floor and one room on the upper half

story. The ground floor room, utilized as a gift shop, is finished with new dimensional lumber and sheets. The floor appears to be original hard wood. A large, historic wood stove is located near the center of the room with stove pipe projecting straight up. The second floor joists, painted white, are exposed in the ceiling and are original. The stairs leading to the upper floor are located along the east wall. The stairs are well worn and appear original.

The upper half story room is utilized as a small office and storage area for the shop below. The north and south walls are finished in the same new dimensional lumber and wood sheet as the ground floor. The floor appears to be original hard wood. The framing of the gable roof appears to have been covered with the new dimensional lumber and sheet, which has been painted white. At the top of the stairs on their west side, the original wood pulley and fixed support are still mounted to the rail. This was assuredly used to lift goods upstairs from the ground floor during the days of the A.A. Johnson General Store.

The interior of the shed addition was not accessible at the time of recording.

22. Architectural style/building type: Pioneer Log

23. Landscaping or special setting features: Outside of the north elevation, which is the store front, some small flowering plants have been planted under the windows, and picnic tables have been placed in an open space located east of the building.

24. Associated buildings, features, or objects:
Outhouse (Feature 2) – the outhouse is located south-southwest of the primary building and measures 6'2" east/west x 5'10" north/south. It rests on a wood sill. The roof is gabled, framed with dimensional lumber, and covered with wood shingles. Metal has been placed over the peak. Siding is vertical dimensional lumber on all elevations excepting the west elevation gable, in which the lumber is horizontal. The gable on the east elevation is open. The door is on the east elevation and is wood with a wood frame. Metal vents are present at the base of the north and south elevations. The interior floor, box, and siding are all plywood. A new plastic seat has been added over the hole in the box.

Also a modern shed. No info or photo provided, but it is on the sketch map.

IV. ARCHITECTURAL HISTORY

25. Date of construction: Estimate: _____ Actual: 1881
Source of information: Neal 2002:195

26 Architect: Likely Albert A. Johnson
Source of information: Neal 2002:195

27. Builder/contractor: Albert A. Johnson
Source of information: Neal 2002:195

28. Original owner: Albert A. Johnson
Source of information: Neal 2002:195

29. Construction history (including description and dates of major additions, alterations, or demolitions):
The A.A. Johnson General Store was built by Albert A. Johnson in 1881 (Neal 2002:195). The main part of the building was constructed first, and the shed portion attached to the west elevation of the main building was added at a specifically unknown date but during the period of significance (1880-1917). The addition was rolled over to the main building on logs from an unknown location in town (Heather Leigh, personal communication September 25, 2019). The metal roof was added to the full building sometime between 1980 and 1990 to protect it from the elements (Christopher Cox, personal communication January 7, 2020).

30. Original location: ☒ Moved: ☐ Date of move: _____

V. HISTORICAL ASSOCIATIONS

31. Original use(s): Commerce/Trade- Department Store

32. Intermediate use(s): _____

33. Current use(s): Commerce/Trade- Department Store

34. Site type(s): General store and post office; now a gift shop

35. Historical background:

The A.A. Johnson General Store was built by Albert A. Johnson in 1881, and the building went on to also house the Crystal post office after it was established in 1882 (Neal 2002:15, 195). Johnson served as postmaster from 1882 until 1893 and carried the mail between Crystal and Crested Butte weekly (Neal 2002:15-16; Vandenbusche 1980:78, 235, 247, 423). Johnson ran the General Store and post office until his death in 1893 (Callihan 2017). Archival research did not reveal any information on the store's ownership after Johnson's death. The Crystal post office, however, continued to operate until is decommissioning in 1909 (Neal 2002:16). No records were found to indicate that the post office was ever housed in a different building, nor that the General Store building was ever used for anything but it's original purpose.

For more information on Albert A. Johnson, please see Item 42 below.

Today, the General Store is owned by Christopher Cox/Crystal Mountain Ranch and is operated as a gift shop seasonally.

Crystal Townsite History

Before the mining boom of the late 19th century, the Crystal Valley, located between Sheep Mountain, Little Bear Mountain, and Mineral Point, was occupied by the Ute Indians. The Utes were forcibly removed from the area and placed on reservations by the federal government around 1879, and infiltration of the former Ute lands by prospecting miners was quick to follow. Euroamerican prospectors began arriving in the Crystal Valley predominantly by way of Crested Butte, Gothic, and Schofield in the late spring and early summer of 1880 (Neal 2002:7; Vandenbusche 1980:245,). Prospectors set up camp near the confluence of the north and south forks of the Crystal River where they located outcroppings of clear quartz crystals which became the settlement's namesake (Vandenbusche 1980:245).

Although lead, copper, zinc, and some gold were present in the quartz formations around Crystal, silver was the main ore attracting miners to the valley. The silver in the area was high in quantity, quality, and, of course, value (Neal 2002:9). The town of Crystal was officially incorporated on August 26, 1881 (Neal 2002:10). Crystal was granted a post office in 1882, with Albert A. Johnson leading that effort and being designated as the first postmaster (Neal 2002:15; Vandenbusche 1980:246).

Other nearby silver mining camps were established during the same time period as Crystal. Located south of Crystal toward Crested Butte was Schofield, the earliest iteration of which was present as early as 1873. Schofield, however, was already in its final decline by late 1883. By that time, most of its residents had moved on, many of them to Crystal (Vandenbusche 1980:249, 252). Several of the original structures in the Crystal mining camp were moved there from Schofield (Neal 2002:7). The Schofield post office was discontinued in 1885, and the town was emptied. A brief revival of Schofield took place in 1899, but it was abandoned for good by 1900 (Neal 2002:134; Vandenbusche 1980:252). Similarly, the once booming mining town of Gothic, located between Schofield and Crested Butte and which was incorporated in 1879, began its sharp decline soon after it had reached its peak in 1881. Like Schofield, by 1883, Gothic was more-or-less abandoned (Vandenbusche 1980:258). Another nearby mining camp included Snowmass City, founded in 1880 and located a mere mile north of Crystal. By 1881, Snowmass City was starting to grow, and in 1883, a road was blasted between Snowmass City and Crystal, connecting Snowmass City with the route over Schofield Pass and into Crested Butte. Snowmass City reached its peak in 1884 but could not overcome its access difficulties and competition from Crystal. It succumbed in 1886 (Vandenbusche 1980:249).

By 1881, there are said to have been 21 or 22 cabins present at Crystal (Neal 2002:8; Vandenbusche 1980:245, Neal 2002:8). Citing the Colorado State Business Directory, Neal relays that the population of Crystal was reported as 600 in 1883; 300 in 1884 and1885; 400 in 1886 and 1888; 200 in 1889; and 101 in 1900 (2002:8). By 1910, however, the Census lists Crystal's population as four (Neal 2002:8). Notably, the 1910 Census was taken mid-May, so the count of four may have represented only year-round residents; only hardy souls over-wintered in Crystal which was, and continues to be, notoriously snowed-in during the cold months of the year (Callihan 2017; Neal 2002:8)

In its heyday, Crystal had a newspaper, a post office, saloons, a stage line, two general stores, a pool hall, a hotel, a "gentleman's club" (5GN6527), a two-story town hall, an assayer and chemist, a livery, a barber shop, over seventy houses, and more (Neal 2002:12-13; Vandenbusche 1980:245). Twelve streetlights were present in Crystal: large metal kerosene lamps hung from poles that were lit at dusk and extinguished at 10:00 pm (Neal 2002:119). A telegraph line ran from Marble through Crystal and on to Crested Butte, and a telephone line was developed from Marble to Crystal in 1904 (Neal 2002:108). The residents of Crystal procured their water from ditches that ran through town on each side of the main road through town, fed by a natural spring located east of town (Neal 2002:10). A blacksmith shop, no longer extant, was located just

west of town, opposite the Sheep Mountain Tunnel Mill/Crystal Mill (5GN1627) (Roger Neal, personal communication September 27, 2019).

Additionally, Crystal also had its own cemetery, located southwest of the town and the Sheep Mountain Tunnel Mill/Crystal Mill (5GN1627) along what is now Gunnison County Road 3. Numerous Crystal residents are interred at the now overgrown cemetery, which is located within an avalanche chute. As such, the cemetery has been subjected to countless avalanches which have pummeled the little graveyard over the years. Burials are obscured by vegetation and avalanche debris. Some wrought iron fencing is still visible along with a single, roughly made headstone- that of Judge Tom O'Bryan, a prominent resident of Crystal from its inception until his death in 1904 (Christopher Cox and Heather Leigh, personal communication September 25, 2019; Roger Neal, personal communication September 26-27, 2019; Neal 2002:23-24).

From the beginning, Albert A. Johnson was Crystal's "leading citizen" (Vandenbusche 1980:247). Johnson operated the general store (5GN6528) and a hotel; edited and printed the town's first newspaper, the *Crystal River Current*; and owned several mining properties including the famed Lead King for a time. Johnson was responsible for securing a post office for Crystal and, as mentioned above, served as the first postmaster (Vandenbusche 1980:247). In addition to his prominent role in development of the Crystal community, Johnson became known regionally as a "legendary postman" who bravely and unfailingly carried mail between Crystal and Crested Butte on skis during the snowy months. His route, through the "feared Crystal Canyon," was extremely perilous due to the terrain and avalanche danger (Vandenbusche et al. 2008:55, 58). Al Johnson was regionally recognized as the "top snowshoer of the Rocky Mountains" for his speed and technique at completing his treacherous mail-carrying route in addition to winning many ski races across Colorado's western slope (Vandenbusche 1980:247, 423, 426-428).

Snowshoeing [skiing] was extremely popular, and necessary, in the broader Gunnison country around the turn of the century (Vandenbusche 1980:247). "Every man, woman, and child had to learn to ski if they wished to get anywhere in the winter in the early mining days" (Vandenbusche et al. 2008:75). Crystal was no exception in its love of skiing. The "Crystal Snowshoe Club" became "legendary in the rocky mountains" and featured the "famed" Al Johnson (Vandenbusche et al. 2008:120). In 1886, the Gunnison Country Snow-Shoe Club was formed with Al Johnson serving on the Executive Committee. The Club organized competitive races in Gunnison, Crested Butte, Irwin, Gothic, and Schofield in February and March of that year, all of which were met with great enthusiasm and support from the local communities (Vandenbusche 1980:426-428).

Since its inception, access to Crystal has been a challenge and a hindrance to the town's development. Until 1883, Crystal was extremely isolated from the rest of the region with only "jack" trails (the period term for mule trails) connecting the town with Crested Butte to the south and Carbondale to the north (Vandenbusche 1980:245). Along the route to Crested Butte, a toll road was completed between the mining settlements of Gothic and Schofield in 1881, and the old jack trail between Schofield and Crystal was finally also converted into a wagon road in 1883 (Neal 2002:11-12, Vandenbusche 1980:245). After the completion of the wagon road from Schofield, Crystal's population rose (Vandenbusche 1980:245-246). Still, the Crystal Canyon Road between Crystal and Schofield and beyond to Crested Butte was extremely dangerous and one of the "most treacherous in Colorado;" in winter, the canyon "vomited avalanches" (Vandenbusche et al. 2008:54).

Silver mines surrounding Crystal included the "Belle of Titusville, Catalpa, Eureka, Jack Whacker, Inez, Bear Mountain, and Daisy," with the most reputable mines in the area being "the Lead King, Black Queen, and Sheep Mountain Tunnel" (Vandenbusche 1980:245). The Sheep Mountain Tunnel is the mine that was most related to the iconic mill located on the Crystal River just west of town- the Sheep Mountain Tunnel Mill /Crystal Mill (5GN1627). The "Mill," which was actually a powerhouse, has become the most photographed site in Colorado, its only competition being the Maroon Bells near Aspen (Vandenbusche 1980:247, Vandenbusche et al. 2008:58). Built in 1892, the Mill contained a water wheel that generated the power to operate a compressor that in turn powered air drills at the Sheep Mountain Tunnel. The water power used to operate the system was created by damming the Crystal River at the entrance to the Sheep Mountain Tunnel, the confluence of the north and south forks of the river. The Mill eventually also provided power to the nearby Inez, Bear Mountain, and Black Queen mines. The presence of the Mill facilitated continued silver mining in the Crystal vicinity during the difficult years of the silver crash; "the community of Crystal owes much of its existence to this power generating facility" (Daily 1985).

Shipping ore from these mines was a constant struggle. The lack of a railroad line at Crystal meant that ore had to be hauled by wagon or jack train along the dangerous rockslide- and snowslide-prone canyon roads to the nearest railroad stations. Between 1886 and 1909, the residents of Crystal were promised several times that a railroad branch would reach the little town, alleviating their transport woes and providing the

mines (and the town) a much needed boost with the ability to easily ship more ore, but the railroad never came (Vandenbusche 1980:245, 248).

Leading up to the Silver Panic of 1893, the declining price of silver resulted in a stark decrease in Crystal's population by 1892. Despite the presence of the advantageous Sheep Mountain Tunnel Mill/Crystal Mill (5GN1627), the town never fully recovered from the decline, with its population cut in half at that time. The *Crystal River Current* ceased operations in 1892, with the *Silver Lance* courageously appearing in 1893 to take its place. Crystal's population continued to dwindle, however, and the *Silver Lance* merged with the *Marble City Time*s in 1899 (Vandenbusche 1980:245, 248). The Crystal post office closed in 1909 (Neal 2002:16).

Crystal was practically deserted by 1915. In 1916, a minor revitalization took place when the Black Queen, Lead King, and Sheep Mountain tunnels began operating and shipping ore once again. By 1917, however, the revival had already died, and the Sheep Mountain Tunnel closed for good, rendering Crystal a veritable ghost town (Vandenbusche 1980:248). Never-ending access difficulties coupled with the decline of the profitability of silver led to the town's final denouement (Neal 2002:138). Still, Crystal can be commemorated as a mountain mining town that persevered through staggering adversity during a time when its neighbors had already folded, notably Gothic, Schofield, and Snowmass City (Vandenbusche 1980:249, 252). Indeed, "Crystal [is] perhaps the best example of a north country town which stood amidst too much adversity" (Vandenbusche 1980:249).

After the mining days ended, a few people continued to seasonally occupy the town. Emmet S. Gould arrived in Crystal from Aspen in 1938 in search of ore. He ended up buying several mining claims, the Sheep Mountain Tunnel Mill/Crystal Mill (5GN1627), and several lots and cabins. Emmet's descendents continue to have a presence in the area as the Crystal Mountain Ranch (Neal 2002:151-152). Several other families called Crystal a summer home during the mid-20th century (and still do today), keeping the sleepy town partially occupied in the summer months (Neal 2002:140-197, 251-253).

By the 1950s, outdoors excursions were being led by individuals residing seasonally in Crystal. Beginning in 1954, Richard "Dick" Car-Skaden guided tourists on hiking trips in the mountains, deeming his operation the Snowmass Wilderness Guide Service. Dick lived seasonally in the back of the Crystal Club (5GN6527), the building that housed the "gentleman's club" in the mining days, from the 1950s into the early 1970s. The Crystal Club also served as the base for his excursions (Neal 2002:141, 175-176). Also beginning in 1954, Theodore "Sarge" Jackson, who lived in various cabins during his time in Crystal, began taking tourists and hunters on guided horseback trips into the surrounding mountains. Eventually, he moved his base of operations up the pass south into Schofield (Neal 2002:142). Area artist John Toly also lived in the back of the Crystal Club seasonally during the 1970s (Neal 2002:176). The Colorado Outward Bound School, established in 1962, created a base camp in the area for teaching life skills through outdoor activities. The school's students have performed service days in Crystal which consist of general maintenance tasks around town (Neal 2002:152-154).

Today, seasonal tourist visitation to Crystal has skyrocketed. People making the trek between Marble and Crested Butte over the infamous Schofield Pass and through Crystal Canyon, in capable 4x4 or other off-highway vehicles, pass through the once booming town. Visitation numbers to the famous Sheep Mountain Tunnel Mill /Crystal Mill (5GN1627) have increased exponentially in recent years to as many as 300 vehicles per day (Heather Leigh, personal communication September 25, 2019). The Mill and most of the townsite is owned by the Crystal Mountain Ranch. The Ranch manages public access to the iconic Mill, again, the most photographed location in all of Colorado, allowing tourists to walk down to the river bank opposite the building for a small fee. Five of the historic cabins belonging to the Crystal Mountain Ranch are available for rent seasonally to tourists. The Ranch also offers a designated camping area and a gift shop in the original A.A. Johnson General Store (5GN6528). Other cabins in the town are owned by private individuals and are used as seasonal homes; Crystal has no year-round occupants.

36. Sources of information:

Anderson, Robert
1995 Historic Building Inventory Record and State Register of Historic Properties Nomination Form for the Tays/Anderson House (5GN2432). Copies available from the Colorado Office of Archaeology and Historic Preservation, Denver.

Bomberger, Bruce D.
1991 Preservation Brief 26: The Preservation and Repair of Historic Log Buildings. National Park Service, US Department of the Interior, U.S. Government Printing Office, Washington, D.C.

Callihan, Michael
2017 Let 'em Run!: Al Johnson and the Great Races of 1886 [a play based on the historical record]. Script on file, Metcalf Archaeological Consultants, Inc., Grand Junction, Colorado.
2020 Discovering the Real Al Johnson. Electronic document, https://crestedbuttemuseum.com/blog/al-johnson/, accessed April 20, 2020.

Daily, Tracey Thrasher
1985 National Register of Historic Places Inventory Nomination Form for the Sheep Mountain Tunnel Mill/Crystal Mill (5GN1627). Copies available from the Colorado Office of Archaeology and Historic Preservation, Denver.

Doggett, Suzanne and Holly Wilson
1999 National Register of Historic Places Multiple Property Documentation Form – Rural School Buildings in Colorado. Electronic document, https://www.historycolorado.org/sites/default/files/media/document/2017/627.pdf, accessed January 6, 2020.

Gunnison County Assessor
2019d Public records for 3881 Forest Service Road 314 , Crystal Townsite Vicinity. Electronic document, https://www.gunnisoncounty.org/327/Property-Record-Search, accessed December 2, 2019.

Gunnison Review Press
1885 "Al Johnson suggested as contender for new Gunnison County Commissioner." 31 January. Gunnison, Colorado.
1886a "Description of Al Johnson's community roles, services, and geniality." 2 January. Gunnison, Colorado.
1886b "Report on Al Johnson's role in the Schofield avalanche recovery." 30 January. Gunnison, Colorado.
1887 "Al Johnson listed as vice president of Gunnison Country Snow-Shoe Club." 22 January. Gunnison, Colorado.

History Colorado
2008 Field Guide to Colorado's Historic Architecture and Engineering. Colorado Historical Society, Denver. Electronic document, https://www.historycolorado.org/colorados-historic-architecture-engineering-guide, accessed April 17, 2020.

Neal, Roger A.
2002 *Crystal....What Really Happened (Revised Fifth Edition)*. Crystal Tale Books. Goshen, Indiana.

Vandenbusche, Duane
1980 *The Gunnison Country*. B & B Printers, Gunnison, Colorado.

Vandenbusche, Duane, the Gunnison Pioneer Museum, and the Crested Butte Mountain Heritage Museum
2008 *Images of America: Around Gunnison and Crested Butte*. Arcadia Publishing, Charleston, South Carolina.

VI. SIGNIFICANCE

37. Local landmark designation: Yes ☐ No ☒ Date of designation: n/a
Designating authority: n/a

38. Applicable National Register Criteria: (reflective of the full townsite's eligibility)

- ☒ A. Associated with events that have made a significant contribution to the broad pattern of our history;
- ☒ B. Associated with the lives of persons significant in our past;
- ☒ C. Embodies the distinctive characteristics of a type, period, or method of construction, or represents the work of a master, or that possess high artistic values, or represents a significant and distinguishable entity whose components may lack individual distinction; or
- ☒ D. Has yielded, or may be likely to yield, information important in history or prehistory.
- ☐ Qualifies under Criteria Considerations A through G (see Manual)

☐ Does not meet any of the above National Register criteria

39. Area(s) of significance: Commerce; Exploration/Settlement; Industry-mining

40. Period of significance: 1881-1917

41. Level of significance: National ☐ State ☒ Local ☒

42. Statement of significance:

5GN6528, the General Store, meets the requirements of NRHP Criteria A, B, C, and D in the areas of Commerce in addition to Exploration/Settlement and Industry-Mining.

Regarding **Criterion A**, the General Store is significant under Commerce for its role in supplying necessary merchandise to residents of Crystal beginning in 1881, with particular importance related to the fact that the store was the only reason some residents could over-winter in the notoriously snowed-in Crystal Valley. With no easy access to outside supplies during snowy months, Al Johnson's well stocked store not only provided needed personal goods to hardy winter residents of Crystal but also provided goods that allowed nearby mines to continue to be worked year-round (Callihan 2017). Additionally, the General Store can be considered significant in the areas of Exploration/Settlement and Industry-mining as it is an element of the late 19th/early 20th century regionally noteworthy mining town of Crystal (5GN1332), the development of which was a part of and directly associated with the historically significant mining boom of that time period in Colorado. Having been built in 1881 and operated as an important facet of the community thereafter, the General Store clearly falls within the full Crystal Townsite's suggested period of significance of 1880-1917.

Regarding **Criterion B**, the General Store is associated with a significant person in history, Albert A. Johnson, a Crystal resident who was a "legendary" figure in the Gunnison country during the late 19th century (Professor Duane Vandenbusche, personal communication March 25, 2020). Johnson built and ran the A.A. Johnson General Store and the post office it contained until his death in 1893. He is significant for his role in helping the town of Crystal develop and thrive between 1881 and 1893 and in popularizing recreational skiing in the region prior to the turn of the century. Born near Montreal in the Laurentain mountain area of Canada in 1851, Al Johnson came to Crystal in 1880 as a silver prospector with his brother Fred (Callihan 2017; Vandenbusche et al. 2008:58). Rather than working directly in mining operations, Al Johnson decided to supply miners with essential goods and opened the "A.A. Johnson General Store" (5GN6528) in Crystal in 1881. Over the years, in addition to the general store, he operated a hotel in Crystal and owned several nearby mining properties, including the famed and lucrative Lead King for a time (Vandenbusche 1980:247).

Johnson has been called Crystal's "leading citizen" for his contributions between 1881 and his death in 1893 (Vandenbusche 1980:247). As a "merchant, miner, post master, mail carrier, man and maid of all work, and boss of good fellows generally" (Gunnison Review Press 1886a), he was "widely respected for his business acumen and outgoing personality" within Crystal and beyond (Callihan 2020). He initiated and perpetuated the town's growth by, first, opening and operating the general store, and, second, by securing the postal contract for Crystal in 1882. Notably, merchandise provided in Johnson's general store allowed stalwart Crystal locals to remain in town year-round. The town of Crystal was, and continues to be, snowbound every winter, with no easy access to supplies. By keeping his store well-stocked, Johnson provided a continuous and reliable inventory to the hardy folks who over-wintered in Crystal, offering products necessary for personal use but also for continuing nearby mining work through the challenging winter months (Callihan 2017; Neal 2002:14).

Importantly, Johnson also housed the Crystal Post Office at his general store, reliably carried the mail between Crystal and Crested Butte on a year-round basis, and served as the town's postmaster until his death in 1893 (Neal 2002:15-16; Vandenbusche 1980:247). In 1885, Johnson was recommended as a potential Gunnison County Commissioner to represent the Crystal area by virtue of his efforts as a "faithful worker for that section of the country…[for while working] for himself he [worked] for others by his pen and otherwise in order to promote the interest of that rich mining region" (Gunnison Review Press 1885). In 1886, Johnson launched Crystal's first newspaper, the *Crystal River Current,* which he edited and published through 1892 in a building (no longer extant) behind his store (Neal 2002:195; Vandenbusche 1980:245). In 1890, Johnson served as Crystal City Council Clerk (Neal 2002:15). That same year, Johnson married Kate Usher, sister of prominent Crystal resident Jim Usher. A baby girl, Crystal Rose, was born to the Johnsons on May 1, 1891 but died on October 29, 1891 (Callihan 2017). By that time, Al Johnson was suffering from a bad cough that was likely due to tuberculosis. In an effort to combat his illness, Johnson spent the winters of at least 1891 through 1893 in Arizona, returning to Crystal during the summers to run his store and the post office, but he died in Phoenix on January 19, 1893, at the age of 42 (Callihan 2017).

Beyond his pivotal role in building and supporting the local Crystal community, Johnson is remembered

regionally for his impressive "snowshoeing," the period term for skiing, and for expanding Gunnison country ski culture. Skiing was extremely popular, and vital, in the broader Gunnison country in the late 19th and early 20th centuries (Vandenbusche 1980:247). "Every man, woman, and child had to learn to ski if they wished to get anywhere in the winter in the early mining days" (Vandenbusche et al. 2008:75). Ski groups flourished throughout the area at various mining camps, and the town of Crystal was no exception in its love of (and need for) skiing. The Crystal Snowshoe [ski] Club became "legendary in the rocky mountains" and featured the "famed" Al Johnson (Vandenbusche et al. 2008:120).

Johnson primarily gained skiing notoriety as one of the few in the Gunnison country who unfailingly carried mail on skis across high elevation, extremely dangerous, snow-covered terrain. Johnson became known regionally as a "legendary postman" who bravely and dependably executed his "anointed task" of carrying mail between Crystal and Crested Butte on what became known as the "Snowshoe Express" (Vandenbusche 1980:247, 423; Vandenbusche et al. 2008:55). His route, which included a stretch through the "feared Crystal Canyon," was extremely perilous, likely the most perilous in the region, due to the terrain and avalanche danger in snowy conditions (Vandenbusche 1980:78; Vandenbusche et al. 2008:58). Johnson became recognized as the "top snowshoer [skier] of the Rocky Mountains" for his speed and technique in completing this treacherous, avalanche-prone mail-carrying route (Vandenbusche 1980:423). Weekly, Johnson donned 11-foot wooden skis to travel the 18 miles from Crystal to Crested Butte, traversing the dreaded Crystal Canyon, with as much as 40 pounds of mail on his back each way (Callihan 2020). Adding to his acclaim, an avalanche one January night in 1886 hit the mining camp at Schofield, located at the top of Crystal Canyon. Upon hearing the news, Johnson skied up the canyon during the continuing blizzard in total darkness to aid the devastated camp. Johnson is noted to have dug victims out of the snow-slide and led people to safety amidst the storm that dumped six feet of snow at Schofield and four feet at Crystal. Following the rescue, he continued on to Crested Butte to deliver news of the avalanche and assembled a rescue party to return to Schofield to carry on with the recovery (Callihan 2020; Gunnison Review Press 1886b).

Beyond his courageous mail delivery on skis, Johnson's fame was bolstered by numerous ski race victories across Colorado's western slope (Vandenbusche 1980:247, 423, 426-428). His fame helped popularize skiing as recreation in Colorado. In 1886, he fostered the extensive ski culture of the region by serving on the Executive Committee of the newly formed Gunnison Country Snow-Shoe (ski) Club, developed to encourage competitive regional ski racing and winter sports, and he was vice-president of the club the following year (Gunnison Review Press 1887) . At Johnson's suggestion and primarily through his efforts, the Club organized wildly popular races in the towns of Gunnison, Crested Butte, Irwin, Gothic, and Schofield during February and March of 1886 (Vandenbusche 1980:426-428). Inspired by similar "snowshoe carnivals" he had experienced back home near Montreal, Johnson led the organization of the races in Crested Butte, Gunnison, Irwin, and Gothic that would cumulatively become known as the "Great Race of 1886" (Callihan 2020). Those four races were met with great enthusiasm and support from the local communities, with excited spectators gathering along the race routes to cheer on contestants from their respective mining camps. An estimated 1,000 people gathered to watch the Crested Butte race, for which a special Denver and Rio Grande Excursion train was chartered (Callihan 2020; Vandenbusche 1980:426-428). The Great Race of 1886, conceived and implemented by Al Johnson, introduced competitive ski racing to the Gunnison country (Vandenbusche 1980:428-429).

Al Johnson was described as "without a doubt, the most graceful snowshoer the Rocky Mountains [had] ever produced…a daring adventurer on shoes [skis]" (Vandenbusche 1980:427). In 1974, the telemark ski community in Crested Butte began the Al Johnson Memorial Uphill/Downhill Telemark Race. The race, honoring Al Johnson, his exceptional skiing abilities, and his devoted public service as a mail carrier through unthinkably hostile weather and terrain, continues to be held annually at Crested Butte Mountain Resort. As a further tribute, "Let 'em Run!: Al Johnson and the Great Races of 1886," a play by Michael Callihan documenting aspects of Johnson's remarkable life, has been produced in Gunnison and Crested Butte annually since 2017, playing to sold out crowds (Michael Callihan, personal communication March 29, 2020).

Regarding **Criterion C**, as a Pioneer Log building (History Colorado 2008), the General Store embodies distinctive characteristics of a type, period, and method of construction. Initially chosen as an expedient and durable form of shelter (especially in the forested mountain areas of the state), Pioneer Log buildings have become an iconic part of Colorado's built heritage. The General Store is a strong representative example of this type. Like other buildings at the Crystal Townsite, it has a distinct form marked by the entry on the gable end—a trait that evolved in the West as a unique response to snow accumulation in the Rocky Mountains (Bomberger 1991). The construction of the General Store reflects a vernacular approach to building similar to others in the vicinity. This particular example of a Pioneer Log building bears subtle characteristics that speak to the building's historic function as well as to its builder's economy, considering the remoteness of the

location and the challenge of acquiring materials. Two types of logs were used to erect the General Store, both hand-hewn and round logs. The builder made the choice to use rounded logs for the building's secondary walls (east, west, and south elevations) and reserved the hewn logs for use on the primary façade (north), which would serve as the public-facing storefront complete with display windows. Marks of the axe blade are still visible across the building's north wall. The special attention paid to the storefront likely has two possible explanations that would be in-keeping with the building's function: either the hand-hewn surface, rather than a rounded-log finish, was considered preferable for the primary façade of a commercial building; or hewing was done as a means of preparing the façade for possible subsequent application of siding no longer present or that was never applied (note that there are no known historic records indicating siding was ever applied to the front façade). If siding was meant to be applied to the front façade, the absence of furring strips would suggest that vertical board-and-batten would have been the intended siding, more easily nailed to the finished surface of the hand-hewn logs than clapboards.

Regarding **Criterion D**, passing observations of surface-exposed cultural material and earthen depressions in addition to the presence of at least one extant outhouse near the General Store suggest archaeological potential associated with the building. The extant outhouse and other likely previous privy locations, at a minimum, could yield information significant to our understanding of the site, the full town, and the larger area, beyond that already available in written or oral documentation.

While some modern repairs and replacements have been made to the General Store, particularly the interior and the roof, the building overall retains a majority of its original materials and construction. Alterations made to the building have not overwhelmed its original design. Furthermore, beyond retaining physical integrity, the building also retains intangible integrity (see Item 43 below). In sum, the building continues to convey its relationship with the areas of significance and can be recommended as eligible to the NRHP under Criteria A, B, C, and D.

43. Assessment of historic physical integrity related to significance:

Regarding the aspects of integrity, the General Store retains location as it remains in its original location. Although some modern improvements have been made to the building, especially the roof and the interior, the aspects of materials, workmanship, and design are overall retained as enough of the original materials, methods of construction, and layout of the building are still present and can still be discerned. Association is retained as the General Store is an early element of the historically significant mining town of Crystal, with its date of construction, 1881, falling within the town's suggested period of significance. Additionally, the General Store is directly associated with Albert A. Johnson, noted as Crystal's "leading citizen," who was a particularly significant figure in the early development, growth, and perpetuation of the town. Also, Al Johnson was noteworthy in the broader region for his skills and involvement in the skiing culture of the area during the late 19th century. Setting and feeling are also retained as little has changed in the surrounding landscape to alter the environment from what it would have been during the period of significance, aside from modern tourist traffic through the town.

VII. NATIONAL REGISTER ELIGIBILITY ASSESSMENT

44. National Register eligibility field assessment:

Eligible ☒ Not Eligible ☐ Needs Data ☐

45. Is there National Register district potential? Yes ☒ No ☐

Given the historical continuity and good condition of the extant buildings, the full Crystal Townsite (5GN1332) holds the potential to be considered eligible for inclusion on the NRHP as a District under Criteria A, B, C, and D for a suggested period of significance of 1880-1917. Crystal fulfills the requirements of **Criterion A**, association with significant events, as the town is inextricably associated with the historically significant late 19th/early 20th century mining boom in Colorado, having been developed, incorporated, and occupied as a direct result of that momentous event in Colorado history.

Discuss: The town fulfills the requirements of **Criterion B** for its association with prominent figure Albert A. Johnson, a Crystal resident who was a "legendary" figure in the Gunnison country during the late 19th century (Professor Duane Vandenbusche, personal communication March 25, 2020). He is significant for his role in helping the town of Crystal develop and thrive between 1881 and 1893 and in popularizing recreational skiing in the region prior to the turn of the century. Born near Montreal in the Laurentain mountain area of Canada in 1851, Al Johnson came to Crystal in 1880 as a silver prospector with his brother Fred (Callihan 2017; Vandenbusche et al. 2008:58). Rather than working directly in mining operations, Al Johnson decided to supply miners with essential goods and opened the "A.A. Johnson General Store"

(5GN6528) in Crystal in 1881. Over the years, in addition to the general store, he operated a hotel in Crystal and owned several nearby mining properties, including the famed and lucrative Lead King for a time (Vandenbusche 1980:247).

Johnson has been called Crystal's "leading citizen" for his contributions between 1881 and his death in 1893 (Vandenbusche 1980:247). As a "merchant, miner, post master, mail carrier, man and maid of all work, and boss of good fellows generally" (Gunnison Review Press 1886a), he was "widely respected for his business acumen and outgoing personality" within Crystal and beyond (Callihan 2020). He initiated and perpetuated the town's growth by, first, opening and operating the general store, and, second, by securing the postal contract for Crystal in 1882. Notably, merchandise provided in Johnson's general store allowed stalwart Crystal locals to remain in town year-round. The town of Crystal was, and continues to be, snowbound every winter, with no easy access to supplies. By keeping his store well-stocked, Johnson provided a continuous and reliable inventory to the hardy folks who over-wintered in Crystal, offering products necessary for personal use but also for continuing nearby mining work through the challenging winter months (Callihan 2017; Neal 2002:14).

Importantly, Johnson also housed the Crystal Post Office at his general store, reliably carried the mail between Crystal and Crested Butte on a year-round basis, and served as the town's postmaster until his death in 1893 (Neal 2002:15-16; Vandenbusche 1980:247). In 1885, Johnson was recommended as a potential Gunnison County Commissioner to represent the Crystal area by virtue of his efforts as a "faithful worker for that section of the country…[for while working] for himself he [worked] for others by his pen and otherwise in order to promote the interest of that rich mining region" (Gunnison Review Press 1885). In 1886, Johnson launched Crystal's first newspaper, the *Crystal River Current,* which he edited and published through 1892 in a building (no longer extant) behind his store (Neal 2002:195; Vandenbusche 1980:245). In 1890, Johnson served as Crystal City Council Clerk (Neal 2002:15). That same year, Johnson married Kate Usher, sister of prominent Crystal resident Jim Usher. A baby girl, Crystal Rose, was born to the Johnsons on May 1, 1891 but died on October 29, 1891 (Callihan 2017). By that time, Al Johnson was suffering from a bad cough that was likely due to tuberculosis. In an effort to combat his illness, Johnson spent the winters of at least 1891 through 1893 in Arizona, returning to Crystal during the summers to run his store and the post office, but he died in Phoenix on January 19, 1893, at the age of 42 (Callihan 2017).

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to deliver news of the avalanche and assembled a rescue party to return to Schofield to carry on with the recovery (Callihan 2020; Gunnison Review Press 1886b).

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Al Johnson was described as "without a doubt, the most graceful snowshoer the Rocky Mountains [had] ever produced…a daring adventurer on shoes [skis]" (Vandenbusche 1980:427). In 1974, the telemark ski community in Crested Butte began the Al Johnson Memorial Uphill/Downhill Telemark Race. The race, honoring Al Johnson, his exceptional skiing abilities, and his devoted public service as a mail carrier through unthinkably hostile weather and terrain, continues to be held annually at Crested Butte Mountain Resort. As a further tribute, "Let 'em Run!: Al Johnson and the Great Races of 1886," a play by Michael Callihan documenting aspects of Johnson's remarkable life, has been produced in Gunnison and Crested Butte annually since 2017, playing to sold out crowds (Michael Callihan, personal communication March 29, 2020).

The townsite fulfills the requirements of **Criterion C** as its buildings retain sufficient integrity to cumulatively convey the historic built character of a late 19th/early 20th century Colorado mountain mining community. Characteristics of the extant buildings, primarily of the dominant Pioneer Log style, reflect vernacular approaches to building and reveal methods, techniques, and materials known and available to the occupants of Crystal at the time of their construction. The Pioneer Log buildings, primarily consisting of common notched log construction with various chinking materials and gabled roofs, represent residences, a commercial building, a social building, and a barn, all of which had important, individualized roles in community life, reflecting the day-today on goings in an isolated mountain mining town. Additionally, the previously recorded and SRHP-listed Tays/Anderson House (5GN2432), a wood frame Victorian building believed to have been a kit home, provides a contrast to the dominant vernacular building methods, exemplifying more formalized building techniques and imported wood building materials available to affluent members of the community (Anderson 1995). Also of particular note among the buildings in the town is the newly recorded Schoolhouse (5GN6532), which is an excellent and well-preserved example of a rural one-room schoolhouse—an increasingly rare property type in the region. Along with its extant ancillary building, the Schoolhouse has a very recognizable design and construction materials that meet specific eligibility criteria laid out in the NRHP Multiple Property Documentation Form for Rural School Buildings in Colorado, including being a single-story with a front gabled roof, having typical fenestration, and being built with wood framing and shiplap siding (Doggett and Wilson 1999).

Finally, the town fulfills the requirements of **Criterion D**, potential to yield information important in history, due to its archaeological promise. Passing observations during the 2019 architectural inventory of surface-exposed cultural material; artifacts partially buried around building foundations, present inside buildings, and fallen through floors; numerous abandoned privy pits; and the presence of many standing outhouses across the entire townsite suggest that Crystal possesses great archaeological potential; archaeological investigations, both

surface survey and subsurface testing, are highly likely to yield further information not already available in written or oral documentation that could significantly contribute to our understanding of the history of the site and the region.

Beyond the townsite itself (5GN1332), a District boundary could be expanded to incorporate other contemporaneous and related features, including the previously recorded and NRHP-listed Sheep Mountain Tunnel Mill/Crystal Mill (5GN1627), the still unrecorded Crystal Cemetery, the unrecorded spring and ditch water supply system, and nearby mine-related features, if found to be extant at a later date.

The General Store (5GN6528) Contribution to District Potential
As the General Store (5GN6528) is an element of and directly associated with the full townsite (5GN1332), and given that the General Store retains sufficient integrity to convey its association with the full townsite's suggested period of significance (1880-1917), it can be considered contributing toward District potential.

If there is National Register district potential, is this building: Contributing ☒ Non-contributing ☐

46. If the building is in existing National Register district, it: Contributing ☐ Non-contributing ☐

VIII. RECORDING INFORMATION

47. Photograph numbers: Roll 19-260, images 705-741
Roll 19-261, images 225-248

Negatives filed at: Metcalf Archaeological Consultants, Inc. (digitally)

48. Report title: Architectural Inventory of the Crystal Townsite for the Gunnison County Historical Commission, Gunnison County, Colorado.

49. Date(s): 09/25/2019 – 09/27/2019

50. Recorder(s): Natasha E Krasnow and Kelly J Pool

51. Organization: Metcalf Archaeological Consultants, Inc.

52. Address: PO Box 899, Eagle, Colorado 81631

53. Phone number(s): 970-328-6244

NOTE: Please include a sketch map, a photocopy of the USGS quad map indicating resource location, and photographs.

History Colorado - Office of Archaeology & Historic Preservation
1200 Broadway, Denver, CO 80203 (303) 866-3395

5GN6528 – General Store.
View of north elevation. View south. (Roll 19-260, image 705, 09/27/2019)

5GN6528 – General Store.
Oblique view of the northwest corner. View southeast. (Roll 19-260, image 711, 09/27/2019)

5GN6528 – General Store.
View of west elevation. View east. (Roll 19-260, image 716, 09/27/2019)

5GN6528 – General Store.
Oblique view of southwest corner. View northeast. (Roll 19-260, image 718, 09/27/2019)

5GN6528 – General Store.
View of south elevation. View north. (Roll 19-260, image 723, 09/27/2019)

5GN6528 – General Store.
Oblique view of southeast corner. View northwest. (Roll 19-260, image 732, 09/27/2019)

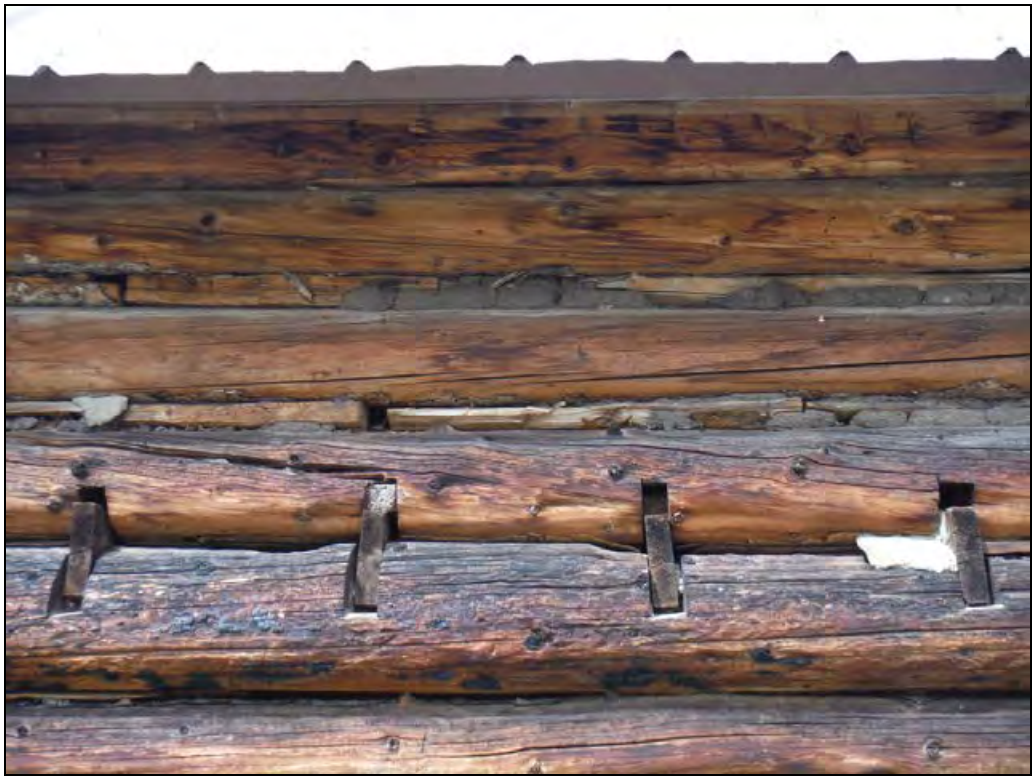
5GN6528 – General Store.
View of east elevation. View west. (Roll 19-260, image 733, 09/27/2019)

5GN6528 – General Store.
Oblique view of northeast corner. View southwest. (Roll 19-260, image 736, 09/27/2019)

5GN6528 – General Store. Detail of steeple log notching on northwest corner. View south.
(Roll 19-260, image 709, 09/27/2019)

5GN6528 – General Store. Detail of steeple log notching on the southwest corner. View northeast.
(Roll 19-260, image 725, 09/27/2019)

5GN6528 – General Store. Detail of steeple log notching on southeast corner. View northwest.
(Roll 19-260, image 730, 09/27/2019)



5GN6528 – General Store. Detail of interior floor joist ends visible on the east elevation. View northwest. (Roll 19-260, image 734, 09/27/2019)

5GN6528 – General Store. Detail of south elevation of the main cabin. Note new aspen logs added to the west of the ground floor window. View north. (Roll 19-260, image 724, 09/27/2019)

5GN6528 – General Store.
Detail of the north elevation of the addition. View south. (Roll 19-260, image 707, 09/27/2019)

5GN6528 – General Store. Oblique view of the northwest corner of the outhouse. View southeast.
(Roll 19-260, image 739, 09/27/2019)

5GN6528 – General Store. View of east elevation of the outhouse. View west.
(Roll 19-260, image 740, 09/27/2019)

5GN6528 – General Store. Oblique view of the southeast corner of the outhouse. View northwest.
(Roll 19-260, image 741, 09/27/2019)

5GN6528 – General Store. View of the interior, southwest corner of the ground floor. View southwest. (Roll 19-261, image 227, 09/27/2019)

5GN6528 – General Store. View of the interior, northeast corner and front door. Note mail slot on the door, which is original. View northeast. (Roll 19-261, image 230, 09/27/2019)

5GN6528 – General Store. View of the interior, stairs along the east wall and south wall. Note use wear on the stairs. View south. (Roll 19-261, image 232, 09/27/2019)

5GN6528 – General Store. View of the interior, stairs along the east wall. View southeast. (Roll 19-261, image 228, 09/27/2019)

5GN6528 – General Store. View of the interior, south wall on the second floor. View south. (Roll 19-261, image 235, 09/27/2019)

5GN6528 – General Store. View of the interior, north wall on the second floor. View north. (Roll 19-261, image 236, 09/27/2019)

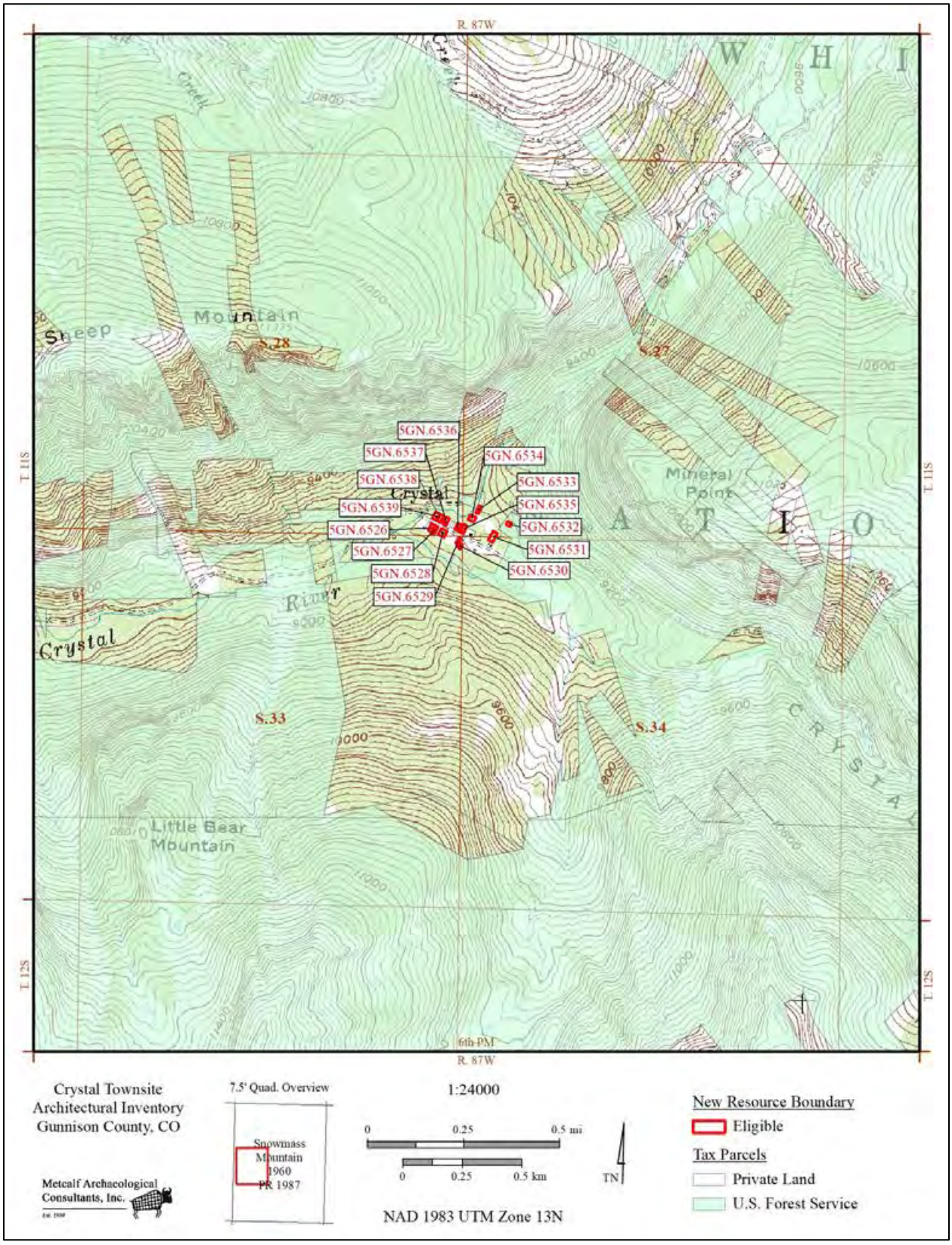
5GN6528 – General Store. View of the interior, original pulley mechanism located on the handrail at the top of the stairs. View southeast/plan. (Roll 19-261, image 239, 09/27/2019)

5GN6528 – General Store. View of the interior, ceiling and northeast corner/east wall on the second floor. View northeast. (Roll 19-261, image 240, 09/27/2019)

5GN6528 – General Store. View of the interior, door located in the south wall on the second floor. View south. (Roll 19-261, image 242, 09/27/2019)

SITE SKETCH MAP

SITE LOCATION MAP



OAHP1403
Rev. 9/98

COLORADO CULTURAL RESOURCE SURVEY

Architectural Inventory Form

Official eligibility determination
(OAHP use only)
Date _____ Initials _____
_____ Determined Eligible- NR
_____ Determined Not Eligible- NR
_____ Determined Eligible- SR
_____ Determined Not Eligible- SR
_____ Need Data
_____ Contributes to eligible NR District
_____ Noncontributing to eligible NR District

I. IDENTIFICATION

1. Resource number: 6GN3536
2. Temporary resource number: Feature 11
3. County: Gunnison
4. City: Crystal
5. Historic building name: Clayton Residence (Silver Lance 1899i)
6. Current building name: Clayton Cabin
7. Building address: 3881 Forest Service Road 314, Crystal Townsite Vicinity (per Gunnison County Assessor records 2019d)
8. Owner name and address: Christopher Cox/Treasure Mountain Ranch, Inc/Crystal Mountain Ranch: 1203 Colorado Avenue, Glenwood Springs, Colorado 81601

II. GEOGRAPHIC INFORMATION

9. P.M.: 6th Township: 11 S Range: 87 W
   SE ¼ of SE ¼ of SE ¼ of SE ¼ of section 28
10. UTM reference:
    Zone: 13 N ; 318199 mE 4325451 mN
11. USGS quad name: Snowmass Mountain
    Year: 1960 (PR 1987) Map scale: 7.5' ☒ 15' ☐ (Attach photocopy of appropriate map section)
12. Lot(s): _____ Block: _____
    Addition: n/a Year of addition: n/a
13. Boundary description and justification:
    Boundary of the Clayton Cabin (5GN6536) is defined by the 100ft that would have been the original lot length to the north and south, by a neighboring parcel to the west, and by the visible extent of the cabin's associated building to the east. Today, the Clayton Cabin is part of the greater, undivided ~400 Treasure Mountain Ranch/Crystal Mountain Ranch (Parcel # 2915-340-00-004) (Gunnison County Assessor 2019d). Note that the associated building (Feature 2) may be partially within Parcel # 2915-340-05-003, which is also owned by Christopher Cox (Gunnison County Assessor 2020).

III. Architectural Description

14. Building plan (footprint, shape): Rectangular
15. Dimensions in feet: Length: 21' X Width: 17'8"
16. Number of stories: 1.5
17. Primary external wall material(s): Wood - log
18. Roof configuration: Gable - front
19. Primary external roof material(s): Metal
20. Special features: None
21. General architectural description:

The Clayton Cabin (Feature 1) is a wood-framed gable-front cabin that rests on a wood sill, at best, which may be made of railroad ties. The cabin generally faces south. The roof has been replaced with new lumber framing covered with seamed metal. A stovepipe projects up from just east of the peak near the roof's center.

The south elevation is the primary façade, with a wood-framed door at center. The door is of vertical dimensional lumber with a square window. A wood-framed screen door covers the door. Two wood framed windows are present on the ground floor, one on either side of the door. They were both originally four-over-four-lite double-hung windows, though a horizontal muntin is missing from the window to the west of the door. Both windows have wood shutters of dimensional lumber and plywood. The ground floor siding is horizontal, square notched hewn logs with thick bands of original fibrous mud chinking. The attic gable is of vertical dimensional lumber siding (board and batten). One wood-framed one-over-one-lite double-hung window is present at the gable's center. It has two wood shutters like those below.

The west elevation has no fenestration. Wire nails are numerous, nailed into the logs and bent over to hold the wood chinking in place. The aforementioned fibrous mud chinking is present at the top of the elevation below the roof/eave.

The north elevation is the hewn, squared notched logs with wood chinking on the ground floor. Wire nails are numerous, nailed into the logs and bent over to hold the wood chinking in place. A wood-framed, fixed window is present toward the east end of the elevation. It has a wood shutter like the rest. A propane tank, to power a stove inside, has been added below the window, and horizontal dimensional lumber has been attached to the exterior below the window to reinforce where the propane line enters the cabin. Another propane tank has been added near the center of the elevation with the line entering the cabin to fuel a refrigerator. The siding in the gable of this elevation is new plywood and tar paper – not original/historic.

The east elevation is the hewn, square notched logs with the aforementioned wood chinking secured with bent wire nails. A wood-framed, fixed window with a wood shutter is located toward the north end of the elevation. A water line has been added, entering the cabin toward its north end, north of the window. New lumber, like that used in the roof, is placed horizontally at the top of the logs below the roof/eave.

A "CLAYTON HOUSE" sign has been added above the front door on the south elevation. A newer, small, dimensional lumber deck has been added on the south/front elevation.

The interior of the cabin consists of one room on the ground floor and one room on the second floor. The room on the main floor has original vertical dimensional lumber wall finish (Christopher Cox, personal communication January 7, 2020). New sawn log support posts have been added from floor to ceiling near the center of the room. The floorboards and floor joists in the ceiling appear original, though the ceiling has been painted. The original opening for the stove pipe is evident and in use by the historic stove present in the cabin today. The stove is located near the center of the east wall. A bed and dressing table are located along the west wall. The northeast corner of the cabin has been fitted with a sink, a propane-powered stove, and a propane-powered refrigerator. The stairs leading up to the second floor are located on the north wall; the stairs themselves appear original based on wear on the tread, but a new sawn log handrail has been installed. In the single room on the second floor, the flooring appears original. The new roofing material is evident. The room is used as a bedroom.

22. Architectural style/building type: Pioneer Log

23. Landscaping or special setting features: None

24. Associated buildings, features, or objects:

Outhouse (Feature 2) – the outhouse is located northeast of the northeast corner of the cabin and measures 6'3" x 6'2.5". It has vertical dimensional lumber siding and a wooden door on the south elevation with a decorative metal doorknob. The roof is gable with wood shingles. The gable is open on the south side but covered with horizontal wood boards on the north. The nails used throughout are wire. Overall, the outhouse sits on the ground above the depression but is minimally lifted/supported by rocks on its northeast corner.

IV. ARCHITECTURAL HISTORY

25. Date of construction: Estimate: _____ Actual: 1895

Source of information: Neal 2002:185

26 Architect: Possibly Jack Clayton

Source of information: Neal 2002:185

27. Builder/contractor: Likely Jack Clayton

    Source of information: Neal 2002:185

28. Original owner: Jack Clayton

    Source of information: Neal 2002:185

29. Construction history (including description and dates of major additions, alterations, or demolitions):
    This cabin was originally built in 1895 by Jack Clayton, a local resident who owned and operated a jack train. (Neal 2002:185). While the chinking is original, some repairs may have been made to it around 1980 (Christopher Cox, personal communication January 7, 2020). The roof, including all framing, was replaced sometime between 1980 and 1990 to preserve the cabin from the elements (Christopher Cox, personal communication January 7, 2020).

30. Original location: ☒ Moved: ☐ Date of move: _____

V. HISTORICAL ASSOCIATIONS

31. Original use(s): Domestic- single dwelling

32. Intermediate use(s): _____

33. Current use(s): Domestic- single dwelling, seasonal dwelling

34. Site type(s): Rural cabin; now AirBnB seasonal rental

35. Historical background:
    This cabin was originally built in 1895 by Jack Clayton who owned and operated a jack train in the area (Neal 2002:185). Mentions in the *Silver Lance* suggest that in August of 1897, the Claytons were living in a cabin in Lead King Basin, making it easier for Mr. Clayton to load his jack trains with ore from the mines there (Silver Lance 1897a). By November of 1897 and into 1898 and 1899, the Claytons are mentioned as being "of Marble" (Silver Lance 1897b, 1898a, 1899h). John Baroni is noted in the newspaper as renting the "Clayton Residence" in August of 1899 (Silver Lance 1899i). Mr. Clayton died in 1911, his body found up Carbonate Creek (Neal 2002:185).

    Today, the Clayton Cabin is owned by Christopher Cox/Crystal Mountain Ranch and is utilized as a seasonal AirBnB rental for ranch guests.

    Crystal Townsite History
    Before the mining boom of the late 19th century, the Crystal Valley, located between Sheep Mountain, Little Bear Mountain, and Mineral Point, was occupied by the Ute Indians. The Utes were forcibly removed from the area and placed on reservations by the federal government around 1879, and infiltration of the former Ute lands by prospecting miners was quick to follow. Euroamerican prospectors began arriving in the Crystal Valley predominantly by way of Crested Butte, Gothic, and Schofield in the late spring and early summer of 1880 (Neal 2002:7; Vandenbusche 1980:245,). Prospectors set up camp near the confluence of the north and south forks of the Crystal River where they located outcroppings of clear quartz crystals which became the settlement's namesake (Vandenbusche 1980:245).

    Although lead, copper, zinc, and some gold were present in the quartz formations around Crystal, silver was the main ore attracting miners to the valley. The silver in the area was high in quantity, quality, and, of course, value (Neal 2002:9). The town of Crystal was officially incorporated on August 26, 1881 (Neal 2002:10). Crystal was granted a post office in 1882, with Albert A. Johnson leading that effort and being designated as the first postmaster (Neal 2002:15; Vandenbusche 1980:246).

    Other nearby silver mining camps were established during the same time period as Crystal. Located south of Crystal toward Crested Butte was Schofield, the earliest iteration of which was present as early as 1873. Schofield, however, was already in its final decline by late 1883. By that time, most of its residents had moved on, many of them to Crystal (Vandenbusche 1980:249, 252). Several of the original structures in the Crystal mining camp were moved there from Schofield (Neal 2002:7). The Schofield post office was discontinued in 1885, and the town was emptied. A brief revival of Schofield took place in 1899, but it was abandoned for good by 1900 (Neal 2002:134; Vandenbusche 1980:252). Similarly, the once booming mining town of Gothic, located between Schofield and Crested Butte and which was incorporated in 1879, began its sharp decline soon after it had reached its peak in 1881. Like Schofield, by 1883, Gothic was more-or-less abandoned (Vandenbusche 1980:258). Another nearby mining camp included Snowmass City, founded in 1880 and located a mere mile north of Crystal. By 1881, Snowmass City was starting to grow, and in 1883, a road was blasted between Snowmass City and Crystal, connecting Snowmass City with the

route over Schofield Pass and into Crested Butte. Snowmass City reached its peak in 1884 but could not overcome its access difficulties and competition from Crystal. It succumbed in 1886 (Vandenbusche 1980:249).

By 1881, there are said to have been 21 or 22 cabins present at Crystal (Neal 2002:8; Vandenbusche 1980:245, Neal 2002:8). Citing the Colorado State Business Directory, Neal relays that the population of Crystal was reported as 600 in 1883; 300 in 1884 and1885; 400 in 1886 and 1888; 200 in 1889; and 101 in 1900 (2002:8). By 1910, however, the Census lists Crystal's population as four (Neal 2002:8). Notably, the 1910 Census was taken mid-May, so the count of four may have represented only year-round residents; only hardy souls over-wintered in Crystal which was, and continues to be, notoriously snowed-in during the cold months of the year (Callihan 2017; Neal 2002:8)

In its heyday, Crystal had a newspaper, a post office, saloons, a stage line, two general stores, a pool hall, a hotel, a "gentleman's club" (5GN6527), a two-story town hall, an assayer and chemist, a livery, a barber shop, over seventy houses, and more (Neal 2002:12-13; Vandenbusche 1980:245). Twelve streetlights were present in Crystal: large metal kerosene lamps hung from poles that were lit at dusk and extinguished at 10:00 pm (Neal 2002:119). A telegraph line ran from Marble through Crystal and on to Crested Butte, and a telephone line was developed from Marble to Crystal in 1904 (Neal 2002:108). The residents of Crystal procured their water from ditches that ran through town on each side of the main road through town, fed by a natural spring located east of town (Neal 2002:10). A blacksmith shop, no longer extant, was located just west of town, opposite the Sheep Mountain Tunnel Mill/Crystal Mill (5GN1627) (Roger Neal, personal communication September 27, 2019).

Additionally, Crystal also had its own cemetery, located southwest of the town and the Sheep Mountain Tunnel Mill/Crystal Mill (5GN1627) along what is now Gunnison County Road 3. Numerous Crystal residents are interred at the now overgrown cemetery, which is located within an avalanche chute. As such, the cemetery has been subjected to countless avalanches which have pummeled the little graveyard over the years. Burials are obscured by vegetation and avalanche debris. Some wrought iron fencing is still visible along with a single, roughly made headstone- that of Judge Tom O'Bryan, a prominent resident of Crystal from its inception until his death in 1904 (Christopher Cox and Heather Leigh, personal communication September 25, 2019; Roger Neal, personal communication September 26-27, 2019; Neal 2002:23-24).

From the beginning, Albert A. Johnson was Crystal's "leading citizen" (Vandenbusche 1980:247). Johnson operated the general store (5GN6528) and a hotel; edited and printed the town's first newspaper, the *Crystal River Current*; and owned several mining properties including the famed Lead King for a time. Johnson was responsible for securing a post office for Crystal and, as mentioned above, served as the first postmaster (Vandenbusche 1980:247). In addition to his prominent role in development of the Crystal community, Johnson became known regionally as a "legendary postman" who bravely and unfailingly carried mail between Crystal and Crested Butte on skis during the snowy months. His route, through the "feared Crystal Canyon," was extremely perilous due to the terrain and avalanche danger (Vandenbusche et al. 2008:55, 58). Al Johnson was regionally recognized as the "top snowshoer of the Rocky Mountains" for his speed and technique at completing his treacherous mail-carrying route in addition to winning many ski races across Colorado's western slope (Vandenbusche 1980:247, 423, 426-428).

Snowshoeing [skiing] was extremely popular, and necessary, in the broader Gunnison country around the turn of the century (Vandenbusche 1980:247). "Every man, woman, and child had to learn to ski if they wished to get anywhere in the winter in the early mining days" (Vandenbusche et al. 2008:75). Crystal was no exception in its love of skiing. The "Crystal Snowshoe Club" became "legendary in the rocky mountains" and featured the "famed" Al Johnson (Vandenbusche et al. 2008:120). In 1886, the Gunnison Country Snow-Shoe Club was formed with Al Johnson serving on the Executive Committee. The Club organized competitive races in Gunnison, Crested Butte, Irwin, Gothic, and Schofield in February and March of that year, all of which were met with great enthusiasm and support from the local communities (Vandenbusche 1980:426-428).

Since its inception, access to Crystal has been a challenge and a hindrance to the town's development. Until 1883, Crystal was extremely isolated from the rest of the region with only "jack" trails (the period term for mule trails) connecting the town with Crested Butte to the south and Carbondale to the north (Vandenbusche 1980:245). Along the route to Crested Butte, a toll road was completed between the mining settlements of Gothic and Schofield in 1881, and the old jack trail between Schofield and Crystal was finally also converted into a wagon road in 1883 (Neal 2002:11-12, Vandenbusche 1980:245). After the completion of the wagon road from Schofield, Crystal's population rose (Vandenbusche 1980:245-246). Still, the Crystal Canyon Road between Crystal and Schofield and beyond to Crested Butte was extremely dangerous and one of the

"most treacherous in Colorado;" in winter, the canyon "vomited avalanches" (Vandenbusche et al. 2008:54).

Silver mines surrounding Crystal included the "Belle of Titusville, Catalpa, Eureka, Jack Whacker, Inez, Bear Mountain, and Daisy," with the most reputable mines in the area being "the Lead King, Black Queen, and Sheep Mountain Tunnel" (Vandenbusche 1980:245). The Sheep Mountain Tunnel is the mine that was most related to the iconic mill located on the Crystal River just west of town- the Sheep Mountain Tunnel Mill /Crystal Mill (5GN1627). The "Mill," which was actually a powerhouse, has become the most photographed site in Colorado, its only competition being the Maroon Bells near Aspen (Vandenbusche 1980:247, Vandenbusche et al. 2008:58). Built in 1892, the Mill contained a water wheel that generated the power to operate a compressor that in turn powered air drills at the Sheep Mountain Tunnel. The water power used to operate the system was created by damming the Crystal River at the entrance to the Sheep Mountain Tunnel, the confluence of the north and south forks of the river. The Mill eventually also provided power to the nearby Inez, Bear Mountain, and Black Queen mines. The presence of the Mill facilitated continued silver mining in the Crystal vicinity during the difficult years of the silver crash; "the community of Crystal owes much of its existence to this power generating facility" (Daily 1985).

Shipping ore from these mines was a constant struggle. The lack of a railroad line at Crystal meant that ore had to be hauled by wagon or jack train along the dangerous rockslide- and snowslide-prone canyon roads to the nearest railroad stations. Between 1886 and 1909, the residents of Crystal were promised several times that a railroad branch would reach the little town, alleviating their transport woes and providing the mines (and the town) a much needed boost with the ability to easily ship more ore, but the railroad never came (Vandenbusche 1980:245, 248).

Leading up to the Silver Panic of 1893, the declining price of silver resulted in a stark decrease in Crystal's population by 1892. Despite the presence of the advantageous Sheep Mountain Tunnel Mill/Crystal Mill (5GN1627), the town never fully recovered from the decline, with its population cut in half at that time. The *Crystal River Current* ceased operations in 1892, with the *Silver Lance* courageously appearing in 1893 to take its place. Crystal's population continued to dwindle, however, and the *Silver Lance* merged with the *Marble City Times* in 1899 (Vandenbusche 1980:245, 248). The Crystal post office closed in 1909 (Neal 2002:16).

Crystal was practically deserted by 1915. In 1916, a minor revitalization took place when the Black Queen, Lead King, and Sheep Mountain tunnels began operating and shipping ore once again. By 1917, however, the revival had already died, and the Sheep Mountain Tunnel closed for good, rendering Crystal a veritable ghost town (Vandenbusche 1980:248). Never-ending access difficulties coupled with the decline of the profitability of silver led to the town's final denouement (Neal 2002:138). Still, Crystal can be commemorated as a mountain mining town that persevered through staggering adversity during a time when its neighbors had already folded, notably Gothic, Schofield, and Snowmass City (Vandenbusche 1980:249, 252). Indeed, "Crystal [is] perhaps the best example of a north country town which stood amidst too much adversity" (Vandenbusche 1980:249).

After the mining days ended, a few people continued to seasonally occupy the town. Emmet S. Gould arrived in Crystal from Aspen in 1938 in search of ore. He ended up buying several mining claims, the Sheep Mountain Tunnel Mill/Crystal Mill (5GN1627), and several lots and cabins. Emmet's descendents continue to have a presence in the area as the Crystal Mountain Ranch (Neal 2002:151-152). Several other families called Crystal a summer home during the mid-20th century (and still do today), keeping the sleepy town partially occupied in the summer months (Neal 2002:140-197, 251-253).

By the 1950s, outdoors excursions were being led by individuals residing seasonally in Crystal. Beginning in 1954, Richard "Dick" Car-Skaden guided tourists on hiking trips in the mountains, deeming his operation the Snowmass Wilderness Guide Service. Dick lived seasonally in the back of the Crystal Club (5GN6527), the building that housed the "gentleman's club" in the mining days, from the 1950s into the early 1970s. The Crystal Club also served as the base for his excursions (Neal 2002:141, 175-176). Also beginning in 1954, Theodore "Sarge" Jackson, who lived in various cabins during his time in Crystal, began taking tourists and hunters on guided horseback trips into the surrounding mountains. Eventually, he moved his base of operations up the pass south into Schofield (Neal 2002:142). Area artist John Toly also lived in the back of the Crystal Club seasonally during the 1970s (Neal 2002:176). The Colorado Outward Bound School, established in 1962, created a base camp in the area for teaching life skills through outdoor activities. The school's students have performed service days in Crystal which consist of general maintenance tasks around town (Neal 2002:152-154).

Today, seasonal tourist visitation to Crystal has skyrocketed. People making the trek between Marble and

Crested Butte over the infamous Schofield Pass and through Crystal Canyon, in capable 4x4 or other off-highway vehicles, pass through the once booming town. Visitation numbers to the famous Sheep Mountain Tunnel Mill /Crystal Mill (5GN1627) have increased exponentially in recent years to as many as 300 vehicles per day (Heather Leigh, personal communication September 25, 2019). The Mill and most of the townsite is owned by the Crystal Mountain Ranch. The Ranch manages public access to the iconic Mill, again, the most photographed location in all of Colorado, allowing tourists to walk down to the river bank opposite the building for a small fee. Five of the historic cabins belonging to the Crystal Mountain Ranch are available for rent seasonally to tourists. The Ranch also offers a designated camping area and a gift shop in the original A.A. Johnson General Store (5GN6528). Other cabins in the town are owned by private individuals and are used as seasonal homes; Crystal has no year-round occupants.

36. Sources of information:

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Callihan, Michael
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2020 Discovering the Real Al Johnson. Electronic document, https://crestedbuttemuseum.com/blog/al-johnson/, accessed April 20, 2020.

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Gunnison Review Press
1885 "Al Johnson suggested as contender for new Gunnison County Commissioner." 31 January. Gunnison, Colorado.
1886a "Description of Al Johnson's community roles, services, and geniality." 2 January. Gunnison, Colorado.
1886b "Report on Al Johnson's role in the Schofield avalanche recovery." 30 January. Gunnison, Colorado.
1887 "Al Johnson listed as vice president of Gunnison Country Snow-Shoe Club." 22 January. Gunnison, Colorado.

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2008 Field Guide to Colorado's Historic Architecture and Engineering. Colorado Historical Society, Denver. Electronic document, https://www.historycolorado.org/colorados-historic-architecture-engineering-guide, accessed April 17, 2020

Neal, Roger A.
2002 *Crystal....What Really Happened (Revised Fifth Edition)*. Crystal Tale Books. Goshen, Indiana.

Vandenbusche, Duane
1980 *The Gunnison Country*. B & B Printers, Gunnison, Colorado.

Vandenbusche, Duane, the Gunnison Pioneer Museum, and the Crested Butte Mountain Heritage Museum
2008 *Images of America: Around Gunnison and Crested Butte*. Arcadia Publishing, Charleston, South Carolina.

VI. SIGNIFICANCE

37. Local landmark designation: Yes ☐ No ☒ Date of designation: n/a

Designating authority: n/a

38. Applicable National Register Criteria: (reflective of full townsite)

☒ A. Associated with events that have made a significant contribution to the broad pattern of our history;

☐ B. Associated with the lives of persons significant in our past;

☒ C. Embodies the distinctive characteristics of a type, period, or method of construction, or represents the work of a master, or that possess high artistic values, or represents a significant and distinguishable entity whose components may lack individual distinction; or

☒ D. Has yielded, or may be likely to yield, information important in history or prehistory.

☐ Qualifies under Criteria Considerations A through G (see Manual)

☐ Does not meet any of the above National Register criteria

39. Area(s) of significance: Exploration/Settlement; Industry-mining

40. Period of significance: 1895 - 1917

41. Level of significance: National ☐ State ☒ Local ☒

42. Statement of significance:

5GN6536, the Clayton Cabin, meets the requirements of NRHP Criteria A, C, and D in the areas of Exploration/Settlement and Industry-Mining.

Regarding **Criterion A**, the Clayton Cabin is an element of the late 19th/early 20th century regionally noteworthy mining town of Crystal (5GN1332), the development of which was a part of and directly associated with the historically significant mining boom of that time period in Colorado. Having been built in 1895 and utilized as a residence thereafter, the Clayton Cabin clearly falls within the full Crystal Townsite's suggested period of significance of 1880-1917.

Regarding **Criterion C**, as a Pioneer Log building (History Colorado 2008), the Clayton Cabin embodies distinctive characteristics of a type, period, and method of construction. Initially chosen as an expedient and durable form of shelter (especially in the forested mountain areas of the state), Pioneer Log buildings have become an iconic part of Colorado's built heritage. The Clayton Cabin is in good condition, retains integrity, and stands as a strong representative example of this property type. Like other buildings at the Crystal Townsite, it has a distinct form marked by the entry on the gable end—a trait that evolved in the West as a unique response to snow accumulation in the Rocky Mountains (Bomberger 1991). This particular example illustrates a common vernacular approach to log construction, using hand-hewn logs and square-notching. The square-hewn logs are at once visually accentuated and practically insulated by thick fibrous mud chinking, further demonstrating the use of locally-sourced materials for expedient but solid construction. Vertical board-and-batten, a common choice for exterior cladding associated with this building type, is used in the framed upper half story.

Regarding **Criterion D**, passing observations of surface-exposed cultural material and earthen depressions in addition to the presence of at least one extant outhouse near the Clayton Cabin suggest archaeological potential associated with the building. The extant outhouse and other likely previous privy locations, at a minimum, could yield information significant to our understanding of the site, the full town, and the larger area, beyond that already available in written or oral documentation.

The Clayton Cabin was not found to be directly associated with any significant persons in history, therefore it is not recommended as eligible under Criterion B.

While some modern repairs/replacements have been made to the Clayton Cabin, particularly the interior and the roof, the building overall retains a majority of its original materials and construction. Alterations made to

the building have not overwhelmed its original design. Furthermore, beyond retaining physical integrity, the building also retains intangible integrity (see Item 43 below). In sum, the building continues to convey its relationship with the areas of significance and can be recommended as eligible to the NRHP under Criteria A, C, and D.

43. Assessment of historic physical integrity related to significance:
Regarding the aspects of integrity, the Clayton Cabin retains location as it remains in its original location. Although some modern improvements/repairs have been made to the building, notably to the interior and the roof, the aspects of materials, workmanship, and design are overall retained as the original materials, methods of construction, and layout of the building are overwhelmingly still present and can be discerned. Association is retained as the Clayton Cabin is an early element of the historically significant mining town of Crystal, with its date of construction, 1895, falling within the town's suggested period of significance. Setting and feeling are retained as little has changed in the surrounding landscape to alter the environment from what it would have been during the period of significance, with the exception of modern tourist traffic through town.

VII. NATIONAL REGISTER ELIGIBILITY ASSESSMENT

44. National Register eligibility field assessment:

Eligible ☒ Not Eligible ☐ Needs Data ☐

45. Is there National Register district potential? Yes ☒ No ☐

Given the historical continuity and good condition of the extant buildings, the full Crystal Townsite (5GN1332) holds the potential to be considered eligible for inclusion on the NRHP as a District under Criteria A, B, C, and D for a suggested period of significance of 1880-1917. Crystal fulfills the requirements of **Criterion A**, association with significant events, as the town is inextricably associated with the historically significant late 19th/early 20th century mining boom in Colorado, having been developed, incorporated, and occupied as a direct result of that momentous event in Colorado history.

The town fulfills the requirements of **Criterion B** for its association with prominent figure Albert A. Johnson, a Crystal resident who was a "legendary" figure in the Gunnison country during the late 19th century (Professor Duane Vandenbusche, personal communication March 25, 2020). He is significant for his role in helping the town of Crystal develop and thrive between 1881 and 1893 and in popularizing recreational skiing in the region prior to the turn of the century. Born near Montreal in the Laurentain mountain area of Canada in 1851, Al Johnson came to Crystal in 1880 as a silver prospector with his brother Fred (Callihan 2017; Vandenbusche et al. 2008:58). Rather than working directly in mining operations, Al Johnson decided to supply miners with essential goods and opened the "A.A. Johnson General Store" (5GN6528) in Crystal in 1881. Over the years, in addition to the general store, he operated a hotel in Crystal and owned several nearby mining properties, including the famed and lucrative Lead King for a time (Vandenbusche 1980:247).

Discuss:

Johnson has been called Crystal's "leading citizen" for his contributions between 1881 and his death in 1893 (Vandenbusche 1980:247). As a "merchant, miner, post master, mail carrier, man and maid of all work, and boss of good fellows generally" (Gunnison Review Press 1886a), he was "widely respected for his business acumen and outgoing personality" within Crystal and beyond (Callihan 2020). He initiated and perpetuated the town's growth by, first, opening and operating the general store, and, second, by securing the postal contract for Crystal in 1882. Notably, merchandise provided in Johnson's general store allowed stalwart Crystal locals to remain in town year-round. The town of Crystal was, and continues to be, snowbound every winter, with no easy access to supplies. By keeping his store well-stocked, Johnson provided a continuous and reliable inventory to the hardy folks who over-wintered in Crystal, offering products necessary for personal use but also for continuing nearby mining work through the challenging winter months (Callihan 2017; Neal 2002:14).

Importantly, Johnson also housed the Crystal Post Office at his general store, reliably carried the mail between Crystal and Crested Butte on a year-round basis, and served as the town's postmaster until his death in 1893 (Neal 2002:15-16; Vandenbusche 1980:247). In 1885, Johnson was recommended as a potential Gunnison County Commissioner to represent the Crystal area by virtue of his efforts as a "faithful worker for that section of the country…[for while working] for himself he [worked] for others by his pen and otherwise in order to promote the interest of that rich mining region" (Gunnison Review Press 1885). In 1886, Johnson

launched Crystal's first newspaper, the *Crystal River Current,* which he edited and published through 1892 in a building (no longer extant) behind his store (Neal 2002:195; Vandenbusche 1980:245). In 1890, Johnson served as Crystal City Council Clerk (Neal 2002:15). That same year, Johnson married Kate Usher, sister of prominent Crystal resident Jim Usher. A baby girl, Crystal Rose, was born to the Johnsons on May 1, 1891 but died on October 29, 1891 (Callihan 2017). By that time, Al Johnson was suffering from a bad cough that was likely due to tuberculosis. In an effort to combat his illness, Johnson spent the winters of at least 1891 through 1893 in Arizona, returning to Crystal during the summers to run his store and the post office, but he died in Phoenix on January 19, 1893, at the age of 42 (Callihan 2017).

Beyond his pivotal role in building and supporting the local Crystal community, Johnson is remembered regionally for his impressive "snowshoeing," the period term for skiing, and for expanding Gunnison country ski culture. Skiing was extremely popular, and vital, in the broader Gunnison country in the late 19th and early 20th centuries (Vandenbusche 1980:247). "Every man, woman, and child had to learn to ski if they wished to get anywhere in the winter in the early mining days" (Vandenbusche et al. 2008:75). Ski groups flourished throughout the area at various mining camps, and the town of Crystal was no exception in its love of (and need for) skiing. The Crystal Snowshoe [ski] Club became "legendary in the rocky mountains" and featured the "famed" Al Johnson (Vandenbusche et al. 2008:120).

Johnson primarily gained skiing notoriety as one of the few in the Gunnison country who unfailingly carried mail on skis across high elevation, extremely dangerous, snow-covered terrain. Johnson became known regionally as a "legendary postman" who bravely and dependably executed his "anointed task" of carrying mail between Crystal and Crested Butte on what became known as the "Snowshoe Express" (Vandenbusche 1980:247, 423; Vandenbusche et al. 2008:55). His route, which included a stretch through the "feared Crystal Canyon," was extremely perilous, likely the most perilous in the region, due to the terrain and avalanche danger in snowy conditions (Vandenbusche 1980:78; Vandenbusche et al. 2008:58). Johnson became recognized as the "top snowshoer [skier] of the Rocky Mountains" for his speed and technique in completing this treacherous, avalanche-prone mail-carrying route (Vandenbusche 1980:423). Weekly, Johnson donned 11-foot wooden skis to travel the 18 miles from Crystal to Crested Butte, traversing the dreaded Crystal Canyon, with as much as 40 pounds of mail on his back each way (Callihan 2020). Adding to his acclaim, an avalanche one January night in 1886 hit the mining camp at Schofield, located at the top of Crystal Canyon. Upon hearing the news, Johnson skied up the canyon during the continuing blizzard in total darkness to aid the devastated camp. Johnson is noted to have dug victims out of the snow-slide and led people to safety amidst the storm that dumped six feet of snow at Schofield and four feet at Crystal. Following the rescue, he continued on to Crested Butte to deliver news of the avalanche and assembled a rescue party to return to Schofield to carry on with the recovery (Callihan 2020; Gunnison Review Press 1886b).

Beyond his courageous mail delivery on skis, Johnson's fame was bolstered by numerous ski race victories across Colorado's western slope (Vandenbusche 1980:247, 423, 426-428). His fame helped popularize skiing as recreation in Colorado. In 1886, he fostered the extensive ski culture of the region by serving on the Executive Committee of the newly formed Gunnison Country Snow-Shoe (ski) Club, developed to encourage competitive regional ski racing and winter sports, and he was vice-president of the club the following year (Gunnison Review Press 1887) . At Johnson's suggestion and primarily through his efforts, the Club organized wildly popular races in the towns of Gunnison, Crested Butte, Irwin, Gothic, and Schofield during February and March of 1886 (Vandenbusche 1980:426-428). Inspired by similar "snowshoe carnivals" he had experienced back home near Montreal, Johnson led the organization of the races in Crested Butte, Gunnison, Irwin, and Gothic that would cumulatively become known as the "Great Race of 1886" (Callihan 2020). Those four races were met with great enthusiasm and support from the local communities, with excited spectators gathering along the race routes to cheer on contestants from their respective mining camps. An estimated 1,000 people gathered to watch the Crested Butte race, for which a special Denver and Rio Grande Excursion train was chartered (Callihan 2020; Vandenbusche 1980:426-428). The Great Race of 1886, conceived and implemented by Al Johnson, introduced competitive ski racing to the Gunnison country (Vandenbusche 1980:428-429).

Al Johnson was described as "without a doubt, the most graceful snowshoer the Rocky

Mountains [had] ever produced…a daring adventurer on shoes [skis]" (Vandenbusche 1980:427). In 1974, the telemark ski community in Crested Butte began the Al Johnson Memorial Uphill/Downhill Telemark Race. The race, honoring Al Johnson, his exceptional skiing abilities, and his devoted public service as a mail carrier through unthinkably hostile weather and terrain, continues to be held annually at Crested Butte Mountain Resort. As a further tribute, "Let 'em Run!: Al Johnson and the Great Races of 1886," a play by Michael Callihan documenting aspects of Johnson's remarkable life, has been produced in Gunnison and Crested Butte annually since 2017, playing to sold out crowds (Michael Callihan, personal communication March 29, 2020).

The townsite fulfills the requirements of **Criterion C** as its buildings retain sufficient integrity to cumulatively convey the historic built character of a late 19th/early 20th century Colorado mountain mining community. Characteristics of the extant buildings, primarily of the dominant Pioneer Log style, reflect vernacular approaches to building and reveal methods, techniques, and materials known and available to the occupants of Crystal at the time of their construction. The Pioneer Log buildings, primarily consisting of common notched log construction with various chinking materials and gabled roofs, represent residences, a commercial building, a social building, and a barn, all of which had important, individualized roles in community life, reflecting the day-today on goings in an isolated mountain mining town. Additionally, the previously recorded and SRHP-listed Tays/Anderson House (5GN2432), a wood frame Victorian building believed to have been a kit home, provides a contrast to the dominant vernacular building methods, exemplifying more formalized building techniques and imported wood building materials available to affluent members of the community (Anderson 1995). Also of particular note among the buildings in the town is the newly recorded Schoolhouse (5GN6532), which is an excellent and well-preserved example of a rural one-room schoolhouse—an increasingly rare property type in the region. Along with its extant ancillary building, the Schoolhouse has a very recognizable design and construction materials that meet specific eligibility criteria laid out in the NRHP Multiple Property Documentation Form for Rural School Buildings in Colorado, including being a single-story with a front gabled roof, having typical fenestration, and being built with wood framing and shiplap siding (Doggett and Wilson 1999).

Finally, the town fulfills the requirements of **Criterion D**, potential to yield information important in history, due to its archaeological promise. Passing observations during the 2019 architectural inventory of surface-exposed cultural material; artifacts partially buried around building foundations, present inside buildings, and fallen through floors; numerous abandoned privy pits; and the presence of many standing outhouses across the entire townsite suggest that Crystal possesses great archaeological potential; archaeological investigations, both surface survey and subsurface testing, are highly likely to yield further information not already available in written or oral documentation that could significantly contribute to our understanding of the history of the site and the region.

Beyond the townsite itself (5GN1332), a District boundary could be expanded to incorporate other contemporaneous and related features, including the previously recorded and NRHP-listed Sheep Mountain Tunnel Mill/Crystal Mill (5GN1627), the still unrecorded Crystal Cemetery, the unrecorded spring and ditch water supply system, and nearby mine-related features, if found to be extant at a later date.

The Clayton Cabin (5GN6536) Contribution to District Potential
As the Clayton Cabin (5GN6536) is an element of and directly associated with the full townsite (5GN1332), and given that the Clayton Cabin retains sufficient integrity to convey its association with the full townsite's suggested period of significance (1880-1917), it can be considered contributing toward District potential.

If there is National Register district potential, is this building: Contributing ☒ Non-contributing ☐

46. If the building is in existing National Register district, it: Contributing ☐ Non-contributing ☐

VIII. RECORDING INFORMATION

47. Photograph numbers: Roll 19-259, images 508-518, 548-552

Negatives filed at: Metcalf Archaeological Consultants, Inc. (digitally)

48. Report title: Architectural Inventory of the Crystal Townsite for the Gunnison County Historical Commission, Gunnison County, Colorado.
49. Date(s): 09/25/2019 – 09/27/2019
50. Recorder(s): Natasha E Krasnow and Kelly J Pool
51. Organization: Metcalf Archaeological Consultants, Inc.
52. Address: PO Box 899, Eagle, Colorado 81631
53. Phone number(s): 970-328-6244

NOTE: Please include a sketch map, a photocopy of the USGS quad map indicating resource location, and photographs.

History Colorado - Office of Archaeology & Historic Preservation
1200 Broadway, Denver, CO 80203 (303) 866-3395

5GN6536 – Clayton Cabin.
View of south elevation. View north. (Roll 19-259, image 508, 09/26/2019)

5GN6536 – Clayton Cabin.
Oblique view of the southeast corner. View northwest. (Roll 19-259, image 509, 09/26/2019)

5GN6536 – Clayton Cabin.
View of the east elevation. View west. (Roll 19-259, image 510, 09/26/2019)

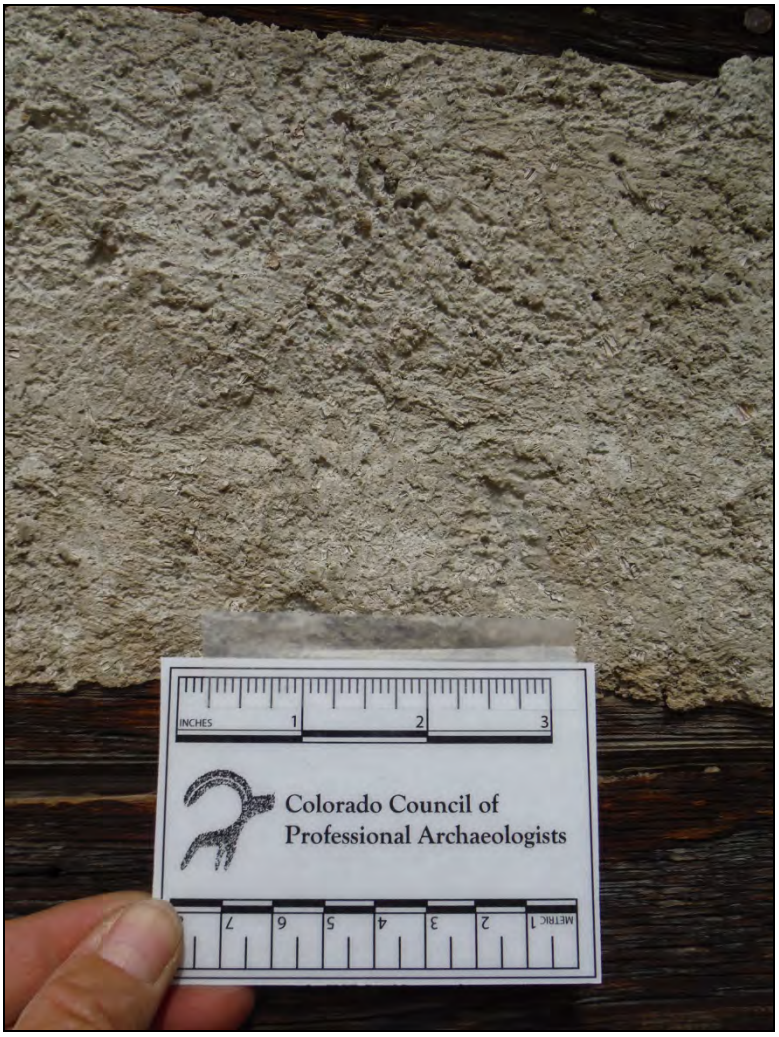
5GN6536 – Clayton Cabin.
Oblique view of the northeast corner. View southwest. (Roll 19-259, image 511, 09/26/2019)

5GN6536 – Clayton Cabin.
Partial view of obscured north elevation. View south. (Roll 19-259, image 512, 09/26/2019)

5GN6536 – Clayton Cabin.
Oblique view of the northwest corner. View southeast. (Roll 19-259, image 513, 09/26/2019)

5GN6536 – Clayton Cabin.
View of the west elevation. View east. (Roll 19-259, image 514, 09/26/2019)

5GN6536 – Clayton Cabin.
Oblique view of the southwest corner. View northeast. (Roll 19-259, image 515, 09/26/2019)



5GN6536 – Clayton Cabin.
Detail of fibrous mud chinking used on the exterior of the cabin.
(Roll 19-259, image 552, 09/26/2019)

5GN6536 – Clayton Cabin.
View of the interior of the cabin, main floor. View northeast. (Roll 19-259, image 551, 09/26/2019)

5GN6536 – Clayton Cabin.
View of the interior of the cabin, main floor. View southwest. (Roll 19-259, image 550, 09/26/2019)

5GN6536 – Clayton Cabin.
View of the interior of the cabin, second floor "attic" space. View north.
(Roll 19-259, image 549, 09/26/2019)

5GN6536 – Clayton Cabin.
View of the south elevation of the outhouse. View north. (Roll 19-259, image 516, 09/26/2019)

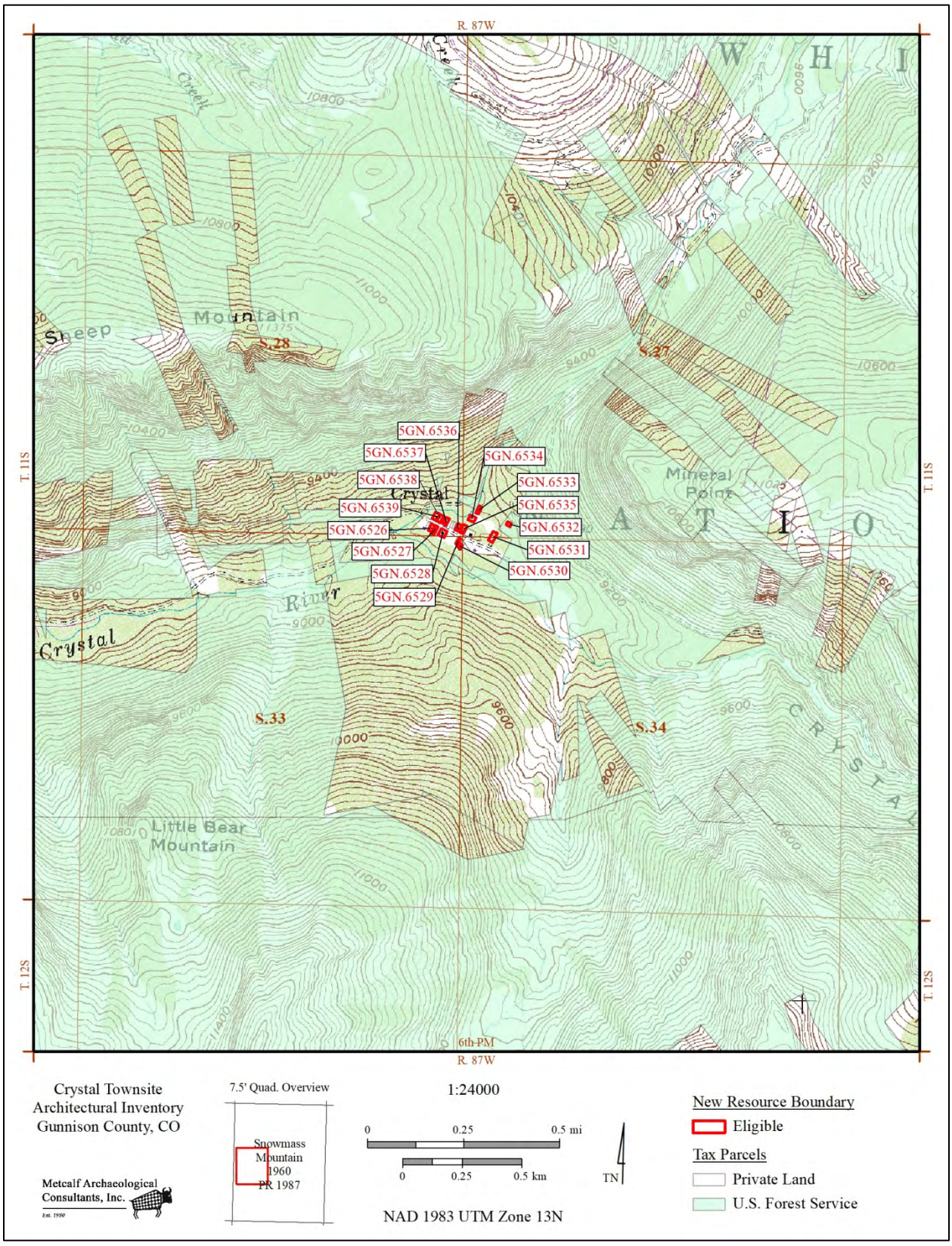
5GN6536 – Clayton Cabin.
Oblique view of the southeast corner of the outhouse. View northwest.
(Roll 19-259, image 516, 09/26/2019)

5GN6536 – Clayton Cabin.
Oblique view of the northwest corner of the outhouse. View southeast.
(Roll 19-259, image 516, 09/26/2019)

Resource Number: 5GN6536
Temporary Resource Number: Feature 11

SITE SKETCH MAP

SITE LOCATION MAP



CLG 76112

G/ES

OAHP1403
Rev. 9/98

COLORADO CULTURAL RESOURCE SURVEY

Architectural Inventory Form

Official eligibility determination
(OAHP use only)
Date _____ Initials _____
_____ Determined Eligible- NR
_____ Determined Not Eligible- NR
_____ Determined Eligible- SR
_____ Determined Not Eligible- SR
_____ Need Data
_____ Contributes to eligible NR District
_____ Noncontributing to eligible NR District

I. IDENTIFICATION

1. Resource number: 5GN6535
2. Temporary resource number: Feature 10
3. County: Gunnison
4. City: Crystal
5. Historic building name: Melton House
6. Current building name: Melton House
7. Building address: 3881 Forest Service Road 314, Crystal Townsite Vicinity (per Gunnison County Assessor 2019d)
8. Owner name and address: Christopher Cox/Treasure Mountain Ranch, Inc/Crystal Mountain Ranch: 1203 Colorado Avenue, Glenwood Springs, Colorado 81601

II. GEOGRAPHIC INFORMATION

9. P.M.: 6th Township: 11 S Range: 87 W
   SE ¼ of SE ¼ of SE ¼ of SE ¼ of section 28
   SW ¼ of SW ¼ of SW ¼ of SW ¼ of section 27
10. UTM reference:
    Zone: 13 ~~N~~ ; 20 318215 mE 41 4325433 mN NAD 83 elev 8950ft
11. USGS quad name: Snowmass Mountain
    Year: 1960 (PR 1987) Map scale: 7.5' ☒ 15' ☐ (Attach photocopy of appropriate map section)
12. Lot(s): _____ Block: _____
    Addition: Yes Year of addition: Unknown, but between 1881-1910
13. Boundary description and justification:
    Boundary of the Melton House (5GN6535) is defined by the physical extent of the primary building and its associated buildings on its north and south sides and by neighboring parcel boundaries on its east and west sides. Today, the Melton House is part of the greater, undivided ~400 Treasure Mountain Ranch/Crystal Mountain Ranch (Parcel # 2915-340-00-004) (Gunnison County Assessor 2019d).

III. Architectural Description

14. Building plan (footprint, shape): Irregular
15. Dimensions in feet: Length: 44' X Width: 27'7" (dimensions reflect the full building footprint)
16. Number of stories: 2
17. Primary external wall material(s): Wood- horizontal siding; Wood- vertical siding
18. Roof configuration: Gable- side
19. Primary external roof material(s): Metal
20. Special features: ~~None~~ porch, stovepipe
21. General architectural description:

The Melton House (Feature 1) has an upright-wing form with a rear addition. The primary façade faces south, with a two-story gable front volume at the west, and a 1.5-story, side-gabled ell/wing that projects east from the east elevation. A shed-roofed porch, supported by two wood posts, spans the south elevation of the wing covering the two main entrances, one on the east elevation and one on the south. The building is wood-framed and has minimal foundation of stones under a wood sill. The single-story, gable-roofed addition and the back of the two story portion of the building are supported by wood stilts. The feature's gable roof is wood framed and covered with new seamed metal to protect from the elements. A stove pipe projects up from the roof of the second story, toward the east eave just south of center along the pitch. Also, a separate plastic pipe projects up and out of the east pitch toward the north end of the roof, just east of the peak. Another stove pipe is present near the center of the roof of the1.5-story ell/wing, just north of the peak. A rectangular skylight is present west of that stovepipe, just north of the peak. The addition's gable roof is covered in wood shingles. A stove pipe projects up from near the south end of the addition's roof just east of the peak.

On the two-story gable-front portion of the south façade, the exterior is clad in horizontal wood siding. Four four-over-four-lite double-hung windows are present – two on the ground floor and two on the second floor. The upper windows have plywood shutters, but the west window is missing its east shutter. All windows are wood framed. The south elevation also includes the covered porch on the side-gabled ell/wing, with the awning supported by dimensional lumber and sawn log posts. The roof of the awning is framed and covered with dimensional lumber and plywood. Rafter ends can be seen under the eave over the porch, and they appear newer. A dimensional lumber deck, which appears original, is protected by the awning. An entrance door is present toward the east end of the elevation – a wood framed screen door covers the main door, which appears original and is paneled wood with two long windows. To the west of the door is one wood framed four-over-four-lite double-hung window. A natural stone walkway has been placed leading up to the door.

The west elevation includes the original building and the rear addition. Both are sided with vertical dimensional lumber. Toward the north end of the original building are two four-over-four-lite double-hung windows, one on the ground floor and one on the second floor. They are directly atop one another. The lower has a plywood shutter.

The west elevation of the addition includes a smaller wood framed window toward its south end and a larger, modern, metal two-lite sliding window toward its north end. Dimensional lumber rafter ends can be seen under the eave.

The north elevation of the addition has newer plywood siding. The north elevation of the original, two story building is visible above the addition and has vertical dimensional lumber siding and one wood-framed two-over-two-lite fixed window toward its east side.

The north elevation of the 1.5-story portion ell/wing has vertical dimensional lumber siding. Dimensional lumber rafters can be seen under the eave. At the center of the elevation is a bump out with a wood framed fixed window at its center. The bump out also has wood framed fixed windows on both of its sides, level with the main north elevation windows. On the east side of the elevation is one more wood framed fixed window. The north elevation here appears to have had many nails replaced recently, seemingly simply re-securing the siding. However, at least 10 square nails were observed in the siding.

The east elevation of the addition is sided in newer plywood. An elevated porch with two wood steps to a wood landing are present at the door, which is slightly off center toward the south end of the addition. The wood door is new. Two wood framed fixed windows are located north of the door; they appear newer. Dimensional lumber rafter ends are visible beneath the eave. The wood edges of the eave show some degradation and moss/lichen growth.

The east elevation of the ell/wing is clad in vertical dimensional lumber siding. Square nails are abundant in the siding on this elevation. Wire nails are also present. One wood framed window is centered along the elevation on the main floor, and the glass in the lower sash is gone. One wood framed fixed window is present in the attic above the sash window. The wood framing of the roof is degrading at the peak along this elevation. Square nails are present in the roof frame.

The east elevation of the two story original house is visible around the 1.5 story portion. Like its south elevation, the east elevation is clad in vertical dimensional lumber siding with horizontal boards atop. A door is present at the juncture with the 1.5 story portion. A wood framed screen door covers a wood, paneled door. Horizontal board siding immediately surrounding the door matches that of the south elevation under

the porch awning.

The two story original building measures 23' 10" north/south x 12' 3" east/west. The 1.5 story side-gabled ell/wing measures 15' 9" east/west x 17' 3" north/south (including the bump-out). The one story addition measures 20' 1" north/south x 13' 6" east/west.
The interior of the Melton House was not accessible at the time of recording.

22. Architectural style/building type: Upright and Wing

23. Landscaping or special setting features: None

24. Associated buildings, features, or objects:

Outhouse (Feature 2) – the outhouse is located north of the main house against the minor slope. It is leaning to the east. It includes vertical dimensional lumber siding with a shed roof covered in cedar shake shingles, which is slumping. It appears to have been braced against the slope with a branch set against the north elevation. At the front/south elevation, it is lifted slightly above the depression with stones. A log sill is present on the west elevation. All nails are wire.

Shed (Feature 3)– the shed is located northeast of the main house and measures 6'2" x 6'2". It has a gable roof of dimensional lumber framing and wood shingles. The siding is also dimensional lumber – vertical on the north, west and south sides and diagonally on the east side. The door into the main part of the shed is on the west side, closed with just a sliding hook. The upper portion of the shed is open to the west, with brackets supporting an extension of the roof over a storage shelf. Scrap wood, likely an old door, made of tongue and groove boards, leans on its side against the brackets, as if it once served as a shutter for the storage space above. The shed is lifted off the ground by dimensional lumber boards underneath. The interior includes built in shelves inside the east elevation wall and a small step ladder to access the upper compartment, for which the floor is tongue and groove planks.

IV. ARCHITECTURAL HISTORY

25. Date of construction: Estimate: Circa 1881 Actual:
Source of information: Heather Leigh, personal communication September 25, 2019; Neal 2002:186; Gunnison County Assessor 2019d

26 Architect: Unknown
Source of information: n/a

27. Builder/contractor: Unknown
Source of information: n/a

28. Original owner: George and Martha Melton
Source of information: Neal 2002:186

29. Construction history (including description and dates of major additions, alterations, or demolitions):

While an exact date is unknown, the Melton House is known to have been built in the 1880s and was most likely constructed circa 1881, the year the Melton family first arrived in Crystal. The main part of the house, consisting of a two-story portion and a 1.5-story portion, is the original 1880s building while the addition at the back of the main house, still historic, was constructed by the Meltons at a later date sometime between 1881 and 1910, the latter being the date when the Meltons left Crystal (Heather Leigh, personal communication September 25, 2019; Roger Neal, personal communication September 26, 2019; Neal 2002:19-20, 186). The metal roof was placed on the building sometime between 1980 and 1990 to protect it from the elements (Christopher Cox, personal communication January 7, 2020).

30. Original location: ☒ Moved: ☐ Date of move: n/a

V. HISTORICAL ASSOCIATIONS

31. Original use(s): Domestic- single dwelling

32. Intermediate use(s): _____

33. Current use(s): Domestic- single dwelling, seasonal dwelling

34. Site type(s): Rural cabin; currently ranch seasonal employee housing

35. Historical background:

George and Martha Melton first came to Crystal with their children Charles, Alice, and Mary in 1881. The Melton House was likely constructed circa their arrival date of 1881. George and Martha built a separate

boarding house in Crystal, which Martha operated. This building was their residence. George worked as a jack train operator along with serving as part owner, organizer, engineer, and superintendent of the Crystal Mountain Mining and Drainage Company. In 1894, George also served as the deputy sheriff of Crystal. The Meltons were known for hosting large, well-attended, and much enjoyed holiday dinners and celebrations at their house. The Meltons lived in Crystal until 1910 when they moved to Grand Junction (Neal 2002:19-20, 30-32, 37, 186; Roger Neal, personal communication September 26, 2019 and January 13, 2020).

Today, the Melton House is owned by Christopher Cox/Crystal Mountain Ranch and is utilized as seasonal employee housing.

Crystal Townsite History

Before the mining boom of the late 19th century, the Crystal Valley, located between Sheep Mountain, Little Bear Mountain, and Mineral Point, was occupied by the Ute Indians. The Utes were forcibly removed from the area and placed on reservations by the federal government around 1879, and infiltration of the former Ute lands by prospecting miners was quick to follow. Euroamerican prospectors began arriving in the Crystal Valley predominantly by way of Crested Butte, Gothic, and Schofield in the late spring and early summer of 1880 (Neal 2002:7; Vandenbusche 1980:245,). Prospectors set up camp near the confluence of the north and south forks of the Crystal River where they located outcroppings of clear quartz crystals which became the settlement's namesake (Vandenbusche 1980:245).

Although lead, copper, zinc, and some gold were present in the quartz formations around Crystal, silver was the main ore attracting miners to the valley. The silver in the area was high in quantity, quality, and, of course, value (Neal 2002:9). The town of Crystal was officially incorporated on August 26, 1881 (Neal 2002:10). Crystal was granted a post office in 1882, with Albert A. Johnson leading that effort and being designated as the first postmaster (Neal 2002:15; Vandenbusche 1980:246).

Other nearby silver mining camps were established during the same time period as Crystal. Located south of Crystal toward Crested Butte was Schofield, the earliest iteration of which was present as early as 1873. Schofield, however, was already in its final decline by late 1883. By that time, most of its residents had moved on, many of them to Crystal (Vandenbusche 1980:249, 252). Several of the original structures in the Crystal mining camp were moved there from Schofield (Neal 2002:7). The Schofield post office was discontinued in 1885, and the town was emptied. A brief revival of Schofield took place in 1899, but it was abandoned for good by 1900 (Neal 2002:134; Vandenbusche 1980:252). Similarly, the once booming mining town of Gothic, located between Schofield and Crested Butte and which was incorporated in 1879, began its sharp decline soon after it had reached its peak in 1881. Like Schofield, by 1883, Gothic was more-or-less abandoned (Vandenbusche 1980:258). Another nearby mining camp included Snowmass City, founded in 1880 and located a mere mile north of Crystal. By 1881, Snowmass City was starting to grow, and in 1883, a road was blasted between Snowmass City and Crystal, connecting Snowmass City with the route over Schofield Pass and into Crested Butte. Snowmass City reached its peak in 1884 but could not overcome its access difficulties and competition from Crystal. It succumbed in 1886 (Vandenbusche 1980:249).

By 1881, there are said to have been 21 or 22 cabins present at Crystal (Neal 2002:8; Vandenbusche 1980:245, Neal 2002:8). Citing the Colorado State Business Directory, Neal relays that the population of Crystal was reported as 600 in 1883; 300 in 1884 and1885; 400 in 1886 and 1888; 200 in 1889; and 101 in 1900 (2002:8). By 1910, however, the Census lists Crystal's population as four (Neal 2002:8). Notably, the 1910 Census was taken mid-May, so the count of four may have represented only year-round residents; only hardy souls over-wintered in Crystal which was, and continues to be, notoriously snowed-in during the cold months of the year (Callihan 2017; Neal 2002:8)

In its heyday, Crystal had a newspaper, a post office, saloons, a stage line, two general stores, a pool hall, a hotel, a "gentleman's club" (5GN6527), a two-story town hall, an assayer and chemist, a livery, a barber shop, over seventy houses, and more (Neal 2002:12-13; Vandenbusche 1980:245). Twelve streetlights were present in Crystal: large metal kerosene lamps hung from poles that were lit at dusk and extinguished at 10:00 pm (Neal 2002:119). A telegraph line ran from Marble through Crystal and on to Crested Butte, and a telephone line was developed from Marble to Crystal in 1904 (Neal 2002:108). The residents of Crystal procured their water from ditches that ran through town on each side of the main road through town, fed by a natural spring located east of town (Neal 2002:10). A blacksmith shop, no longer extant, was located just west of town, opposite the Sheep Mountain Tunnel Mill/Crystal Mill (5GN1627) (Roger Neal, personal communication September 27, 2019).

Additionally, Crystal also had its own cemetery, located southwest of the town and the Sheep Mountain

Tunnel Mill/Crystal Mill (5GN1627) along what is now Gunnison County Road 3. Numerous Crystal residents are interred at the now overgrown cemetery, which is located within an avalanche chute. As such, the cemetery has been subjected to countless avalanches which have pummeled the little graveyard over the years. Burials are obscured by vegetation and avalanche debris. Some wrought iron fencing is still visible along with a single, roughly made headstone- that of Judge Tom O'Bryan, a prominent resident of Crystal from its inception until his death in 1904 (Christopher Cox and Heather Leigh, personal communication September 25, 2019; Roger Neal, personal communication September 26-27, 2019; Neal 2002:23-24).

From the beginning, Albert A. Johnson was Crystal's "leading citizen" (Vandenbusche 1980:247). Johnson operated the general store (5GN6528) and a hotel; edited and printed the town's first newspaper, the *Crystal River Current*; and owned several mining properties including the famed Lead King for a time. Johnson was responsible for securing a post office for Crystal and, as mentioned above, served as the first postmaster (Vandenbusche 1980:247). In addition to his prominent role in development of the Crystal community, Johnson became known regionally as a "legendary postman" who bravely and unfailingly carried mail between Crystal and Crested Butte on skis during the snowy months. His route, through the "feared Crystal Canyon," was extremely perilous due to the terrain and avalanche danger (Vandenbusche et al. 2008:55, 58). Al Johnson was regionally recognized as the "top snowshoer of the Rocky Mountains" for his speed and technique at completing his treacherous mail-carrying route in addition to winning many ski races across Colorado's western slope (Vandenbusche 1980:247, 423, 426-428).

Snowshoeing [skiing] was extremely popular, and necessary, in the broader Gunnison country around the turn of the century (Vandenbusche 1980:247). "Every man, woman, and child had to learn to ski if they wished to get anywhere in the winter in the early mining days" (Vandenbusche et al. 2008:75). Crystal was no exception in its love of skiing. The "Crystal Snowshoe Club" became "legendary in the rocky mountains" and featured the "famed" Al Johnson (Vandenbusche et al. 2008:120). In 1886, the Gunnison Country Snow-Shoe Club was formed with Al Johnson serving on the Executive Committee. The Club organized competitive races in Gunnison, Crested Butte, Irwin, Gothic, and Schofield in February and March of that year, all of which were met with great enthusiasm and support from the local communities (Vandenbusche 1980:426-428).

Since its inception, access to Crystal has been a challenge and a hindrance to the town's development. Until 1883, Crystal was extremely isolated from the rest of the region with only "jack" trails (the period term for mule trails) connecting the town with Crested Butte to the south and Carbondale to the north (Vandenbusche 1980:245). Along the route to Crested Butte, a toll road was completed between the mining settlements of Gothic and Schofield in 1881, and the old jack trail between Schofield and Crystal was finally also converted into a wagon road in 1883 (Neal 2002:11-12, Vandenbusche 1980:245). After the completion of the wagon road from Schofield, Crystal's population rose (Vandenbusche 1980:245-246). Still, the Crystal Canyon Road between Crystal and Schofield and beyond to Crested Butte was extremely dangerous and one of the "most treacherous in Colorado;" in winter, the canyon "vomited avalanches" (Vandenbusche et al. 2008:54).

Silver mines surrounding Crystal included the "Belle of Titusville, Catalpa, Eureka, Jack Whacker, Inez, Bear Mountain, and Daisy," with the most reputable mines in the area being "the Lead King, Black Queen, and Sheep Mountain Tunnel" (Vandenbusche 1980:245). The Sheep Mountain Tunnel is the mine that was most related to the iconic mill located on the Crystal River just west of town- the Sheep Mountain Tunnel Mill /Crystal Mill (5GN1627). The "Mill," which was actually a powerhouse, has become the most photographed site in Colorado, its only competition being the Maroon Bells near Aspen (Vandenbusche 1980:247, Vandenbusche et al. 2008:58). Built in 1892, the Mill contained a water wheel that generated the power to operate a compressor that in turn powered air drills at the Sheep Mountain Tunnel. The water power used to operate the system was created by damming the Crystal River at the entrance to the Sheep Mountain Tunnel, the confluence of the north and south forks of the river. The Mill eventually also provided power to the nearby Inez, Bear Mountain, and Black Queen mines. The presence of the Mill facilitated continued silver mining in the Crystal vicinity during the difficult years of the silver crash; "the community of Crystal owes much of its existence to this power generating facility" (Daily 1985).

Shipping ore from these mines was a constant struggle. The lack of a railroad line at Crystal meant that ore had to be hauled by wagon or jack train along the dangerous rockslide- and snowslide-prone canyon roads to the nearest railroad stations. Between 1886 and 1909, the residents of Crystal were promised several times that a railroad branch would reach the little town, alleviating their transport woes and providing the mines (and the town) a much needed boost with the ability to easily ship more ore, but the railroad never came (Vandenbusche 1980:245, 248).

Leading up to the Silver Panic of 1893, the declining price of silver resulted in a stark decrease in Crystal's

population by 1892. Despite the presence of the advantageous Sheep Mountain Tunnel Mill/Crystal Mill (5GN1627), the town never fully recovered from the decline, with its population cut in half at that time. The *Crystal River Current* ceased operations in 1892, with the *Silver Lance* courageously appearing in 1893 to take its place. Crystal's population continued to dwindle, however, and the *Silver Lance* merged with the *Marble City Times* in 1899 (Vandenbusche 1980:245, 248). The Crystal post office closed in 1909 (Neal 2002:16).

Crystal was practically deserted by 1915. In 1916, a minor revitalization took place when the Black Queen, Lead King, and Sheep Mountain tunnels began operating and shipping ore once again. By 1917, however, the revival had already died, and the Sheep Mountain Tunnel closed for good, rendering Crystal a veritable ghost town (Vandenbusche 1980:248). Never-ending access difficulties coupled with the decline of the profitability of silver led to the town's final denouement (Neal 2002:138). Still, Crystal can be commemorated as a mountain mining town that persevered through staggering adversity during a time when its neighbors had already folded, notably Gothic, Schofield, and Snowmass City (Vandenbusche 1980:249, 252). Indeed, "Crystal [is] perhaps the best example of a north country town which stood amidst too much adversity" (Vandenbusche 1980:249).

After the mining days ended, a few people continued to seasonally occupy the town. Emmet S. Gould arrived in Crystal from Aspen in 1938 in search of ore. He ended up buying several mining claims, the Sheep Mountain Tunnel Mill/Crystal Mill (5GN1627), and several lots and cabins. Emmet's descendents continue to have a presence in the area as the Crystal Mountain Ranch (Neal 2002:151-152). Several other families called Crystal a summer home during the mid-20th century (and still do today), keeping the sleepy town partially occupied in the summer months (Neal 2002:140-197, 251-253).

By the 1950s, outdoors excursions were being led by individuals residing seasonally in Crystal. Beginning in 1954, Richard "Dick" Car-Skaden guided tourists on hiking trips in the mountains, deeming his operation the Snowmass Wilderness Guide Service. Dick lived seasonally in the back of the Crystal Club (5GN6527), the building that housed the "gentleman's club" in the mining days, from the 1950s into the early 1970s. The Crystal Club also served as the base for his excursions (Neal 2002:141, 175-176). Also beginning in 1954, Theodore "Sarge" Jackson, who lived in various cabins during his time in Crystal, began taking tourists and hunters on guided horseback trips into the surrounding mountains. Eventually, he moved his base of operations up the pass south into Schofield (Neal 2002:142). Area artist John Toly also lived in the back of the Crystal Club seasonally during the 1970s (Neal 2002:176). The Colorado Outward Bound School, established in 1962, created a base camp in the area for teaching life skills through outdoor activities. The school's students have performed service days in Crystal which consist of general maintenance tasks around town (Neal 2002:152-154).

Today, seasonal tourist visitation to Crystal has skyrocketed. People making the trek between Marble and Crested Butte over the infamous Schofield Pass and through Crystal Canyon, in capable 4x4 or other off-highway vehicles, pass through the once booming town. Visitation numbers to the famous Sheep Mountain Tunnel Mill /Crystal Mill (5GN1627) have increased exponentially in recent years to as many as 300 vehicles per day (Heather Leigh, personal communication September 25, 2019). The Mill and most of the townsite is owned by the Crystal Mountain Ranch. The Ranch manages public access to the iconic Mill, again, the most photographed location in all of Colorado, allowing tourists to walk down to the river bank opposite the building for a small fee. Five of the historic cabins belonging to the Crystal Mountain Ranch are available for rent seasonally to tourists. The Ranch also offers a designated camping area and a gift shop in the original A.A. Johnson General Store (5GN6528). Other cabins in the town are owned by private individuals and are used as seasonal homes; Crystal has no year-round occupants.

36. Sources of information:

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1995 Historic Building Inventory Record and State Register of Historic Properties Nomination Form for the Tays/Anderson House (5GN2432). Copies available from the Colorado Office of Archaeology and Historic Preservation, Denver.

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2019d Public records for 3881 Forest Service Road 314 , Crystal Townsite Vicinity. Electronic document, https://www.gunnisoncounty.org/327/Property-Record-Search, accessed December 2, 2019.

Gunnison Review Press
1885 "Al Johnson suggested as contender for new Gunnison County Commissioner." 31 January. Gunnison, Colorado.
1886a "Description of Al Johnson's community roles, services, and geniality." 2 January. Gunnison, Colorado.
1886b "Report on Al Johnson's role in the Schofield avalanche recovery." 30 January. Gunnison, Colorado.
1887 "Al Johnson listed as vice president of Gunnison Country Snow-Shoe Club." 22 January. Gunnison, Colorado.

McAlester, Virginia Savage
2013 A Field Guide to American Houses: The Definitive Guide to Identifying and Understanding America's Domestic Architecture. 2nd Ed. Knopf, New York.

Neal, Roger A.
2002 *Crystal....What Really Happened (Revised Fifth Edition)*. Crystal Tale Books. Goshen, Indiana.

Vandenbusche, Duane
1980 *The Gunnison Country*. B & B Printers, Gunnison, Colorado.

Vandenbusche, Duane, the Gunnison Pioneer Museum, and the Crested Butte Mountain Heritage Museum
2008 *Images of America: Around Gunnison and Crested Butte*. Arcadia Publishing, Charleston, South Carolina.

VI. SIGNIFICANCE

37. Local landmark designation: Yes ☐ No ☒ Date of designation: n/a
Designating authority: n/a

38. Applicable National Register Criteria: (reflective of full townsite)

- ☒ A. Associated with events that have made a significant contribution to the broad pattern of our history;
- ☐ B. Associated with the lives of persons significant in our past;
- ☒ C. Embodies the distinctive characteristics of a type, period, or method of construction, or represents the work of a master, or that possess high artistic values, or represents a significant and distinguishable entity whose components may lack individual distinction; or
- ☒ D. Has yielded, or may be likely to yield, information important in history or prehistory.
- ☐ Qualifies under Criteria Considerations A through G (see Manual)
- ☐ Does not meet any of the above National Register criteria

39. Area(s) of significance: Exploration/Settlement; Industry-mining

40. Period of significance: Ca. 1881-1917

41. Level of significance: National ☐ State ☒ Local ☒

42. Statement of significance:
5GN6535, the Melton House, meets the requirements of NRHP Criteria A, C, and D in the areas of Exploration/Settlement and Industry-Mining.

Regarding **Criterion A**, the Melton House is an element of the late 19th/early 20th century regionally

noteworthy mining town of Crystal (5GN1332), the development of which was a part of and directly associated with the historically significant mining boom of that time period in Colorado. Having been built in ca. 1881 and utilized as a residence thereafter, the Melton House clearly falls within the full Crystal Townsite's suggested period of significance of 1880-1917.

Regarding **Criterion C**, the Melton House embodies distinctive characteristics of a type, period, and method of construction. The building is an interesting example of an upright-and-wing plan, a common vernacular form consisting of a 1.5-story wing with a front facing gable roof and a single-story side wing set at a right angle. The form was widely used in both rural and urban settings. While the form itself is non-stylistic, it is often associated with Greek Revival architecture in the United States or, later, Queen Anne and Italianate dwellings (McAlester 2013). Here, there is virtually no stylistic embellishment. Rather, it appears to be a unique vernacular approach to frame construction within an environment where contemporaneous buildings were built of log, using basic techniques and locally-sourced materials. The distinction between log and frame houses in Crystal may reflect the affluence of the owners and their access to imported materials or expectation of establishing a permanent family home. The Meltons, for example, were already raising a family when they arrived at Crystal in 1881, and George Melton had a prominent role with the Crystal Mountain Mining and Drainage Company as a part owner, organizer, engineer and superintendent. The Meltons were also a dual-income family, as Martha ran a boarding house in town. Given this context, its relative plainness makes it a strong representative example illustrating the adaptability of the upright-and-wing type.

Regarding **Criterion D**, passing observations of surface-exposed cultural material and earthen depressions in addition to the presence of at least one extant outhouse near the Melton House suggest archaeological potential associated with the building. The extant outhouse and other likely previous privy locations, at a minimum, could yield information significant to our understanding of the site, the full town, and the larger area, beyond that already available in written or oral documentation.

The Melton House was not found to be directly associated with any significant persons in history, therefore it is not recommended as eligible under Criterion B.

While some modern repairs/replacements have been made to the Melton House, particularly the roof, the building overall retains a majority of its original materials and construction. Alterations made to the building have not overwhelmed its original design Furthermore, beyond retaining physical integrity, the building also retains intangible integrity (see Item 43 below). In sum, the building continues to convey its relationship with the areas of significance and is recommended as eligible to the NRHP under Criteria A, C, and D.

43. Assessment of historic physical integrity related to significance:

Regarding the aspects of integrity, the Melton House retains location as it remains in its original location. Although suffering from some deterioration and having had some modern improvements made, especially to the roof and siding on the addition, materials, workmanship, and design are overall retained as the majority of the original materials, methods of construction, and layout of the structure can still be discerned. Association is retained as the cabin is an early element of the historically significant mining town of Crystal, with its date of construction, circa 1881, falling within the town's suggested period of significance. Setting and feeling are retained as little has changed in the surrounding landscape to alter the environment from what it would have been during the period of significance, with the exception of modern tourist traffic through town.

VII. NATIONAL REGISTER ELIGIBILITY ASSESSMENT

44. National Register eligibility field assessment:

Eligible ☒ Not Eligible ☐ Needs Data ☐

45. Is there National Register district potential? Yes ☒ No ☐

Discuss: Given the historical continuity and good condition of the extant buildings, the full Crystal Townsite (5GN1332) holds the potential to be considered eligible for inclusion on the NRHP as a District under Criteria A, B, C, and D for a suggested period of significance of 1880-1917. Crystal fulfills the requirements of **Criterion A**, association with significant events, as the town is inextricably associated with the historically significant late 19th/early 20th century mining boom in Colorado, having been developed, incorporated, and occupied as a direct result of that momentous event in Colorado history.

The town fulfills the requirements of **Criterion B** for its association with prominent figure Albert A. Johnson, a Crystal resident who was a "legendary" figure in the Gunnison country during

the late 19th century (Professor Duane Vandenbusche, personal communication March 25, 2020). He is significant for his role in helping the town of Crystal develop and thrive between 1881 and 1893 and in popularizing recreational skiing in the region prior to the turn of the century. Born near Montreal in the Laurentain mountain area of Canada in 1851, Al Johnson came to Crystal in 1880 as a silver prospector with his brother Fred (Callihan 2017; Vandenbusche et al. 2008:58). Rather than working directly in mining operations, Al Johnson decided to supply miners with essential goods and opened the "A.A. Johnson General Store" (5GN6528) in Crystal in 1881. Over the years, in addition to the general store, he operated a hotel in Crystal and owned several nearby mining properties, including the famed and lucrative Lead King for a time (Vandenbusche 1980:247).

Johnson has been called Crystal's "leading citizen" for his contributions between 1881 and his death in 1893 (Vandenbusche 1980:247). As a "merchant, miner, post master, mail carrier, man and maid of all work, and boss of good fellows generally" (Gunnison Review Press 1886a), he was "widely respected for his business acumen and outgoing personality" within Crystal and beyond (Callihan 2020). He initiated and perpetuated the town's growth by, first, opening and operating the general store, and, second, by securing the postal contract for Crystal in 1882. Notably, merchandise provided in Johnson's general store allowed stalwart Crystal locals to remain in town year-round. The town of Crystal was, and continues to be, snowbound every winter, with no easy access to supplies. By keeping his store well-stocked, Johnson provided a continuous and reliable inventory to the hardy folks who over-wintered in Crystal, offering products necessary for personal use but also for continuing nearby mining work through the challenging winter months (Callihan 2017; Neal 2002:14).

Importantly, Johnson also housed the Crystal Post Office at his general store, reliably carried the mail between Crystal and Crested Butte on a year-round basis, and served as the town's postmaster until his death in 1893 (Neal 2002:15-16; Vandenbusche 1980:247). In 1885, Johnson was recommended as a potential Gunnison County Commissioner to represent the Crystal area by virtue of his efforts as a "faithful worker for that section of the country…[for while working] for himself he [worked] for others by his pen and otherwise in order to promote the interest of that rich mining region" (Gunnison Review Press 1885). In 1886, Johnson launched Crystal's first newspaper, the *Crystal River Current*, which he edited and published through 1892 in a building (no longer extant) behind his store (Neal 2002:195; Vandenbusche 1980:245). In 1890, Johnson served as Crystal City Council Clerk (Neal 2002:15). That same year, Johnson married Kate Usher, sister of prominent Crystal resident Jim Usher. A baby girl, Crystal Rose, was born to the Johnsons on May 1, 1891 but died on October 29, 1891 (Callihan 2017). By that time, Al Johnson was suffering from a bad cough that was likely due to tuberculosis. In an effort to combat his illness, Johnson spent the winters of at least 1891 through 1893 in Arizona, returning to Crystal during the summers to run his store and the post office, but he died in Phoenix on January 19, 1893, at the age of 42 (Callihan 2017).

Beyond his pivotal role in building and supporting the local Crystal community, Johnson is remembered regionally for his impressive "snowshoeing," the period term for skiing, and for expanding Gunnison country ski culture. Skiing was extremely popular, and vital, in the broader Gunnison country in the late 19th and early 20th centuries (Vandenbusche 1980:247). "Every man, woman, and child had to learn to ski if they wished to get anywhere in the winter in the early mining days" (Vandenbusche et al. 2008:75). Ski groups flourished throughout the area at various mining camps, and the town of Crystal was no exception in its love of (and need for) skiing. The Crystal Snowshoe [ski] Club became "legendary in the rocky mountains" and featured the "famed" Al Johnson (Vandenbusche et al. 2008:120).

Johnson primarily gained skiing notoriety as one of the few in the Gunnison country who unfailingly carried mail on skis across high elevation, extremely dangerous, snow-covered terrain. Johnson became known regionally as a "legendary postman" who bravely and dependably executed his "anointed task" of carrying mail between Crystal and Crested Butte on what became known as the "Snowshoe Express" (Vandenbusche 1980:247, 423; Vandenbusche et al. 2008:55). His route, which included a stretch through the "feared Crystal Canyon," was extremely perilous, likely the most perilous in the region, due to the terrain and avalanche danger in snowy conditions (Vandenbusche 1980:78; Vandenbusche et al. 2008:58). Johnson became recognized as the "top snowshoer [skier] of the Rocky Mountains" for his speed and technique in completing this treacherous, avalanche-prone mail-carrying route (Vandenbusche 1980:423). Weekly, Johnson donned 11-foot wooden skis to travel the

18 miles from Crystal to Crested Butte, traversing the dreaded Crystal Canyon, with as much as 40 pounds of mail on his back each way (Callihan 2020). Adding to his acclaim, an avalanche one January night in 1886 hit the mining camp at Schofield, located at the top of Crystal Canyon. Upon hearing the news, Johnson skied up the canyon during the continuing blizzard in total darkness to aid the devastated camp. Johnson is noted to have dug victims out of the snow-slide and led people to safety amidst the storm that dumped six feet of snow at Schofield and four feet at Crystal. Following the rescue, he continued on to Crested Butte to deliver news of the avalanche and assembled a rescue party to return to Schofield to carry on with the recovery (Callihan 2020; Gunnison Review Press 1886b).

Beyond his courageous mail delivery on skis, Johnson's fame was bolstered by numerous ski race victories across Colorado's western slope (Vandenbusche 1980:247, 423, 426-428). His fame helped popularize skiing as recreation in Colorado. In 1886, he fostered the extensive ski culture of the region by serving on the Executive Committee of the newly formed Gunnison Country Snow-Shoe (ski) Club, developed to encourage competitive regional ski racing and winter sports, and he was vice-president of the club the following year (Gunnison Review Press 1887) . At Johnson's suggestion and primarily through his efforts, the Club organized wildly popular races in the towns of Gunnison, Crested Butte, Irwin, Gothic, and Schofield during February and March of 1886 (Vandenbusche 1980:426-428). Inspired by similar "snowshoe carnivals" he had experienced back home near Montreal, Johnson led the organization of the races in Crested Butte, Gunnison, Irwin, and Gothic that would cumulatively become known as the "Great Race of 1886" (Callihan 2020). Those four races were met with great enthusiasm and support from the local communities, with excited spectators gathering along the race routes to cheer on contestants from their respective mining camps. An estimated 1,000 people gathered to watch the Crested Butte race, for which a special Denver and Rio Grande Excursion train was chartered (Callihan 2020; Vandenbusche 1980:426-428). The Great Race of 1886, conceived and implemented by Al Johnson, introduced competitive ski racing to the Gunnison country (Vandenbusche 1980:428-429).

Al Johnson was described as "without a doubt, the most graceful snowshoer the Rocky Mountains [had] ever produced…a daring adventurer on shoes [skis]" (Vandenbusche 1980:427). In 1974, the telemark ski community in Crested Butte began the Al Johnson Memorial Uphill/Downhill Telemark Race. The race, honoring Al Johnson, his exceptional skiing abilities, and his devoted public service as a mail carrier through unthinkably hostile weather and terrain, continues to be held annually at Crested Butte Mountain Resort. As a further tribute, "Let 'em Run!: Al Johnson and the Great Races of 1886," a play by Michael Callihan documenting aspects of Johnson's remarkable life, has been produced in Gunnison and Crested Butte annually since 2017, playing to sold out crowds (Michael Callihan, personal communication March 29, 2020).

The townsite fulfills the requirements of **Criterion C** as its buildings retain sufficient integrity to cumulatively convey the historic built character of a late 19th/early 20th century Colorado mountain mining community. Characteristics of the extant buildings, primarily of the dominant Pioneer Log style, reflect vernacular approaches to building and reveal methods, techniques, and materials known and available to the occupants of Crystal at the time of their construction. The Pioneer Log buildings, primarily consisting of common notched log construction with various chinking materials and gabled roofs, represent residences, a commercial building, a social building, and a barn, all of which had important, individualized roles in community life, reflecting the day-today on goings in an isolated mountain mining town. Additionally, the previously recorded and SRHP-listed Tays/Anderson House (5GN2432), a wood frame Victorian building believed to have been a kit home, provides a contrast to the dominant vernacular building methods, exemplifying more formalized building techniques and imported wood building materials available to affluent members of the community (Anderson 1995). Also of particular note among the buildings in the town is the newly recorded Schoolhouse (5GN6532), which is an excellent and well-preserved example of a rural one-room schoolhouse—an increasingly rare property type in the region. Along with its extant ancillary building, the Schoolhouse has a very recognizable design and construction materials that meet specific eligibility criteria laid out in the NRHP Multiple Property Documentation Form for Rural School Buildings in Colorado, including being a single-story with a front gabled roof, having typical fenestration, and being built with wood framing and shiplap siding (Doggett and Wilson 1999).

Finally, the town fulfills the requirements of **Criterion D**, potential to yield information important in history, due to its archaeological promise. Passing observations during the 2019 architectural inventory of surface-exposed cultural material; artifacts partially buried around building foundations, present inside buildings, and fallen through floors; numerous abandoned privy pits; and the presence of many standing outhouses across the entire townsite suggest that Crystal possesses great archaeological potential; archaeological investigations, both surface survey and subsurface testing, are highly likely to yield further information not already available in written or oral documentation that could significantly contribute to our understanding of the history of the site and the region.

Beyond the townsite itself (5GN1332), a District boundary could be expanded to incorporate other contemporaneous and related features, including the previously recorded and NRHP-listed Sheep Mountain Tunnel Mill/Crystal Mill (5GN1627), the still unrecorded Crystal Cemetery, the unrecorded spring and ditch water supply system, and nearby mine-related features, if found to be extant at a later date.

The Melton House (5GN6535) Contribution to District Potential
As the Melton House (5GN6535) is an element of and directly associated with the full townsite (5GN1332), and given that the Melton House retains sufficient integrity to convey its association with the full townsite's suggested period of significance (1880-1917), it can be considered contributing toward District potential.

If there is National Register district potential, is this building: Contributing ☒ Non-contributing ☐

46. If the building is in existing National Register district, it: Contributing ☐ Non-contributing ☐

VIII. RECORDING INFORMATION

47. Photograph numbers: Roll 19-259 images 519-535, 553-555, 585
Roll 19-261 images 199-222

Negatives filed at: Metcalf Archaeological Consultants, Inc. (digitally)

48. Report title: Architectural Inventory of the Crystal Townsite for the Gunnison County Historical Commission, Gunnison County, Colorado.

49. Date(s): 09/25/2019 – 09/27/2019

50. Recorder(s): Natasha E Krasnow and Kelly J Pool

51. Organization: Metcalf Archaeological Consultants, Inc.

52. Address: PO Box 899, Eagle, Colorado 81631

53. Phone number(s): 970-328-6244

NOTE: Please include a sketch map, a photocopy of the USGS quad map indicating resource location, and photographs.

History Colorado - Office of Archaeology & Historic Preservation
1200 Broadway, Denver, CO 80203 (303) 866-3395

5GN6535 – Melton House.
View of south elevation. View north. (Roll 19-259, image 519, 09/26/2019)

5GN6535 – Melton House.
Oblique view of southeast corner. View northwest. (Roll 19-259, image 520, 09/26/2019)

5GN6535 – Melton House.
View of east elevation. View west. (Roll 19-259, image 521, 09/26/2019)

5GN6535 – Melton House.
Oblique view of northeast corner. View southwest. (Roll 19-259, image 522, 09/26/2019)

5GN6535 – Melton House.
View of north elevation. View south. (Roll 19-259, image 524, 09/26/2019)

5GN6535 – Melton House.
Oblique view of the northwest corner. View southeast. (Roll 19-259, image 525, 09/26/2019)

5GN6535 – Melton House.
View of west elevation. View east. (Roll 19-259, image 526, 09/26/2019)

5GN6535 – Melton House.
Oblique view of the southwest corner. View northeast. (Roll 19-259, image 527, 09/26/2019)

5GN6535 – Melton House. View of the gable on the north elevation of the original building also detailing shingles on the addition. View south-southwest. (Roll 19-261, image 208, 09/26/2019)

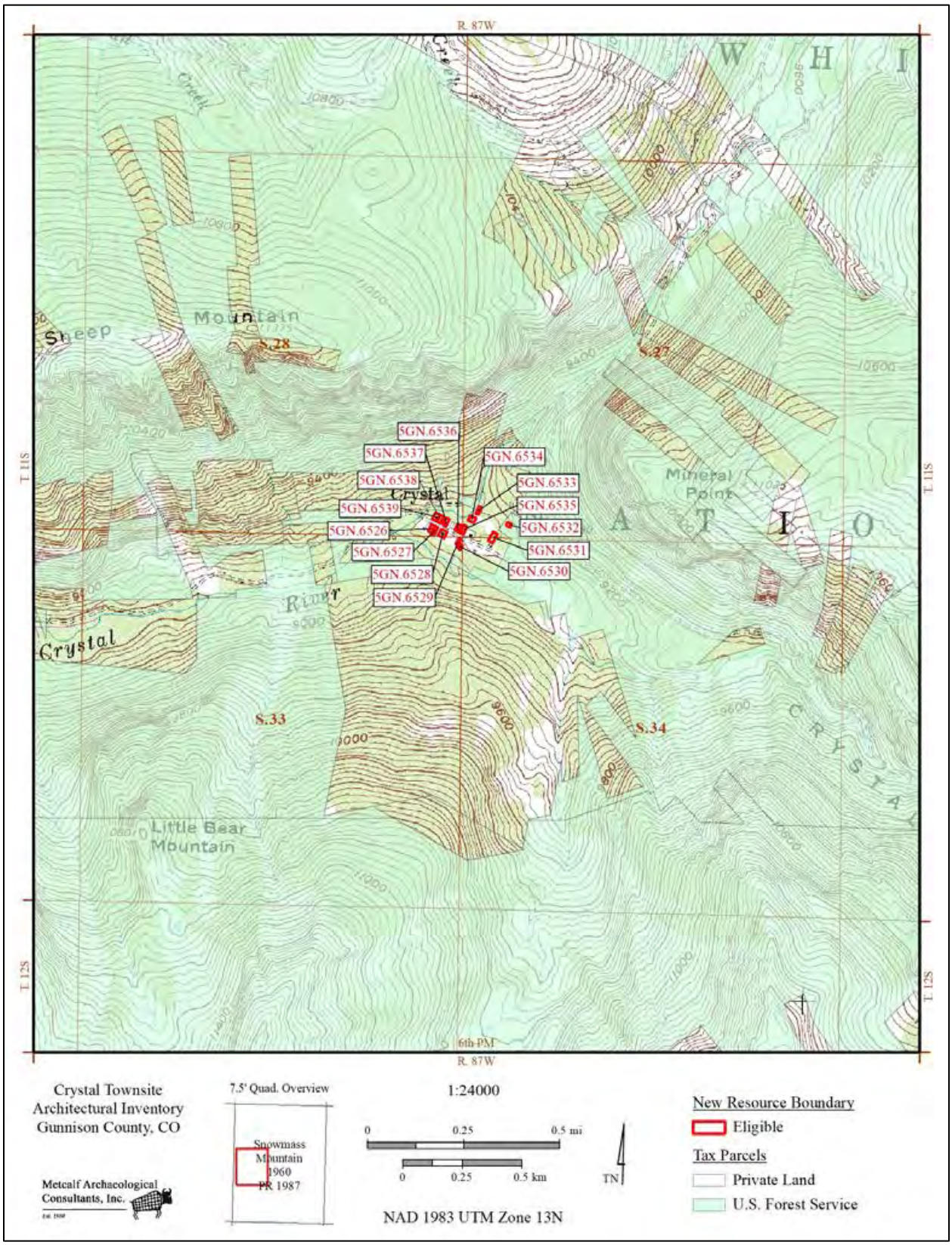
5GN6535 – Melton House.
View of the shed. View northeast. (Roll 19-259, image 529, 09/26/2019)

5GN6535 – Melton House.
View of the south elevation of the outhouse. View north. (Roll 19-259, image 531, 09/26/2019)

5GN6535 – Melton House.
Oblique view of the southeast corner of the outhouse. View northwest.
(Roll 19-259, image 532, 09/26/2019)

SITE SKETCH MAP

SITE LOCATION MAP



CLG 76112

G/ES

Resource Number: 5GN6529
Temporary Resource Number: Feature 4

OAHP1403
Rev. 9/98

COLORADO CULTURAL RESOURCE SURVEY

Architectural Inventory Form

Official eligibility determination
(OAHP use only)
Date _____ Initials _____
____ Determined Eligible- NR
____ Determined Not Eligible- NR
____ Determined Eligible- SR
____ Determined Not Eligible- SR
____ Need Data
____ Contributes to eligible NR District
____ Noncontributing to eligible NR District

I. IDENTIFICATION

1. Resource number: 5GN6529
2. Temporary resource number: Feature 4
3. County: Gunnison
4. City: Crystal
5. Historic building name: Rosetti Residence
6. Current building name: Rosetta Cabin
7. Building address: 3881 Forest Service Road 314, Crystal Townsite Vicinity (per Gunnison County Assessor 2019d)
8. Owner name and address: Christopher Cox/Treasure Mountain Ranch, Inc/Crystal Mountain Ranch: 1203 Colorado Avenue, Glenwood Springs, Colorado 81601

II. GEOGRAPHIC INFORMATION

9. P.M.: 6th Township: 11 S Range: 87 W
NE ¼ of NE ¼ of NE ¼ of NE ¼ of section 33 projected
10. UTM reference:
Zone: 13 ~~N~~ ; 318200 mE 4325390 mN NAD 83 elev 8950ft
11. USGS quad name: Snowmass Mountain
Year: 1960 (PR 1987) Map scale: 7.5' ☒ 15' ☐ (Attach photocopy of appropriate map section)
12. Lot(s): _____ Block: _____
Addition: Yes Year of addition: 1950s
13. Boundary description and justification:
Boundary of the Rosetta Cabin (5GN6529) is defined by the boundaries of neighboring parcels on the east and west and by the 100ft that would have been the length of the original lot to the north and south. Today, the Rosetta Cabin is part of the greater, undivided ~400 Treasure Mountain Ranch/Crystal Mountain Ranch (Parcel # 2915-340-00-004) (Gunnison County Assessor 2019d).

III. Architectural Description

14. Building plan (footprint, shape): Rectangular
15. Dimensions in feet: Length: 43' X Width: 21'
16. Number of stories: 1.5
17. Primary external wall material(s): Wood- log
18. Roof configuration: Gable- front front gabled roof
19. Primary external roof material(s): Metal
20. Special features: Decorative shingling in the north elevation gable – see description in Item 21
21. General architectural description: stovepipe
The Rosetta Cabin (Feature 1) consists of the main cabin, which is a hewn log cabin with square notching that measures approximately 30' long x 21' wide, and a shed addition on the back/south elevation, which

measures approximately 13' x 10'. The addition now serves as a bathhouse. The cabin generally faces north. Overall, the main cabin's foundation may be a wood sill. Otherwise, some stones are present on the west elevation, and the southeast corner appears to be supported by some concrete. Square nails are present throughout, but some wire nails are also present. The roof is a gable-front, framed with dimensional lumber, which appears to be original. Metal flashing is present around the eaves. Seamed metal has been placed over the roof to preserve the cabin from the elements. The stove pipe projects up from the roof slightly north of center near the middle of the west pitch.

The north elevation is the front of the cabin. Exterior siding consists of the exposed hewn, square-notched logs with minimal wood chinking. Some mud chinking may also be present. Square nails are present at the ends of the logs. The upper half story within the gable is sided in wood shingles. The front door is placed toward the west end of the façade and appears to be original. The wood, paneled door has two large rounded-arch windows and includes a faux crystal doorknob with an ornate metal plate and an ornate mechanical twist doorbell. The door is wood framed and covered with a wood screen door that is painted red. Two wood windows are present east of the door – both are wood framed and painted red. Both were likely two-over-two-lite windows, though the westmost window appears to have a missing muntin in the upper sash. Plywood has been nailed to the logs between the two ground floor windows. A single wood-framed four-over-four-lite double-hung window is centered in the gable apex and is painted red like the others. Directly above the window, the shingle work bows to create a decorative eyebrow hood with a sawtooth pattern in the bottom course of shingles. On either side of the gable window, shingles have been cut and placed to create a decorative diamond pattern against the "background" shingles. A new dimensional lumber deck has been added at ground level under the windows and door, A piece of dimensional lumber is nailed to the elevation on the west of the door – it extends out and connects to an upright sawn branch post embedded in the ground just west of the cabin.

The west elevation is the hewn, square notched logs with some wood and mud chinking present. Square nails are visible in the ends of the logs, connecting them to those of the north and south elevations. One two-lite fixed window is present toward the south end of the elevation. The window has a decorative wood frame, painted red, with a small diamond cut out of the frame above the window. The window is screened. Some rock foundation is present along this elevation. A new water line enters the cabin at the south end under the window.

The south elevation of the main cabin is the same hewn, square-notched logs with wood and mud chinking. Square nails are present in these logs like other elevations. One wood framed one-over-one-lite window is present between the west end of the elevation and the bathhouse addition. A propane line enters the cabin under this window. The propane line splits and also heads into the west elevation of the bathhouse (described below). Only a small part of the main cabin's south elevation on its east end can be seen. It consists of the hewn, square notched log ends and includes square nails. The gable of the main cabin's south elevation is visible above the addition. It appears to have been re-sided in new wood, board-and-batten. The original, wood-framed four-over-four-lite double-hung window is at the gable center.

The east elevation is the same hewn, square notched logs and wood and mud chinking. One vertical wood framed sash window is present toward the south end of the elevation. The window has a plywood shutter and is also screened. Another horizontal wood framed fixed window is just north of the sash window. The frames of both windows are painted red. An ornate metal hook, perhaps for a hanging plant, is attached to the logs just above and north of the fixed window. Some sort of cable enters the cabin in two holes near the north end of this elevation. Square nails are present in the log ends like the rest.

The addition on the south elevation is used as a bathhouse. It has a shed roof of dimensional lumber covered in asphalt roll then topped with seamed metal. The west elevation of the addition is board-and-batten with one wood framed window toward the north end. The window has a dimensional lumber shutter. An exhaust pipe exits the bathhouse near its center on this elevation. The south elevation is also board and batten with one wood framed fixed window toward the east end; it also has a dimensional lumber shutter. Dimensional lumber rafter ends are visible under the eave on this elevation of the bathhouse. The east elevation of the bathhouse is the same vertical board-and-batten siding and includes the entrance door, which is also board and batten. A small, wood framed fixed window is present north of the door and south of the back/south elevation of the main cabin. The window frame is partially painted red. A wood "Bath House" sign is nailed to the door.

The interior of the cabin includes two floors. An entryway is present upon entering the cabin on the ground floor. The entryway has horizontal board wall finish, painted white, and includes the first flight of well-worn wood stairs that lead south, up to the first landing. The floor was covered with linoleum at the time of

recording, and the entryway ceiling is covered in the same white wood boards as the walls. In the east wall of the entryway is a doorway with a wood, paneled door, painted yellow, that leads into the main ground floor area of the cabin. The main area is separated into two rooms. The first room at the front/north end of the cabin is a bedroom at present. The wall finish is the same horizontal wood boards painted white and the flooring is the same linoleum as the entryway. The second floor joists are exposed in the ceiling above, painted white. Two windows are present in the north wall, and a wood stove is present in the southwest corner of the room. Corrugated aluminum has been added to this corner from ceiling to floor, backing the stove. The stove pipe heads straight up through the ceiling into the north room on the second floor. The back/south room on the ground floor is the kitchen/dining area. Bead board wainscoting, painted light blue, wraps around the entire room with the aforementioned white horizontal wood boards placed above the wainscoting to the ceiling. Upon entering this room from the front room, a pantry with a vertical wood board door is present on the west side. A propane powered refrigerator is present in the northwest corner of the room, and a small sink and counter are present along the west wall. A propane powered stove is present along the south wall. Toward the southeast corner in the south wall is a vertical wood board door that leads into the bathhouse addition. Another smaller sink/vanity is present along the east wall in the southeast corner. Flooring in this room appears to be the original hard wood. The second floor joists are also exposed on the ceiling in this room and are also painted white.

The second floor is accessed by the stairs in the entryway. After ascending to the first landing, another flight of well-worn wood stairs heads east and accesses the second floor. The second floor is separated into two rooms, north and south. Both rooms are bedrooms at present and are separated by a horizontal wood board partition wall at the top of the stairs on the north side. The wall appears to have original posts, but the boards may have been replaced. The north side of the wall has been covered with plywood. A vertical wood board door at the center of the wall opens into the north room. The roof framing, which appears original, is exposed in both rooms and is painted white. New dimensional lumber wall framing has been added at the top of the stairs on the south side. Flooring in the south room is plywood. The finish on the south wall is dimensional lumber posts with sheets of wood board painted white. A single window is present in the south wall. The north room also has plywood flooring. The siding on the north wall is also dimensional lumber posts with sheets of wood board, however it is not painted white in this room. A single window is present in the north wall. The stove pipe passes through the southwest corner of the north room where it exits the cabin through the roof.

The interior of the bathhouse addition includes two separate spaces. The ceiling throughout is of new dimensional lumber boards. Upon entering the bathhouse through the east wall, an entryway is present. In the entryway's north wall, which is the south elevation of the main cabin, a wood board door is present that leads into the main cabin. In the entryway's west wall is a wood, paneled door that leads into a storage closet. In the entryway's south wall is a wood, paneled door that leads into the bathroom. A single window is present in the east wall between the exterior door and the main cabin wall. The floor in the entryway is concrete. Interior wall finish consists of new dimensional lumber framing and plywood. The bathroom space includes siding of new dimensional lumber framing, plywood, and vertical wood boards. A propane-powered hot water heater is present on the west wall near the northwest corner, and a shower is present in the southwest corner. A flushing toilet and sink/counter are present along the south wall. A window is present in the south wall.

22. Architectural style/building type: Pioneer log

23. Landscaping or special setting features:
East of the cabin is an open area amongst the aspen trees with a picnic table and a large fire pit. This social space is shared with the Edgerton Cabin (5GN6530), which is located just southeast of the Rosetta Cabin.

24. Associated buildings, features, or objects:
Coal Bin (Feature 2) – the coal bin is located south of the southwest corner of the main cabin and is dilapidated. It includes two compartments, both still filled with some coal. The lid is gone and the south side of the bin has fallen away. The north side and east and west ends are intact. It is built of dimensional lumber and wire nails. The partition wall inside the bin is relatively intact. The bin measures 3' 2.5" wide x 6' 2.5" long x 3' 11" tall. An old key-operated "Master" pad lock is still present on the now useless latch.

IV. ARCHITECTURAL HISTORY

25. Date of construction: Estimate: pre-1895 Actual: _____
Source of information: Neal 2002:194

26 Architect: Unknown
Source of information: n/a

27. Builder/contractor: Unknown

    Source of information: n/a

28. Original owner: Possibly George Rosetti

    Source of information: Neal 2002:194, 249

29. Construction history (including description and dates of major additions, alterations, or demolitions):
    The Rosetta Cabin was originally built sometime prior to1895 (Neal 2002:194). The shed addition on the south elevation was constructed sometime in the 1950s and was made into a bathhouse during the same timeframe (Christopher Cox, personal communication January 7, 2020). The seamed metal was added to the roof sometime between 1980 and 1990 to protect the cabin from the elements (Christopher Cox, personal communication January 7, 2020).

30. Original location: ☒ Moved: ☐ Date of move: _____

V. HISTORICAL ASSOCIATIONS

31. Original use(s): Domestic- single dwelling

32. Intermediate use(s):

33. Current use(s): Domestic- single dwelling, seasonal dwelling

34. Site type(s): Rural cabin; now AirBnB seasonal rental

35. Historical background:
    The Rosetta Cabin (also known as the Rosetti Cabin) was built prior to 1895. During the early mining heyday of Crystal, it was the Rosetti's residence. During the 1950s and 1960s, the cabin was owned and occupied by Warren and Maxine Fowler and their family (Neal 2002:194).

    One George Rosetti is mentioned in the newspaper as working at the Bear Mountain Tunnel as a mucker in 1899 (Neal 2002:67), and children James (Jimmie) Rosetti and Rosa (Rosie) Rosetti are mentioned as attending the Crystal School in 1899 (Neal 2002:115-117). A Henry Rosetti is mentioned in the *Silver Lance* as moving in to the "Wise building" for the summer in June of 1898 (Silver Lance 1898b).

    Crystal Townsite History
    Before the mining boom of the late 19th century, the Crystal Valley, located between Sheep Mountain, Little Bear Mountain, and Mineral Point, was occupied by the Ute Indians. The Utes were forcibly removed from the area and placed on reservations by the federal government around 1879, and infiltration of the former Ute lands by prospecting miners was quick to follow. Euroamerican prospectors began arriving in the Crystal Valley predominantly by way of Crested Butte, Gothic, and Schofield in the late spring and early summer of 1880 (Neal 2002:7; Vandenbusche 1980:245,). Prospectors set up camp near the confluence of the north and south forks of the Crystal River where they located outcroppings of clear quartz crystals which became the settlement's namesake (Vandenbusche 1980:245).

    Although lead, copper, zinc, and some gold were present in the quartz formations around Crystal, silver was the main ore attracting miners to the valley. The silver in the area was high in quantity, quality, and, of course, value (Neal 2002:9). The town of Crystal was officially incorporated on August 26, 1881 (Neal 2002:10). Crystal was granted a post office in 1882, with Albert A. Johnson leading that effort and being designated as the first postmaster (Neal 2002:15; Vandenbusche 1980:246).

    Other nearby silver mining camps were established during the same time period as Crystal. Located south of Crystal toward Crested Butte was Schofield, the earliest iteration of which was present as early as 1873. Schofield, however, was already in its final decline by late 1883. By that time, most of its residents had moved on, many of them to Crystal (Vandenbusche 1980:249, 252). Several of the original structures in the Crystal mining camp were moved there from Schofield (Neal 2002:7). The Schofield post office was discontinued in 1885, and the town was emptied. A brief revival of Schofield took place in 1899, but it was abandoned for good by 1900 (Neal 2002:134; Vandenbusche 1980:252). Similarly, the once booming mining town of Gothic, located between Schofield and Crested Butte and which was incorporated in 1879, began its sharp decline soon after it had reached its peak in 1881. Like Schofield, by 1883, Gothic was more-or-less abandoned (Vandenbusche 1980:258). Another nearby mining camp included Snowmass City, founded in 1880 and located a mere mile north of Crystal. By 1881, Snowmass City was starting to grow, and in 1883, a road was blasted between Snowmass City and Crystal, connecting Snowmass City with the route over Schofield Pass and into Crested Butte. Snowmass City reached its peak in 1884 but could not overcome its access difficulties and competition from Crystal. It succumbed in 1886 (Vandenbusche

1980:249).

By 1881, there are said to have been 21 or 22 cabins present at Crystal (Neal 2002:8; Vandenbusche 1980:245, Neal 2002:8). Citing the Colorado State Business Directory, Neal relays that the population of Crystal was reported as 600 in 1883; 300 in 1884 and1885; 400 in 1886 and 1888; 200 in 1889; and 101 in 1900 (2002:8). By 1910, however, the Census lists Crystal's population as four (Neal 2002:8). Notably, the 1910 Census was taken mid-May, so the count of four may have represented only year-round residents; only hardy souls over-wintered in Crystal which was, and continues to be, notoriously snowed-in during the cold months of the year (Callihan 2017; Neal 2002:8)

In its heyday, Crystal had a newspaper, a post office, saloons, a stage line, two general stores, a pool hall, a hotel, a "gentleman's club" (5GN6527), a two-story town hall, an assayer and chemist, a livery, a barber shop, over seventy houses, and more (Neal 2002:12-13; Vandenbusche 1980:245). Twelve streetlights were present in Crystal: large metal kerosene lamps hung from poles that were lit at dusk and extinguished at 10:00 pm (Neal 2002:119). A telegraph line ran from Marble through Crystal and on to Crested Butte, and a telephone line was developed from Marble to Crystal in 1904 (Neal 2002:108). The residents of Crystal procured their water from ditches that ran through town on each side of the main road through town, fed by a natural spring located east of town (Neal 2002:10). A blacksmith shop, no longer extant, was located just west of town, opposite the Sheep Mountain Tunnel Mill/Crystal Mill (5GN1627) (Roger Neal, personal communication September 27, 2019).

Additionally, Crystal also had its own cemetery, located southwest of the town and the Sheep Mountain Tunnel Mill/Crystal Mill (5GN1627) along what is now Gunnison County Road 3. Numerous Crystal residents are interred at the now overgrown cemetery, which is located within an avalanche chute. As such, the cemetery has been subjected to countless avalanches which have pummeled the little graveyard over the years. Burials are obscured by vegetation and avalanche debris. Some wrought iron fencing is still visible along with a single, roughly made headstone- that of Judge Tom O'Bryan, a prominent resident of Crystal from its inception until his death in 1904 (Christopher Cox and Heather Leigh, personal communication September 25, 2019; Roger Neal, personal communication September 26-27, 2019; Neal 2002:23-24).

From the beginning, Albert A. Johnson was Crystal's "leading citizen" (Vandenbusche 1980:247). Johnson operated the general store (5GN6528) and a hotel; edited and printed the town's first newspaper, the *Crystal River Current*; and owned several mining properties including the famed Lead King for a time. Johnson was responsible for securing a post office for Crystal and, as mentioned above, served as the first postmaster (Vandenbusche 1980:247). In addition to his prominent role in development of the Crystal community, Johnson became known regionally as a "legendary postman" who bravely and unfailingly carried mail between Crystal and Crested Butte on skis during the snowy months. His route, through the "feared Crystal Canyon," was extremely perilous due to the terrain and avalanche danger (Vandenbusche et al. 2008:55, 58). Al Johnson was regionally recognized as the "top snowshoer of the Rocky Mountains" for his speed and technique at completing his treacherous mail-carrying route in addition to winning many ski races across Colorado's western slope (Vandenbusche 1980:247, 423, 426-428).

Snowshoeing [skiing] was extremely popular, and necessary, in the broader Gunnison country around the turn of the century (Vandenbusche 1980:247). "Every man, woman, and child had to learn to ski if they wished to get anywhere in the winter in the early mining days" (Vandenbusche et al. 2008:75). Crystal was no exception in its love of skiing. The "Crystal Snowshoe Club" became "legendary in the rocky mountains" and featured the "famed" Al Johnson (Vandenbusche et al. 2008:120). In 1886, the Gunnison Country Snow-Shoe Club was formed with Al Johnson serving on the Executive Committee. The Club organized competitive races in Gunnison, Crested Butte, Irwin, Gothic, and Schofield in February and March of that year, all of which were met with great enthusiasm and support from the local communities (Vandenbusche 1980:426-428).

Since its inception, access to Crystal has been a challenge and a hindrance to the town's development. Until 1883, Crystal was extremely isolated from the rest of the region with only "jack" trails (the period term for mule trails) connecting the town with Crested Butte to the south and Carbondale to the north (Vandenbusche 1980:245). Along the route to Crested Butte, a toll road was completed between the mining settlements of Gothic and Schofield in 1881, and the old jack trail between Schofield and Crystal was finally also converted into a wagon road in 1883 (Neal 2002:11-12, Vandenbusche 1980:245). After the completion of the wagon road from Schofield, Crystal's population rose (Vandenbusche 1980:245-246). Still, the Crystal Canyon Road between Crystal and Schofield and beyond to Crested Butte was extremely dangerous and one of the "most treacherous in Colorado;" in winter, the canyon "vomited avalanches" (Vandenbusche et al. 2008:54).

Silver mines surrounding Crystal included the "Belle of Titusville, Catalpa, Eureka, Jack Whacker, Inez, Bear Mountain, and Daisy," with the most reputable mines in the area being "the Lead King, Black Queen, and Sheep Mountain Tunnel" (Vandenbusche 1980:245). The Sheep Mountain Tunnel is the mine that was most related to the iconic mill located on the Crystal River just west of town- the Sheep Mountain Tunnel Mill /Crystal Mill (5GN1627). The "Mill," which was actually a powerhouse, has become the most photographed site in Colorado, its only competition being the Maroon Bells near Aspen (Vandenbusche 1980:247, Vandenbusche et al. 2008:58). Built in 1892, the Mill contained a water wheel that generated the power to operate a compressor that in turn powered air drills at the Sheep Mountain Tunnel. The water power used to operate the system was created by damming the Crystal River at the entrance to the Sheep Mountain Tunnel, the confluence of the north and south forks of the river. The Mill eventually also provided power to the nearby Inez, Bear Mountain, and Black Queen mines. The presence of the Mill facilitated continued silver mining in the Crystal vicinity during the difficult years of the silver crash; "the community of Crystal owes much of its existence to this power generating facility" (Daily 1985).

Shipping ore from these mines was a constant struggle. The lack of a railroad line at Crystal meant that ore had to be hauled by wagon or jack train along the dangerous rockslide- and snowslide-prone canyon roads to the nearest railroad stations. Between 1886 and 1909, the residents of Crystal were promised several times that a railroad branch would reach the little town, alleviating their transport woes and providing the mines (and the town) a much needed boost with the ability to easily ship more ore, but the railroad never came (Vandenbusche 1980:245, 248).

Leading up to the Silver Panic of 1893, the declining price of silver resulted in a stark decrease in Crystal's population by 1892. Despite the presence of the advantageous Sheep Mountain Tunnel Mill/Crystal Mill (5GN1627), the town never fully recovered from the decline, with its population cut in half at that time. The *Crystal River Current* ceased operations in 1892, with the *Silver Lance* courageously appearing in 1893 to take its place. Crystal's population continued to dwindle, however, and the *Silver Lance* merged with the *Marble City Times* in 1899 (Vandenbusche 1980:245, 248). The Crystal post office closed in 1909 (Neal 2002:16).

Crystal was practically deserted by 1915. In 1916, a minor revitalization took place when the Black Queen, Lead King, and Sheep Mountain tunnels began operating and shipping ore once again. By 1917, however, the revival had already died, and the Sheep Mountain Tunnel closed for good, rendering Crystal a veritable ghost town (Vandenbusche 1980:248). Never-ending access difficulties coupled with the decline of the profitability of silver led to the town's final denouement (Neal 2002:138). Still, Crystal can be commemorated as a mountain mining town that persevered through staggering adversity during a time when its neighbors had already folded, notably Gothic, Schofield, and Snowmass City (Vandenbusche 1980:249, 252). Indeed, "Crystal [is] perhaps the best example of a north country town which stood amidst too much adversity" (Vandenbusche 1980:249).

After the mining days ended, a few people continued to seasonally occupy the town. Emmet S. Gould arrived in Crystal from Aspen in 1938 in search of ore. He ended up buying several mining claims, the Sheep Mountain Tunnel Mill/Crystal Mill (5GN1627), and several lots and cabins. Emmet's descendents continue to have a presence in the area as the Crystal Mountain Ranch (Neal 2002:151-152). Several other families called Crystal a summer home during the mid-20th century (and still do today), keeping the sleepy town partially occupied in the summer months (Neal 2002:140-197, 251-253).

By the 1950s, outdoors excursions were being led by individuals residing seasonally in Crystal. Beginning in 1954, Richard "Dick" Car-Skaden guided tourists on hiking trips in the mountains, deeming his operation the Snowmass Wilderness Guide Service. Dick lived seasonally in the back of the Crystal Club (5GN6527), the building that housed the "gentleman's club" in the mining days, from the 1950s into the early 1970s. The Crystal Club also served as the base for his excursions (Neal 2002:141, 175-176). Also beginning in 1954, Theodore "Sarge" Jackson, who lived in various cabins during his time in Crystal, began taking tourists and hunters on guided horseback trips into the surrounding mountains. Eventually, he moved his base of operations up the pass south into Schofield (Neal 2002:142). Area artist John Toly also lived in the back of the Crystal Club seasonally during the 1970s (Neal 2002:176). The Colorado Outward Bound School, established in 1962, created a base camp in the area for teaching life skills through outdoor activities. The school's students have performed service days in Crystal which consist of general maintenance tasks around town (Neal 2002:152-154).

Today, seasonal tourist visitation to Crystal has skyrocketed. People making the trek between Marble and Crested Butte over the infamous Schofield Pass and through Crystal Canyon, in capable 4x4 or other off-highway vehicles, pass through the once booming town. Visitation numbers to the famous Sheep Mountain

Tunnel Mill /Crystal Mill (5GN1627) have increased exponentially in recent years to as many as 300 vehicles per day (Heather Leigh, personal communication September 25, 2019). The Mill and most of the townsite is owned by the Crystal Mountain Ranch. The Ranch manages public access to the iconic Mill, again, the most photographed location in all of Colorado, allowing tourists to walk down to the river bank opposite the building for a small fee. Five of the historic cabins belonging to the Crystal Mountain Ranch are available for rent seasonally to tourists. The Ranch also offers a designated camping area and a gift shop in the original A.A. Johnson General Store (5GN6528). Other cabins in the town are owned by private individuals and are used as seasonal homes; Crystal has no year-round occupants.

36. Sources of information:

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Neal, Roger A.
2002 *Crystal....What Really Happened (Revised Fifth Edition)*. Crystal Tale Books. Goshen, Indiana.

Vandenbusche, Duane
1980 *The Gunnison Country*. B & B Printers, Gunnison, Colorado.

Vandenbusche, Duane, the Gunnison Pioneer Museum, and the Crested Butte Mountain Heritage Museum

2008 *Images of America: Around Gunnison and Crested Butte*. Arcadia Publishing, Charleston, South Carolina.

VI. SIGNIFICANCE

37. Local landmark designation: Yes ☐ No ☒ Date of designation: n/a

Designating authority: n/a

38. Applicable National Register Criteria: (reflective of full townsite)

- ☒ A. Associated with events that have made a significant contribution to the broad pattern of our history;
- ☐ B. Associated with the lives of persons significant in our past;
- ☒ C. Embodies the distinctive characteristics of a type, period, or method of construction, or represents the work of a master, or that possess high artistic values, or represents a significant and distinguishable entity whose components may lack individual distinction; or
- ☒ D. Has yielded, or may be likely to yield, information important in history or prehistory.
- ☐ Qualifies under Criteria Considerations A through G (see Manual)
- ☐ Does not meet any of the above National Register criteria

39. Area(s) of significance: Exploration/Settlement; Industry-mining

40. Period of significance: Pre-1895-1917

41. Level of significance: National ☐ State ☒ Local ☒

42. Statement of significance:

5GN6529, the Rosetta Cabin, meets the requirements of NRHP Criteria A, C, and D in the areas of Exploration/Settlement and Industry-Mining.

Regarding **Criterion A**, the Rosetta Cabin is an element of the late 19th/early 20th century regionally noteworthy mining town of Crystal (5GN1332), the development of which was a part of and directly associated with the historically significant mining boom of that time period in Colorado. Having been built in before 1895 and utilized as a residence thereafter, the Rosetta Cabin clearly falls within the full Crystal Townsite's suggested period of significance of 1880-1917.

Regarding **Criterion C**, as a Pioneer Log building (History Colorado 2008), the Rosetta Cabin embodies distinctive characteristics of a type, period, and method of construction. Initially chosen as an expedient and durable form of shelter (especially in the forested mountain areas of the state), Pioneer Log buildings have become an iconic part of Colorado's built heritage. The Rosetta Cabin is in good condition, retains integrity, and stands as a strong representative example of this property type. Like other buildings at the Crystal Townsite, it has a distinct form marked by the entry on the gable end—a trait that evolved in the West as a unique response to snow accumulation in the Rocky Mountains (Bomberger 1991). This particular example illustrates a common vernacular approach to log construction, using hand-hewn logs and square-notching. In addition, it has diamond patterned wood shingles in the front gable and a notable eyebrow-like hood over the center window. These artful embellishments show the influence of contemporaneous architectural styles. Together, the character defining elements of this building help illustrate the versatility of Pioneer Log buildings and the skill and creativity of those who built them.

Regarding **Criterion D**, passing observations of surface-exposed cultural material and earthen depressions near the Rosetta Cabin suggest archaeological potential associated with the building. Likely previous privy locations, at a minimum, could yield information significant to our understanding of the site, the full town, and the larger area, beyond that already available in written or oral documentation.

The Rosetta Cabin was not found to be directly associated with any significant persons in history, therefore it is not recommended as eligible under Criterion B.

While some modern repairs and replacements have been made to the Rosetta Cabin, particularly the interior and the roof, the building overall retains a majority of its original materials and construction. Alterations and additions made to the building have not overwhelmed its original design. Beyond retaining physical integrity, the building also retains intangible integrity (see Item 43 below). In sum, the building continues to convey its relationship with the areas of significance and can be recommended as eligible to the NRHP under Criteria A, C, and D.

43. Assessment of historic physical integrity related to significance:

Regarding the aspects of integrity, the Rosetta Cabin retains location as it remains in its original location. Although some modern repairs and improvements have been made to the building, notably the addition of the bath house to the rear of the building and repairs to the roof and the interior, the aspects of materials, workmanship, and design are all retained as a majority of the original materials, methods of construction, and layout of the structure are still present and can still be discerned. Association is retained as the Rosetta Cabin is an early element of the historically significant mining town of Crystal, with its date of construction, pre-1895, falling within the town's suggested period of significance. Setting and feeling are retained as little has changed in the surrounding landscape to alter the environment from what it would have been during the period of significance, with the exception of some modern tourist traffic through town.

VII. NATIONAL REGISTER ELIGIBILITY ASSESSMENT

44. National Register eligibility field assessment:

Eligible ☒ Not Eligible ☐ Needs Data ☐

45. Is there National Register district potential? Yes ☒ No ☐

Given the historical continuity and good condition of the extant buildings, the full Crystal Townsite (5GN1332) holds the potential to be considered eligible for inclusion on the NRHP as a District under Criteria A, B, C, and D for a suggested period of significance of 1880-1917. Crystal fulfills the requirements of **Criterion A**, association with significant events, as the town is inextricably associated with the historically significant late 19th/early 20th century mining boom in Colorado, having been developed, incorporated, and occupied as a direct result of that momentous event in Colorado history.

The town fulfills the requirements of **Criterion B** for its association with prominent figure Albert A. Johnson, a Crystal resident who was a "legendary" figure in the Gunnison country during the late 19th century (Professor Duane Vandenbusche, personal communication March 25, 2020). He is significant for his role in helping the town of Crystal develop and thrive between 1881 and 1893 and in popularizing recreational skiing in the region prior to the turn of the century. Born near Montreal in the Laurentain mountain area of Canada in 1851, Al Johnson came to Crystal in 1880 as a silver prospector with his brother Fred (Callihan 2017; Vandenbusche et al. 2008:58). Rather than working directly in mining operations, Al Johnson decided to supply miners with essential goods and opened the "A.A. Johnson General Store" (5GN6528) in Crystal in 1881. Over the years, in addition to the general store, he operated a hotel in Crystal and owned several nearby mining properties, including the famed and lucrative Lead King for a time (Vandenbusche 1980:247).

Discuss:

Johnson has been called Crystal's "leading citizen" for his contributions between 1881 and his death in 1893 (Vandenbusche 1980:247). As a "merchant, miner, post master, mail carrier, man and maid of all work, and boss of good fellows generally" (Gunnison Review Press 1886a), he was "widely respected for his business acumen and outgoing personality" within Crystal and beyond (Callihan 2020). He initiated and perpetuated the town's growth by, first, opening and operating the general store, and, second, by securing the postal contract for Crystal in 1882. Notably, merchandise provided in Johnson's general store allowed stalwart Crystal locals to remain in town year-round. The town of Crystal was, and continues to be, snowbound every winter, with no easy access to supplies. By keeping his store well-stocked, Johnson provided a continuous and reliable inventory to the hardy folks who over-wintered in Crystal, offering products necessary for personal use but also for continuing nearby mining work through the challenging winter months (Callihan 2017; Neal 2002:14).

Importantly, Johnson also housed the Crystal Post Office at his general store, reliably carried the mail between Crystal and Crested Butte on a year-round basis, and served as the town's postmaster until his death in 1893 (Neal 2002:15-16; Vandenbusche 1980:247). In 1885, Johnson was recommended as a potential Gunnison County Commissioner to represent the Crystal area by virtue of his efforts as a "faithful worker for that section of the country…[for while working] for himself he [worked] for others by his pen and otherwise in order to promote the interest of that rich mining region" (Gunnison Review Press 1885). In 1886, Johnson launched Crystal's first newspaper, the *Crystal River Current,* which he edited and published through 1892 in a building (no longer extant) behind his store (Neal 2002:195; Vandenbusche 1980:245). In 1890, Johnson served as Crystal City Council Clerk (Neal 2002:15). That same year, Johnson married Kate Usher, sister of prominent Crystal resident Jim Usher. A baby girl, Crystal Rose, was born to the Johnsons on May 1, 1891 but died on October 29, 1891

(Callihan 2017). By that time, Al Johnson was suffering from a bad cough that was likely due to tuberculosis. In an effort to combat his illness, Johnson spent the winters of at least 1891 through 1893 in Arizona, returning to Crystal during the summers to run his store and the post office, but he died in Phoenix on January 19, 1893, at the age of 42 (Callihan 2017).

Beyond his pivotal role in building and supporting the local Crystal community, Johnson is remembered regionally for his impressive "snowshoeing," the period term for skiing, and for expanding Gunnison country ski culture. Skiing was extremely popular, and vital, in the broader Gunnison country in the late 19th and early 20th centuries (Vandenbusche 1980:247). "Every man, woman, and child had to learn to ski if they wished to get anywhere in the winter in the early mining days" (Vandenbusche et al. 2008:75). Ski groups flourished throughout the area at various mining camps, and the town of Crystal was no exception in its love of (and need for) skiing. The Crystal Snowshoe [ski] Club became "legendary in the rocky mountains" and featured the "famed" Al Johnson (Vandenbusche et al. 2008:120).

Johnson primarily gained skiing notoriety as one of the few in the Gunnison country who unfailingly carried mail on skis across high elevation, extremely dangerous, snow-covered terrain. Johnson became known regionally as a "legendary postman" who bravely and dependably executed his "anointed task" of carrying mail between Crystal and Crested Butte on what became known as the "Snowshoe Express" (Vandenbusche 1980:247, 423; Vandenbusche et al. 2008:55). His route, which included a stretch through the "feared Crystal Canyon," was extremely perilous, likely the most perilous in the region, due to the terrain and avalanche danger in snowy conditions (Vandenbusche 1980:78; Vandenbusche et al. 2008:58). Johnson became recognized as the "top snowshoer [skier] of the Rocky Mountains" for his speed and technique in completing this treacherous, avalanche-prone mail-carrying route (Vandenbusche 1980:423). Weekly, Johnson donned 11-foot wooden skis to travel the 18 miles from Crystal to Crested Butte, traversing the dreaded Crystal Canyon, with as much as 40 pounds of mail on his back each way (Callihan 2020). Adding to his acclaim, an avalanche one January night in 1886 hit the mining camp at Schofield, located at the top of Crystal Canyon. Upon hearing the news, Johnson skied up the canyon during the continuing blizzard in total darkness to aid the devastated camp. Johnson is noted to have dug victims out of the snow-slide and led people to safety amidst the storm that dumped six feet of snow at Schofield and four feet at Crystal. Following the rescue, he continued on to Crested Butte to deliver news of the avalanche and assembled a rescue party to return to Schofield to carry on with the recovery (Callihan 2020; Gunnison Review Press 1886b).

Beyond his courageous mail delivery on skis, Johnson's fame was bolstered by numerous ski race victories across Colorado's western slope (Vandenbusche 1980:247, 423, 426-428). His fame helped popularize skiing as recreation in Colorado. In 1886, he fostered the extensive ski culture of the region by serving on the Executive Committee of the newly formed Gunnison Country Snow-Shoe (ski) Club, developed to encourage competitive regional ski racing and winter sports, and he was vice-president of the club the following year (Gunnison Review Press 1887) . At Johnson's suggestion and primarily through his efforts, the Club organized wildly popular races in the towns of Gunnison, Crested Butte, Irwin, Gothic, and Schofield during February and March of 1886 (Vandenbusche 1980:426-428). Inspired by similar "snowshoe carnivals" he had experienced back home near Montreal, Johnson led the organization of the races in Crested Butte, Gunnison, Irwin, and Gothic that would cumulatively become known as the "Great Race of 1886" (Callihan 2020). Those four races were met with great enthusiasm and support from the local communities, with excited spectators gathering along the race routes to cheer on contestants from their respective mining camps. An estimated 1,000 people gathered to watch the Crested Butte race, for which a special Denver and Rio Grande Excursion train was chartered (Callihan 2020; Vandenbusche 1980:426-428). The Great Race of 1886, conceived and implemented by Al Johnson, introduced competitive ski racing to the Gunnison country (Vandenbusche 1980:428-429).

Al Johnson was described as "without a doubt, the most graceful snowshoer the Rocky Mountains [had] ever produced…a daring adventurer on shoes [skis]" (Vandenbusche 1980:427). In 1974, the telemark ski community in Crested Butte began the Al Johnson Memorial Uphill/Downhill Telemark Race. The race, honoring Al Johnson, his exceptional skiing abilities, and his devoted public service as a mail carrier through unthinkably hostile weather and terrain, continues to be held annually at Crested Butte Mountain Resort. As a

further tribute, "Let 'em Run!: Al Johnson and the Great Races of 1886," a play by Michael Callihan documenting aspects of Johnson's remarkable life, has been produced in Gunnison and Crested Butte annually since 2017, playing to sold out crowds (Michael Callihan, personal communication March 29, 2020).

The townsite fulfills the requirements of **Criterion C** as its buildings retain sufficient integrity to cumulatively convey the historic built character of a late 19th/early 20th century Colorado mountain mining community. Characteristics of the extant buildings, primarily of the dominant Pioneer Log style, reflect vernacular approaches to building and reveal methods, techniques, and materials known and available to the occupants of Crystal at the time of their construction. The Pioneer Log buildings, primarily consisting of common notched log construction with various chinking materials and gabled roofs, represent residences, a commercial building, a social building, and a barn, all of which had important, individualized roles in community life, reflecting the day-today on goings in an isolated mountain mining town. Additionally, the previously recorded and SRHP-listed Tays/Anderson House (5GN2432), a wood frame Victorian building believed to have been a kit home, provides a contrast to the dominant vernacular building methods, exemplifying more formalized building techniques and imported wood building materials available to affluent members of the community (Anderson 1995). Also of particular note among the buildings in the town is the newly recorded Schoolhouse (5GN6532), which is an excellent and well-preserved example of a rural one-room schoolhouse—an increasingly rare property type in the region. Along with its extant ancillary building, the Schoolhouse has a very recognizable design and construction materials that meet specific eligibility criteria laid out in the NRHP Multiple Property Documentation Form for Rural School Buildings in Colorado, including being a single-story with a front gabled roof, having typical fenestration, and being built with wood framing and shiplap siding (Doggett and Wilson 1999).

Finally, the town fulfills the requirements of **Criterion D**, potential to yield information important in history, due to its archaeological promise. Passing observations during the 2019 architectural inventory of surface-exposed cultural material; artifacts partially buried around building foundations, present inside buildings, and fallen through floors; numerous abandoned privy pits; and the presence of many standing outhouses across the entire townsite suggest that Crystal possesses great archaeological potential; archaeological investigations, both surface survey and subsurface testing, are highly likely to yield further information not already available in written or oral documentation that could significantly contribute to our understanding of the history of the site and the region.

Beyond the townsite itself (5GN1332), a District boundary could be expanded to incorporate other contemporaneous and related features, including the previously recorded and NRHP-listed Sheep Mountain Tunnel Mill/Crystal Mill (5GN1627), the still unrecorded Crystal Cemetery, the unrecorded spring and ditch water supply system, and nearby mine-related features, if found to be extant at a later date.

The Rosetta Cabin (5GN6529) Contribution to District Potential
As the Rosetta Cabin (5GN6529) is an element of and directly associated with the full townsite (5GN1332), and given that the Rosetta Cabin retains sufficient integrity to convey its association with the full townsite's suggested period of significance (1880-1917), it can be considered contributing toward District potential.

If there is National Register district potential, is this building: Contributing ☒ Non-contributing ☐

46. If the building is in existing National Register district, it: Contributing ☐ Non-contributing ☐

VIII. RECORDING INFORMATION

47. Photograph numbers: Roll 19-260, images 606-617, 673-704
Roll 19-261, images 176-198

Negatives filed at: Metcalf Archaeological Consultants, Inc. (digitally)

48. Report title: Architectural Inventory of the Crystal Townsite for the Gunnison County Historical Commission, Gunnison County, Colorado.

49. Date(s): 09/25/2019 – 09/27/2019

50. Recorder(s): Natasha E Krasnow and Kelly J Pool

51. Organization: Metcalf Archaeological Consultants, Inc.

52. Address: PO Box 899, Eagle, Colorado 81631

53. Phone number(s): 970-328-6244

NOTE: Please include a sketch map, a photocopy of the USGS quad map indicating resource location, and photographs.

History Colorado - Office of Archaeology & Historic Preservation
1200 Broadway, Denver, CO 80203 (303) 866-3395

5GN6529 – Rosetta Cabin.
View of north elevation. View south. (Roll 19-260, image 606, 09/27/2019)

5GN6529 – Rosetta Cabin.
Oblique view of the northwest corner. View southeast. (Roll 19-260, image 607, 09/27/2019)

5GN6529 – Rosetta Cabin.
View of west elevation. View east. (Roll 19-260, image 608, 09/27/2019)

5GN6529 – Rosetta Cabin.
Oblique view of southwest corner. View northeast. (Roll 19-260, image 609, 09/27/2019)

5GN6529 – Rosetta Cabin.
View of south elevation. View north. (Roll 19-260, image 610, 09/27/2019)

5GN6529 – Rosetta Cabin.
Oblique view of southeast corner. View northwest. (Roll 19-260, image 612, 09/27/2019)

5GN6529 – Rosetta Cabin.
View of east elevation including south end. View west. (Roll 19-260, image 613, 09/27/2019)

5GN6529 – Rosetta Cabin.
View of east elevation including north end. View west. (Roll 19-260, image 614, 09/27/2019)

5GN6529 – Rosetta Cabin.
Oblique view of northeast corner. View southwest. (Roll 19-260, image 616, 09/27/2019)

5GN6529 – Rosetta Cabin. Detail of decorative shingle pattern and eyebrow dormer in the gable on the north elevation. View south. (Roll 19-261, image 179, 09/27/2019)

5GN6529 – Rosetta Cabin. Detail of square log notching on northeast corner. View southwest.
(Roll 19-260, image 617, 09/27/2019)

5GN6529 – Rosetta Cabin. Detail of square log notching on northwest corner. View southeast.
(Roll 19-261, image 185, 09/27/2019)

5GN6529 – Rosetta Cabin. Detail of the front door on the north elevation. View south. (Roll 19-260, image 704, 09/27/2019)

5GN6529 – Rosetta Cabin. Detail of square nails used in the construction of the cabin at the northwest corner. View south. (Roll 19-261, image 176, 09/27/2019)

5GN6529 – Rosetta Cabin.
View of coal bin located southwest of the cabin. View north. (Roll 19-261, image 186, 09/27/2019)

5GN6529 – Rosetta Cabin.
View inside the door of the bathhouse on the east elevation. View west.
(Roll 19-261, image 190, 09/27/2019)

5GN6529 – Rosetta Cabin.
View of the back door that leads into the cabin from inside the bathhouse door. View north.
(Roll 19-261, image 198, 09/27/2019)

5GN6529 – Rosetta Cabin.
Detail of the interior juncture of the main cabin with the added bathhouse. View northeast.
(Roll 19-261, image 192, 09/27/2019)

5GN6529 – Rosetta Cabin.
View of the interior of the bathhouse. Note shower and water heater.
View west. (Roll 19-261, image 193, 09/27/2019)

5GN6529 – Rosetta Cabin.
View of the interior of the bathhouse. View east. (Roll 19-261, image 194, 09/27/2019)

5GN6529 – Rosetta Cabin. Detail of the interior of the bathhouse showing ceiling. View east/up. (Roll 19-261, image 194, 09/27/2019)

5GN6529 – Rosetta Cabin.
Interior of the cabin, ground floor main room looking into the dining/kitchen space. View south.

(Roll 19-260, image 675, 09/27/2019)

5GN6529 – Rosetta Cabin.
Interior of the cabin, ground floor main room. View east.
(Roll 19-260, image 674, 09/27/2019)

5GN6529 – Rosetta Cabin.
Interior of the cabin, ground floor dining room/kitchen. View southeast.
(Roll 19-260, image 676, 09/27/2019)

5GN6529 – Rosetta Cabin. Interior of the cabin, ground floor dining room/kitchen. View west-northwest. (Roll 19-260, image 677, 09/27/2019)

5GN6529 – Rosetta Cabin. Interior of the cabin, ground floor dining room/kitchen. View north. (Roll 19-260, image 678, 09/27/2019)

5GN6529 – Rosetta Cabin. Interior of the cabin, ground floor dining room/kitchen. View southwest. (Roll 19-260, image 680, 09/27/2019)

5GN6529 – Rosetta Cabin. Interior of the cabin, detail of the ground floor ceiling with floor joists and underside second floor floorboards visible. View up. (Roll 19-260, image 685, 09/27/2019)

5GN6529 – Rosetta Cabin. Interior of the cabin, view of entryway and first set of stairs leading up to the second story. View south. (Roll 19-260, image 686, 09/27/2019)

5GN6529 – Rosetta Cabin. Interior of the cabin, view of south bedroom on the second story. View southwest. (Roll 19-260, image 689, 09/27/2019)

5GN6529 – Rosetta Cabin. Interior of the cabin, view from the north bedroom into the south on the second story. View south. (Roll 19-260, image 695, 09/27/2019)

5GN6529 – Rosetta Cabin. Interior of the cabin, detail of framing inside the roof peak. View north.
(Roll 19-260, image 697, 09/27/2019)

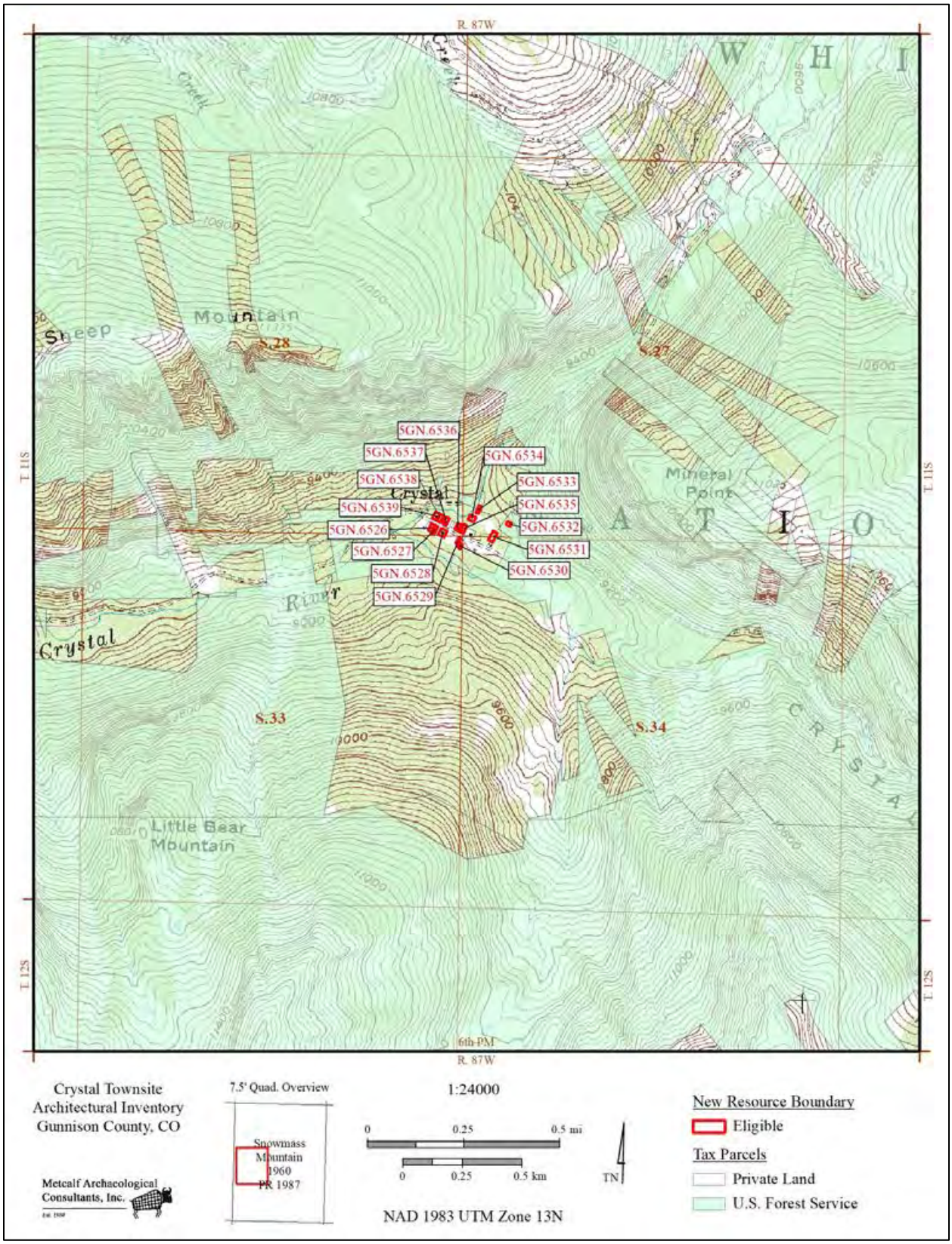
5GN6529 – Rosetta Cabin. Interior of the cabin, view of the entryway and front door from the first landing. View north-northeast. (Roll 19-260, image 700, 09/27/2019)

5GN6529 – Rosetta Cabin. Interior of the cabin, the main room on the ground floor. View east-northeast. (Roll 19-260, image 701, 09/27/2019)

5GN6529 – Rosetta Cabin. Interior of the cabin, the main room on the ground floor also looking into the entryway. View west-southwest. (Roll 19-260, image 702, 09/27/2019)

SITE SKETCH MAP

SITE LOCATION MAP



CLG 76112

G/ES

OAHP1403
Rev. 9/98

COLORADO CULTURAL RESOURCE SURVEY

Architectural Inventory Form

Official eligibility determination
(OAHP use only)
Date _____ Initials _____
_____ Determined Eligible- NR
_____ Determined Not Eligible- NR
_____ Determined Eligible- SR
_____ Determined Not Eligible- SR
_____ Need Data
_____ Contributes to eligible NR District
_____ Noncontributing to eligible NR District

I. IDENTIFICATION

1. Resource number: 5GN6530
2. Temporary resource number: Feature 5
3. County: Gunnison
4. City: Crystal
5. Historic building name: Edgerton Cabin
6. Current building name: Edgerton Cabin
7. Building address: 3881 Forest Service Road 314, Crystal Townsite Vicinity (per Gunnison County Assessor 2019d)
8. Owner name and address: Christopher Cox/Treasure Mountain Ranch, Inc/Crystal Mountain Ranch: 1203 Colorado Avenue, Glenwood Springs, Colorado 81601

II. GEOGRAPHIC INFORMATION

9. P.M.: 6th Township: 11 S Range: 87 W
   NE ¼ of NE ¼ of NE ¼ of NE ¼ of section 33
10. UTM reference:
    Zone: 13 ~~N~~ ; 318215 mE 4325372 mN NAD 83 elev 8950ft
11. USGS quad name: Snowmass Mountain
    Year: 1960 (PR 1987) Map scale: 7.5' ☒ 15' ☐ (Attach photocopy of appropriate map section)
12. Lot(s): _____ Block: _____
    Addition: n/a Year of addition: n/a
13. Boundary description and justification:
    Boundary of the Edgerton Cabin (5GN6530) is defined by the physical extent of the primary building and its associated building and features on its north, east, and south sides. In the northwest corner, the boundary is defined by a neighboring parcel. Today, the Edgerton Cabin is part of the greater, undivided ~400 Treasure Mountain Ranch/Crystal Mountain Ranch (Parcel # 2915-340-00-004) (Gunnison County Assessor 2019d).

III. Architectural Description

14. Building plan (footprint, shape): Rectangular
15. Dimensions in feet: Length: 19'5" X Width: 15'5"
16. Number of stories: ~~1.5~~ 1
17. Primary external wall material(s): Wood- log
18. Roof configuration: Gable-front front gabled roof
19. Primary external roof material(s): Metal
20. Special features: stovepipe, square notching
    On the north elevation of the cabin, between the front door and window, is a noticeable axe-made notch in the second log below the gable. This notch is visible in an undated historic photo of the cabin (see Neal 2002:27).

21. General architectural description:

The Edgerton Cabin (Feature 1) is generally north facing. It is a hewn log cabin with square-notching. The roof is front gabled and has been replaced with new dimensional lumber framing and seamed metal. The stove pipe projects up just east of the peak toward the north end of the cabin. Stone foundation can be seen intermittently around the cabin.

The north façade shows the hewn, square-notched log siding with no noticeable chinking. The main door, paneled wood with a wood frame, is set toward the east end of the elevation. The door has been sawn off on the bottom to fit with the addition of a wood deck, and it has one decorative metal hinge like those seen throughout town. A wood framed screen door covers the main door. A wood framed four-over-four-lite double-hung window is west of the door. It has a plywood shutter. A piece of dimensional lumber board is nailed vertically to the exterior just east of the window, and the hook-eye for closing the shutter is embedded in the board. The gable is covered in wood shingles with one wood framed fixed window centered. The window has a plywood shutter. Dimensional lumber purlin ends are visible under the eave. A newer dimensional lumber porch has been newly added at ground level, centered along the elevation. There may be some stone foundation present on this elevation. Inside the west door jamb is scratched, historic graffiti- "BE / '46'".

The west elevation is of the hewn, square/rectangular notched logs with wood chinking. One wood framed sliding window is present more-or-less centered. The window has a plywood shutter. A new dimensional lumber board is attached horizontally to the rafter ends, likely for the attachment of the new seamed metal roof. A stone foundation is present on this elevation.

The south elevation is the hewn, square/rectangular notched logs with wood chinking. A wood framed wood door, resembling board-and-batten construction, is present toward the west end of the elevation. It is no longer used. A wood framed screen door is covering the door. A propane tank line has been added through the door to fuel a cook-stove inside. The gable siding is vertical board-and-batten with a wood framed fixed two-lite window centered. Dimensional lumber purlin ends are exposed under the eave. No foundation is evident along this elevation.

The east elevation is also the hewn, square/rectangular notched logs with wood chinking. The single wood framed fixed two-over-two-lite window is set toward the south end. A dimensional lumber shutter is present at the window. Like the west elevation, a new dimensional lumber board is attached horizontally to the rafter ends, likely for the attachment of the new seamed metal roof. Minimal stone foundation is visible on this elevation. Three large wire nails are embedded in a high log toward the north end of the elevation, and a rusty chain with a bolt snap clasp is hanging on two of them.

The interior of the cabin is a single room. The walls are finished in vertical dimensional lumber, and the floorboards are hardwood. A substantial wood cook stove is located along the east wall near the northeast corner. Shelving is also present on the east wall in the northeast corner. A propane-powered cook stove is located along the south wall toward the southwest corner. A small counter and sink are present along the west wall toward the southwest corner. Two beds are present inside the cabin, one in the southeast corner and one in the northwest corner. The doors and window frames/sills have been painted turquoise. The new roofing material is fully exposed.

22. Architectural style/building type: Pioneer log

23. Landscaping or special setting features:

The cabin is surrounded closely by a grove of aspen trees. Also, south of the cabin is an open area amongst the aspen trees with a picnic table and a large fire pit. This social space is shared with the Rosetta Cabin (5GN6529), which is located just northwest of the Edgerton Cabin.

24. Associated buildings, features, or objects:

Outhouse (Feature 2), shed (Feature 3), and fence (Feature 4)

Outhouse (F2) – the outhouse is set southwest from the house. It measures 4'8" east/west x 5'8"north/south with a gable-front roof. Siding is all vertical dimensional lumber. The door is on the north elevation and is paneled wood with wood frame. The gable is open on the north elevation. The roof appears new, constructed of a dimensional lumber frame with shake shingles and a sheet metal strip covering the peak. Both the east and west elevations have a rectangular metal vent cut into the base of the wall. The south gable is screened. Rusty and new wire nails are present throughout. The outhouse sits on a stone foundation over the depression. The interior box and floor are plywood, and a plastic toilet seat has been added over the hole in the box. The interior siding is also plywood.

Shed (F3)– the shed is located south of the house. It has a shed roof, which is sagging, that is framed and covered in dimensional lumber. Plywood with asphalt roll remnants are visible atop the lumber. Siding is vertical dimensional lumber on the north and south elevations and board and batten on the east and west. A wood framed, paneled wood door is present in the north elevation toward the west end. A wood framed window is present east of the door – it is boarded over with plywood. The shed rests on a wood sill foundation. It is currently used for storage and measures 6'11.5" north/south x 10'9" east/west.

Fence (F4)– the fence more-or-less encloses the space between the cabin's south elevation and the shed, a kind of "backyard." It is built of hewn, saddle notched logs. The east stretch (running north/south) is four courses high and 15'3" long. The south stretch (running east/west) traverses in front of the shed and stops at the shed door. This piece is also four courses high and is 10' long. Another short stretch continues on the west side of the shed door and meets up with the west fence line; this short stretch is 4'6" long and only two courses with the top log heavily degraded. The west stretch (running north/south) is heavily degraded; it appears to have been two or three courses and was 10'5" long. There is an opening into the "backyard" between the north end of the west stretch of the fence and the south elevation of the cabin.

IV. ARCHITECTURAL HISTORY

25. Date of construction: Estimate: Ca. 1885 Actual: _____
    Source of information: Neal 2002:26, 193; Roger Neal, personal communication January 13, 2020
26 Architect: Likely Frank Edgerton
    Source of information: Neal 2002:26
27. Builder/contractor: Frank Edgerton
    Source of information: Neal 2002:26
28. Original owner: Frank and Rose Edgerton
    Source of information: Neal 2002:193
29. Construction history (including description and dates of major additions, alterations, or demolitions):
    An exact construction date for the Edgerton Cabin is not known, but it was likely originally constructed around 1885 as the Edgerton Family kept a journal of their lives in Crystal while *already* living in the cabin from 1886-1895 (Roger Neal, personal communication January 13, 2020). The roof, including all boards, rafters, and beams, was replaced sometime between 1980 and 1990 to protect the building from the elements (Christopher Cox, personal communication January 7, 2020).
30. Original location: ☒ Moved: ☐ Date of move: _____

V. HISTORICAL ASSOCIATIONS

31. Original use(s): Domestic- Single Dwelling
32. Intermediate use(s):
33. Current use(s): Domestic- Single Dwelling, Seasonal Dwelling
34. Site type(s): Rural cabin; now AirBnB seasonal rental
35. Historical background:
    The Edgerton Cabin was originally owned by Frank and Rose Edgerton. The Edgertons kept a daily journal of their experiences living in Crystal from 1886 through1895. Frank was a Civil War veteran, having been at the Battle of Shiloh, and he owned stock in several mines around Crystal. He served as an agent for mining companies with the authority to rent, lease, and/or sell mining properties (Neal 2002:193). Mr. Edgerton spent a great deal of time constructing his cabin (Neal 2002:26).

    In February of 1899, the *Silver Lance* reported that Bud Smith and Tom Parman had opened a "bachelor's hall" at the "Edgerton Residence" (Silver Lance 1899j).

    Today, the Edgerton Cabin is owned by Christopher Cox/Crystal Mountain Ranch and is utilized as a seasonal AirBnB rental for ranch guests.

    Crystal Townsite History
    Before the mining boom of the late 19th century, the Crystal Valley, located between Sheep Mountain, Little Bear Mountain, and Mineral Point, was occupied by the Ute Indians. The Utes were forcibly removed from

the area and placed on reservations by the federal government around 1879, and infiltration of the former Ute lands by prospecting miners was quick to follow. Euroamerican prospectors began arriving in the Crystal Valley predominantly by way of Crested Butte, Gothic, and Schofield in the late spring and early summer of 1880 (Neal 2002:7; Vandenbusche 1980:245,). Prospectors set up camp near the confluence of the north and south forks of the Crystal River where they located outcroppings of clear quartz crystals which became the settlement's namesake (Vandenbusche 1980:245).

Although lead, copper, zinc, and some gold were present in the quartz formations around Crystal, silver was the main ore attracting miners to the valley. The silver in the area was high in quantity, quality, and, of course, value (Neal 2002:9). The town of Crystal was officially incorporated on August 26, 1881 (Neal 2002:10). Crystal was granted a post office in 1882, with Albert A. Johnson leading that effort and being designated as the first postmaster (Neal 2002:15; Vandenbusche 1980:246).

Other nearby silver mining camps were established during the same time period as Crystal. Located south of Crystal toward Crested Butte was Schofield, the earliest iteration of which was present as early as 1873. Schofield, however, was already in its final decline by late 1883. By that time, most of its residents had moved on, many of them to Crystal (Vandenbusche 1980:249, 252). Several of the original structures in the Crystal mining camp were moved there from Schofield (Neal 2002:7). The Schofield post office was discontinued in 1885, and the town was emptied. A brief revival of Schofield took place in 1899, but it was abandoned for good by 1900 (Neal 2002:134; Vandenbusche 1980:252). Similarly, the once booming mining town of Gothic, located between Schofield and Crested Butte and which was incorporated in 1879, began its sharp decline soon after it had reached its peak in 1881. Like Schofield, by 1883, Gothic was more-or-less abandoned (Vandenbusche 1980:258). Another nearby mining camp included Snowmass City, founded in 1880 and located a mere mile north of Crystal. By 1881, Snowmass City was starting to grow, and in 1883, a road was blasted between Snowmass City and Crystal, connecting Snowmass City with the route over Schofield Pass and into Crested Butte. Snowmass City reached its peak in 1884 but could not overcome its access difficulties and competition from Crystal. It succumbed in 1886 (Vandenbusche 1980:249).

By 1881, there are said to have been 21 or 22 cabins present at Crystal (Neal 2002:8; Vandenbusche 1980:245, Neal 2002:8). Citing the Colorado State Business Directory, Neal relays that the population of Crystal was reported as 600 in 1883; 300 in 1884 and1885; 400 in 1886 and 1888; 200 in 1889; and 101 in 1900 (2002:8). By 1910, however, the Census lists Crystal's population as four (Neal 2002:8). Notably, the 1910 Census was taken mid-May, so the count of four may have represented only year-round residents; only hardy souls over-wintered in Crystal which was, and continues to be, notoriously snowed-in during the cold months of the year (Callihan 2017; Neal 2002:8)

In its heyday, Crystal had a newspaper, a post office, saloons, a stage line, two general stores, a pool hall, a hotel, a "gentleman's club" (5GN6527), a two-story town hall, an assayer and chemist, a livery, a barber shop, over seventy houses, and more (Neal 2002:12-13; Vandenbusche 1980:245). Twelve streetlights were present in Crystal: large metal kerosene lamps hung from poles that were lit at dusk and extinguished at 10:00 pm (Neal 2002:119). A telegraph line ran from Marble through Crystal and on to Crested Butte, and a telephone line was developed from Marble to Crystal in 1904 (Neal 2002:108). The residents of Crystal procured their water from ditches that ran through town on each side of the main road through town, fed by a natural spring located east of town (Neal 2002:10). A blacksmith shop, no longer extant, was located just west of town, opposite the Sheep Mountain Tunnel Mill/Crystal Mill (5GN1627) (Roger Neal, personal communication September 27, 2019).

Additionally, Crystal also had its own cemetery, located southwest of the town and the Sheep Mountain Tunnel Mill/Crystal Mill (5GN1627) along what is now Gunnison County Road 3. Numerous Crystal residents are interred at the now overgrown cemetery, which is located within an avalanche chute. As such, the cemetery has been subjected to countless avalanches which have pummeled the little graveyard over the years. Burials are obscured by vegetation and avalanche debris. Some wrought iron fencing is still visible along with a single, roughly made headstone- that of Judge Tom O'Bryan, a prominent resident of Crystal from its inception until his death in 1904 (Christopher Cox and Heather Leigh, personal communication September 25, 2019; Roger Neal, personal communication September 26-27, 2019; Neal 2002:23-24).

From the beginning, Albert A. Johnson was Crystal's "leading citizen" (Vandenbusche 1980:247). Johnson operated the general store (5GN6528) and a hotel; edited and printed the town's first newspaper, the *Crystal River Current*; and owned several mining properties including the famed Lead King for a time. Johnson was responsible for securing a post office for Crystal and, as mentioned above, served as the first postmaster (Vandenbusche 1980:247). In addition to his prominent role in development of the Crystal community,

Johnson became known regionally as a "legendary postman" who bravely and unfailingly carried mail between Crystal and Crested Butte on skis during the snowy months. His route, through the "feared Crystal Canyon," was extremely perilous due to the terrain and avalanche danger (Vandenbusche et al. 2008:55, 58). Al Johnson was regionally recognized as the "top snowshoer of the Rocky Mountains" for his speed and technique at completing his treacherous mail-carrying route in addition to winning many ski races across Colorado's western slope (Vandenbusche 1980:247, 423, 426-428).

Snowshoeing [skiing] was extremely popular, and necessary, in the broader Gunnison country around the turn of the century (Vandenbusche 1980:247). "Every man, woman, and child had to learn to ski if they wished to get anywhere in the winter in the early mining days" (Vandenbusche et al. 2008:75). Crystal was no exception in its love of skiing. The "Crystal Snowshoe Club" became "legendary in the rocky mountains" and featured the "famed" Al Johnson (Vandenbusche et al. 2008:120). In 1886, the Gunnison Country Snow-Shoe Club was formed with Al Johnson serving on the Executive Committee. The Club organized competitive races in Gunnison, Crested Butte, Irwin, Gothic, and Schofield in February and March of that year, all of which were met with great enthusiasm and support from the local communities (Vandenbusche 1980:426-428).

Since its inception, access to Crystal has been a challenge and a hindrance to the town's development. Until 1883, Crystal was extremely isolated from the rest of the region with only "jack" trails (the period term for mule trails) connecting the town with Crested Butte to the south and Carbondale to the north (Vandenbusche 1980:245). Along the route to Crested Butte, a toll road was completed between the mining settlements of Gothic and Schofield in 1881, and the old jack trail between Schofield and Crystal was finally also converted into a wagon road in 1883 (Neal 2002:11-12, Vandenbusche 1980:245). After the completion of the wagon road from Schofield, Crystal's population rose (Vandenbusche 1980:245-246). Still, the Crystal Canyon Road between Crystal and Schofield and beyond to Crested Butte was extremely dangerous and one of the "most treacherous in Colorado;" in winter, the canyon "vomited avalanches" (Vandenbusche et al. 2008:54).

Silver mines surrounding Crystal included the "Belle of Titusville, Catalpa, Eureka, Jack Whacker, Inez, Bear Mountain, and Daisy," with the most reputable mines in the area being "the Lead King, Black Queen, and Sheep Mountain Tunnel" (Vandenbusche 1980:245). The Sheep Mountain Tunnel is the mine that was most related to the iconic mill located on the Crystal River just west of town- the Sheep Mountain Tunnel Mill /Crystal Mill (5GN1627). The "Mill," which was actually a powerhouse, has become the most photographed site in Colorado, its only competition being the Maroon Bells near Aspen (Vandenbusche 1980:247, Vandenbusche et al. 2008:58). Built in 1892, the Mill contained a water wheel that generated the power to operate a compressor that in turn powered air drills at the Sheep Mountain Tunnel. The water power used to operate the system was created by damming the Crystal River at the entrance to the Sheep Mountain Tunnel, the confluence of the north and south forks of the river. The Mill eventually also provided power to the nearby Inez, Bear Mountain, and Black Queen mines. The presence of the Mill facilitated continued silver mining in the Crystal vicinity during the difficult years of the silver crash; "the community of Crystal owes much of its existence to this power generating facility" (Daily 1985).

Shipping ore from these mines was a constant struggle. The lack of a railroad line at Crystal meant that ore had to be hauled by wagon or jack train along the dangerous rockslide- and snowslide-prone canyon roads to the nearest railroad stations. Between 1886 and 1909, the residents of Crystal were promised several times that a railroad branch would reach the little town, alleviating their transport woes and providing the mines (and the town) a much needed boost with the ability to easily ship more ore, but the railroad never came (Vandenbusche 1980:245, 248).

Leading up to the Silver Panic of 1893, the declining price of silver resulted in a stark decrease in Crystal's population by 1892. Despite the presence of the advantageous Sheep Mountain Tunnel Mill/Crystal Mill (5GN1627), the town never fully recovered from the decline, with its population cut in half at that time. The *Crystal River Current* ceased operations in 1892, with the *Silver Lance* courageously appearing in 1893 to take its place. Crystal's population continued to dwindle, however, and the *Silver Lance* merged with the *Marble City Times* in 1899 (Vandenbusche 1980:245, 248). The Crystal post office closed in 1909 (Neal 2002:16).

Crystal was practically deserted by 1915. In 1916, a minor revitalization took place when the Black Queen, Lead King, and Sheep Mountain tunnels began operating and shipping ore once again. By 1917, however, the revival had already died, and the Sheep Mountain Tunnel closed for good, rendering Crystal a veritable ghost town (Vandenbusche 1980:248). Never-ending access difficulties coupled with the decline of the profitability of silver led to the town's final denouement (Neal 2002:138). Still, Crystal can be commemorated as a mountain mining town that persevered through staggering adversity during a time when its neighbors

had already folded, notably Gothic, Schofield, and Snowmass City (Vandenbusche 1980:249, 252). Indeed, "Crystal [is] perhaps the best example of a north country town which stood amidst too much adversity" (Vandenbusche 1980:249).

After the mining days ended, a few people continued to seasonally occupy the town. Emmet S. Gould arrived in Crystal from Aspen in 1938 in search of ore. He ended up buying several mining claims, the Sheep Mountain Tunnel Mill/Crystal Mill (5GN1627), and several lots and cabins. Emmet's descendents continue to have a presence in the area as the Crystal Mountain Ranch (Neal 2002:151-152). Several other families called Crystal a summer home during the mid-20th century (and still do today), keeping the sleepy town partially occupied in the summer months (Neal 2002:140-197, 251-253).

By the 1950s, outdoors excursions were being led by individuals residing seasonally in Crystal. Beginning in 1954, Richard "Dick" Car-Skaden guided tourists on hiking trips in the mountains, deeming his operation the Snowmass Wilderness Guide Service. Dick lived seasonally in the back of the Crystal Club (5GN6527), the building that housed the "gentleman's club" in the mining days, from the 1950s into the early 1970s. The Crystal Club also served as the base for his excursions (Neal 2002:141, 175-176). Also beginning in 1954, Theodore "Sarge" Jackson, who lived in various cabins during his time in Crystal, began taking tourists and hunters on guided horseback trips into the surrounding mountains. Eventually, he moved his base of operations up the pass south into Schofield (Neal 2002:142). Area artist John Toly also lived in the back of the Crystal Club seasonally during the 1970s (Neal 2002:176). The Colorado Outward Bound School, established in 1962, created a base camp in the area for teaching life skills through outdoor activities. The school's students have performed service days in Crystal which consist of general maintenance tasks around town (Neal 2002:152-154).

Today, seasonal tourist visitation to Crystal has skyrocketed. People making the trek between Marble and Crested Butte over the infamous Schofield Pass and through Crystal Canyon, in capable 4x4 or other off-highway vehicles, pass through the once booming town. Visitation numbers to the famous Sheep Mountain Tunnel Mill /Crystal Mill (5GN1627) have increased exponentially in recent years to as many as 300 vehicles per day (Heather Leigh, personal communication September 25, 2019). The Mill and most of the townsite is owned by the Crystal Mountain Ranch. The Ranch manages public access to the iconic Mill, again, the most photographed location in all of Colorado, allowing tourists to walk down to the river bank opposite the building for a small fee. Five of the historic cabins belonging to the Crystal Mountain Ranch are available for rent seasonally to tourists. The Ranch also offers a designated camping area and a gift shop in the original A.A. Johnson General Store (5GN6528). Other cabins in the town are owned by private individuals and are used as seasonal homes; Crystal has no year-round occupants.

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2019d Public records for 3881 Forest Service Road 314 , Crystal Townsite Vicinity. Electronic document, https://www.gunnisoncounty.org/327/Property-Record-Search, accessed December 2, 2019.

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1980 *The Gunnison Country*. B & B Printers, Gunnison, Colorado.

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VI. SIGNIFICANCE

37. Local landmark designation: Yes ☐ No ☒ Date of designation: n/a

Designating authority: n/a

38. Applicable National Register Criteria: (reflective of full townsite)

- ☒ A. Associated with events that have made a significant contribution to the broad pattern of our history;
- ☐ B. Associated with the lives of persons significant in our past;
- ☒ C. Embodies the distinctive characteristics of a type, period, or method of construction, or represents the work of a master, or that possess high artistic values, or represents a significant and distinguishable entity whose components may lack individual distinction; or
- ☒ D. Has yielded, or may be likely to yield, information important in history or prehistory.
- ☐ Qualifies under Criteria Considerations A through G (see Manual)
- ☐ Does not meet any of the above National Register criteria

39. Area(s) of significance: Exploration/Settlement; Industry-mining

40. Period of significance: Ca. 1885-1917

41. Level of significance: National ☐ State ☒ Local ☒

42. Statement of significance:

5GN6530, the Edgerton Cabin, meets the requirements of NRHP Criteria A, C, and D in the areas of Exploration/Settlement and Industry-Mining.

Regarding **Criterion A**, the Edgerton Cabin is an element of the late 19th/early 20th century regionally noteworthy mining town of Crystal (5GN1332), the development of which was a part of and directly associated with the historically significant mining boom of that time period in Colorado. Having been built ca. 1885 and utilized as a residence thereafter, the Edgerton Cabin clearly falls within the full Crystal Townsite's suggested period of significance of 1880-1917.

Regarding **Criterion C**, as a Pioneer Log building (History Colorado 2008), the Edgerton Cabin embodies

distinctive characteristics of a type, period, and method of construction. Initially chosen as an expedient and durable form of shelter (especially in the forested mountain areas of the state), Pioneer Log buildings have become an iconic part of Colorado's built heritage. The Edgerton Cabin is in good condition, retains integrity, and stands as a strong representative example of this property type. Like other buildings at the Crystal Townsite, it has a distinct form marked by the entry on the gable end—a trait that evolved in the West as a unique response to snow accumulation in the Rocky Mountains (Bomberger 1991). This particular example strongly illustrates a common vernacular approach to log construction, using hand-hewn logs and square-notching, with wood shingles in the framed upper half story.

Regarding **Criterion D**, passing observations of surface-exposed cultural material and earthen depressions in addition to the presence of at least one extant outhouse near the Edgerton Cabin suggest archaeological potential associated with the building. The extant outhouse and other likely previous privy locations, at a minimum, could yield information significant to our understanding of the site, the full town, and the larger area, beyond that already available in written or oral documentation.

Archival research did not reveal that the Edgerton Cabin was associated with any specific significant persons in history, therefore it is not recommended as eligible under Criterion B.

While some modern repairs/replacements have been made to the Edgerton Cabin, particularly the interior and the roof, the building overall retains a majority of its original materials and construction. Alterations made to the building have not overwhelmed its original design. Furthermore, beyond retaining physical integrity, the building also retains intangible integrity (see Item 43 below). In sum, the building continues to convey its relationship with the areas of significance and can be recommended as eligible to the NRHP under Criteria A, C, and D.

43. Assessment of historic physical integrity related to significance:

Regarding the aspects of integrity, the Edgerton Cabin retains location as it remains in its original location. Although suffering from some deterioration and having had some modern improvements made, especially to the interior and the roof, overall, the aspects of materials, workmanship, and design are retained as much of the original materials, methods of construction, and layout of the structure can still be discerned. Association is retained as the cabin is an early element of the historically significant mining town of Crystal, with its date of construction, between 1886-1895, falling within the town's suggested period of significance. Setting and feeling are retained as little has changed in the surrounding landscape to alter the environment from what it would have been during the period of significance, with the exception of some modern tourist traffic through town.

VII. NATIONAL REGISTER ELIGIBILITY ASSESSMENT

44. National Register eligibility field assessment:

Eligible ☒ Not Eligible ☐ Needs Data ☐

45. Is there National Register district potential? Yes ☒ No ☐

Given the historical continuity and good condition of the extant buildings, the full Crystal Townsite (5GN1332) holds the potential to be considered eligible for inclusion on the NRHP as a District under Criteria A, B, C, and D for a suggested period of significance of 1880-1917. Crystal fulfills the requirements of **Criterion A**, association with significant events, as the town is inextricably associated with the historically significant late 19th/early 20th century mining boom in Colorado, having been developed, incorporated, and occupied as a direct result of that momentous event in Colorado history.

Discuss:

The town fulfills the requirements of **Criterion B** for its association with prominent figure Albert A. Johnson, a Crystal resident who was a "legendary" figure in the Gunnison country during the late 19th century (Professor Duane Vandenbusche, personal communication March 25, 2020). He is significant for his role in helping the town of Crystal develop and thrive between 1881 and 1893 and in popularizing recreational skiing in the region prior to the turn of the century. Born near Montreal in the Laurentain mountain area of Canada in 1851, Al Johnson came to Crystal in 1880 as a silver prospector with his brother Fred (Callihan 2017; Vandenbusche et al. 2008:58). Rather than working directly in mining operations, Al Johnson decided to supply miners with essential goods and opened the "A.A. Johnson General Store" (5GN6528) in Crystal in 1881. Over the years, in addition to the general store, he operated a hotel in Crystal and owned several nearby mining properties, including the famed and lucrative Lead King for a time (Vandenbusche 1980:247).

Johnson has been called Crystal's "leading citizen" for his contributions between 1881 and his death in 1893 (Vandenbusche 1980:247). As a "merchant, miner, post master, mail carrier, man and maid of all work, and boss of good fellows generally" (Gunnison Review Press 1886a), he was "widely respected for his business acumen and outgoing personality" within Crystal and beyond (Callihan 2020). He initiated and perpetuated the town's growth by, first, opening and operating the general store, and, second, by securing the postal contract for Crystal in 1882. Notably, merchandise provided in Johnson's general store allowed stalwart Crystal locals to remain in town year-round. The town of Crystal was, and continues to be, snowbound every winter, with no easy access to supplies. By keeping his store well-stocked, Johnson provided a continuous and reliable inventory to the hardy folks who over-wintered in Crystal, offering products necessary for personal use but also for continuing nearby mining work through the challenging winter months (Callihan 2017; Neal 2002:14).

Importantly, Johnson also housed the Crystal Post Office at his general store, reliably carried the mail between Crystal and Crested Butte on a year-round basis, and served as the town's postmaster until his death in 1893 (Neal 2002:15-16; Vandenbusche 1980:247). In 1885, Johnson was recommended as a potential Gunnison County Commissioner to represent the Crystal area by virtue of his efforts as a "faithful worker for that section of the country…[for while working] for himself he [worked] for others by his pen and otherwise in order to promote the interest of that rich mining region" (Gunnison Review Press 1885). In 1886, Johnson launched Crystal's first newspaper, the *Crystal River Current,* which he edited and published through 1892 in a building (no longer extant) behind his store (Neal 2002:195; Vandenbusche 1980:245). In 1890, Johnson served as Crystal City Council Clerk (Neal 2002:15). That same year, Johnson married Kate Usher, sister of prominent Crystal resident Jim Usher. A baby girl, Crystal Rose, was born to the Johnsons on May 1, 1891 but died on October 29, 1891 (Callihan 2017). By that time, Al Johnson was suffering from a bad cough that was likely due to tuberculosis. In an effort to combat his illness, Johnson spent the winters of at least 1891 through 1893 in Arizona, returning to Crystal during the summers to run his store and the post office, but he died in Phoenix on January 19, 1893, at the age of 42 (Callihan 2017).

Beyond his pivotal role in building and supporting the local Crystal community, Johnson is remembered regionally for his impressive "snowshoeing," the period term for skiing, and for expanding Gunnison country ski culture. Skiing was extremely popular, and vital, in the broader Gunnison country in the late 19th and early 20th centuries (Vandenbusche 1980:247). "Every man, woman, and child had to learn to ski if they wished to get anywhere in the winter in the early mining days" (Vandenbusche et al. 2008:75). Ski groups flourished throughout the area at various mining camps, and the town of Crystal was no exception in its love of (and need for) skiing. The Crystal Snowshoe [ski] Club became "legendary in the rocky mountains" and featured the "famed" Al Johnson (Vandenbusche et al. 2008:120).

Johnson primarily gained skiing notoriety as one of the few in the Gunnison country who unfailingly carried mail on skis across high elevation, extremely dangerous, snow-covered terrain. Johnson became known regionally as a "legendary postman" who bravely and dependably executed his "anointed task" of carrying mail between Crystal and Crested Butte on what became known as the "Snowshoe Express" (Vandenbusche 1980:247, 423; Vandenbusche et al. 2008:55). His route, which included a stretch through the "feared Crystal Canyon," was extremely perilous, likely the most perilous in the region, due to the terrain and avalanche danger in snowy conditions (Vandenbusche 1980:78; Vandenbusche et al. 2008:58). Johnson became recognized as the "top snowshoer [skier] of the Rocky Mountains" for his speed and technique in completing this treacherous, avalanche-prone mail-carrying route (Vandenbusche 1980:423). Weekly, Johnson donned 11-foot wooden skis to travel the 18 miles from Crystal to Crested Butte, traversing the dreaded Crystal Canyon, with as much as 40 pounds of mail on his back each way (Callihan 2020). Adding to his acclaim, an avalanche one January night in 1886 hit the mining camp at Schofield, located at the top of Crystal Canyon. Upon hearing the news, Johnson skied up the canyon during the continuing blizzard in total darkness to aid the devastated camp. Johnson is noted to have dug victims out of the snow-slide and led people to safety amidst the storm that dumped six feet of snow at Schofield and four feet at Crystal. Following the rescue, he continued on to Crested Butte to deliver news of the avalanche and assembled a rescue party to return to Schofield to carry on with the recovery (Callihan 2020; Gunnison Review Press 1886b).

Beyond his courageous mail delivery on skis, Johnson's fame was bolstered by numerous ski

race victories across Colorado's western slope (Vandenbusche 1980:247, 423, 426-428). His fame helped popularize skiing as recreation in Colorado. In 1886, he fostered the extensive ski culture of the region by serving on the Executive Committee of the newly formed Gunnison Country Snow-Shoe (ski) Club, developed to encourage competitive regional ski racing and winter sports, and he was vice-president of the club the following year (Gunnison Review Press 1887) . At Johnson's suggestion and primarily through his efforts, the Club organized wildly popular races in the towns of Gunnison, Crested Butte, Irwin, Gothic, and Schofield during February and March of 1886 (Vandenbusche 1980:426-428). Inspired by similar "snowshoe carnivals" he had experienced back home near Montreal, Johnson led the organization of the races in Crested Butte, Gunnison, Irwin, and Gothic that would cumulatively become known as the "Great Race of 1886" (Callihan 2020). Those four races were met with great enthusiasm and support from the local communities, with excited spectators gathering along the race routes to cheer on contestants from their respective mining camps. An estimated 1,000 people gathered to watch the Crested Butte race, for which a special Denver and Rio Grande Excursion train was chartered (Callihan 2020; Vandenbusche 1980:426-428). The Great Race of 1886, conceived and implemented by Al Johnson, introduced competitive ski racing to the Gunnison country (Vandenbusche 1980:428-429).

Al Johnson was described as "without a doubt, the most graceful snowshoer the Rocky Mountains [had] ever produced…a daring adventurer on shoes [skis]" (Vandenbusche 1980:427). In 1974, the telemark ski community in Crested Butte began the Al Johnson Memorial Uphill/Downhill Telemark Race. The race, honoring Al Johnson, his exceptional skiing abilities, and his devoted public service as a mail carrier through unthinkably hostile weather and terrain, continues to be held annually at Crested Butte Mountain Resort. As a further tribute, "Let 'em Run!: Al Johnson and the Great Races of 1886," a play by Michael Callihan documenting aspects of Johnson's remarkable life, has been produced in Gunnison and Crested Butte annually since 2017, playing to sold out crowds (Michael Callihan, personal communication March 29, 2020).

The townsite fulfills the requirements of **Criterion C** as its buildings retain sufficient integrity to cumulatively convey the historic built character of a late 19th/early 20th century Colorado mountain mining community. Characteristics of the extant buildings, primarily of the dominant Pioneer Log style, reflect vernacular approaches to building and reveal methods, techniques, and materials known and available to the occupants of Crystal at the time of their construction. The Pioneer Log buildings, primarily consisting of common notched log construction with various chinking materials and gabled roofs, represent residences, a commercial building, a social building, and a barn, all of which had important, individualized roles in community life, reflecting the day-today on goings in an isolated mountain mining town. Additionally, the previously recorded and SRHP-listed Tays/Anderson House (5GN2432), a wood frame Victorian building believed to have been a kit home, provides a contrast to the dominant vernacular building methods, exemplifying more formalized building techniques and imported wood building materials available to affluent members of the community (Anderson 1995). Also of particular note among the buildings in the town is the newly recorded Schoolhouse (5GN6532), which is an excellent and well-preserved example of a rural one-room schoolhouse—an increasingly rare property type in the region. Along with its extant ancillary building, the Schoolhouse has a very recognizable design and construction materials that meet specific eligibility criteria laid out in the NRHP Multiple Property Documentation Form for Rural School Buildings in Colorado, including being a single-story with a front gabled roof, having typical fenestration, and being built with wood framing and shiplap siding (Doggett and Wilson 1999).

Finally, the town fulfills the requirements of **Criterion D**, potential to yield information important in history, due to its archaeological promise. Passing observations during the 2019 architectural inventory of surface-exposed cultural material; artifacts partially buried around building foundations, present inside buildings, and fallen through floors; numerous abandoned privy pits; and the presence of many standing outhouses across the entire townsite suggest that Crystal possesses great archaeological potential; archaeological investigations, both surface survey and subsurface testing, are highly likely to yield further information not already available in written or oral documentation that could significantly contribute to our understanding of the history of the site and the region.

Beyond the townsite itself (5GN1332), a District boundary could be expanded to incorporate other contemporaneous and related features, including the previously recorded and NRHP-listed Sheep Mountain Tunnel Mill/Crystal Mill (5GN1627), the still unrecorded Crystal Cemetery, the unrecorded spring and ditch water supply system, and nearby mine-related features, if found to be extant at a later date.

The Edgerton Cabin (5GN6530) Contribution to District Potential
As the Edgerton Cabin (5GN6530) is an element of and directly associated with the full townsite (5GN1332), and given that the Edgerton Cabin retains sufficient integrity to convey its association with the full townsite's suggested period of significance (1880-1917), it can be considered contributing toward District potential.

If there is National Register district potential, is this building: Contributing ☒ Non-contributing ☐

46. If the building is in existing National Register district, it: Contributing ☐ Non-contributing ☐

VIII. RECORDING INFORMATION

47. Photograph numbers: Roll 19-259, images 589-605
Roll 19-260, images 665-672, 747
Roll 19-261, images 131-134

Negatives filed at: Metcalf Archaeological Consultants, Inc. (digitally)

48. Report title: Architectural Inventory of the Crystal Townsite for the Gunnison County Historical Commission, Gunnison County, Colorado.

49. Date(s): 09/25/2019 – 09/27/2019

50. Recorder(s): Natasha E Krasnow and Kelly J Pool

51. Organization: Metcalf Archaeological Consultants, Inc.

52. Address: PO Box 899, Eagle, Colorado 81631

53. Phone number(s): 970-328-6244

NOTE: Please include a sketch map, a photocopy of the USGS quad map indicating resource location, and photographs.

History Colorado - Office of Archaeology & Historic Preservation
1200 Broadway, Denver, CO 80203 (303) 866-3395

5GN6530 – Edgerton Cabin. View of north elevation showing setting in aspen trees. View south. (Roll 19-259, image 589, 09/26/2019)

5GN6530 – Edgerton Cabin.
View of north elevation. View south. (Roll 19-259, image 590, 09/26/2019)

5GN6530 – Edgerton Cabin.
Oblique view of northwest corner. View southeast. (Roll 19-259, image 591, 09/26/2019)

5GN6530 – Edgerton Cabin.
View of west elevation. View east. (Roll 19-259, image 592, 09/26/2019)

5GN6530 – Edgerton Cabin.
Oblique view of southwest corner. View northeast. (Roll 19-259, image 593, 09/26/2019)

5GN6530 – Edgerton Cabin.
View of south elevation. View north. (Roll 19-259, image 595, 09/26/2019)

5GN6530 – Edgerton Cabin.
Oblique view of southeast corner. View northwest. (Roll 19-259, image 598, 09/26/2019)

5GN6530 – Edgerton Cabin.
View of east elevation. View west. (Roll 19-259, image 597, 09/26/2019)

5GN6530 – Edgerton Cabin.
Oblique view of northeast corner. View southwest. (Roll 19-259, image 599, 09/26/2019)

5GN6530 – Edgerton Cabin. Detail of notch in the log on the north elevation which is visible in an historic photo (Neal 2002:27). View south. (Roll 19-260, image 747, 09/27/2019)

5GN6530 – Edgerton Cabin.
Detail of log notching on southwest corner. View northeast. (Roll 19-259, image 594, 09/26/2019)

5GN6530 – Edgerton Cabin.
Detail of graffiti inside the front door west jamb (north elevation). View west.
(Roll 19-261, image 131, 09/27/2019)

5GN6530 – Edgerton Cabin.
Detail of decorative hinge on the front door (north elevation). View east.
(Roll 19-261, image 131a, 09/27/2019)

5GN6530 – Edgerton Cabin.
View of north elevation of the outhouse. View south. (Roll 19-259, image 600, 09/26/2019)

5GN6530 – Edgerton Cabin.
Oblique view of the northwest corner of the outhouse. View southeast.
(Roll 19-259, image 601, 09/26/2019)

5GN6530 – Edgerton Cabin.
Oblique view of the southeast corner of the outhouse. View northwest.
(Roll 19-259, image 602, 09/26/2019)

5GN6530 – Edgerton Cabin.
View of the north elevation of the shed. View south. (Roll 19-259, image 603, 09/26/2019)

5GN6530 – Edgerton Cabin. Oblique view of the northwest corner of the shed. View southeast.
(Roll 19-259, image 604, 09/26/2019)

5GN6530 – Edgerton Cabin. Oblique view of the southeast corner of the shed. View northwest. (Roll 19-259, image 605, 09/26/2019)

5GN6530 – Edgerton Cabin. View of the "backyard" showing the relationship of the east stretch of the log fence with the shed. View southeast. (Roll 19-261, image 132, 09/27/2019)

5GN6530 – Edgerton Cabin. View of the east stretch of log fence where it connects with the cabin. View east. (Roll 19-261, image 134, 09/27/2019)

5GN6530 – Edgerton Cabin.
View of the interior of the cabin. View south. (Roll 19-260, image 665, 09/27/2019)

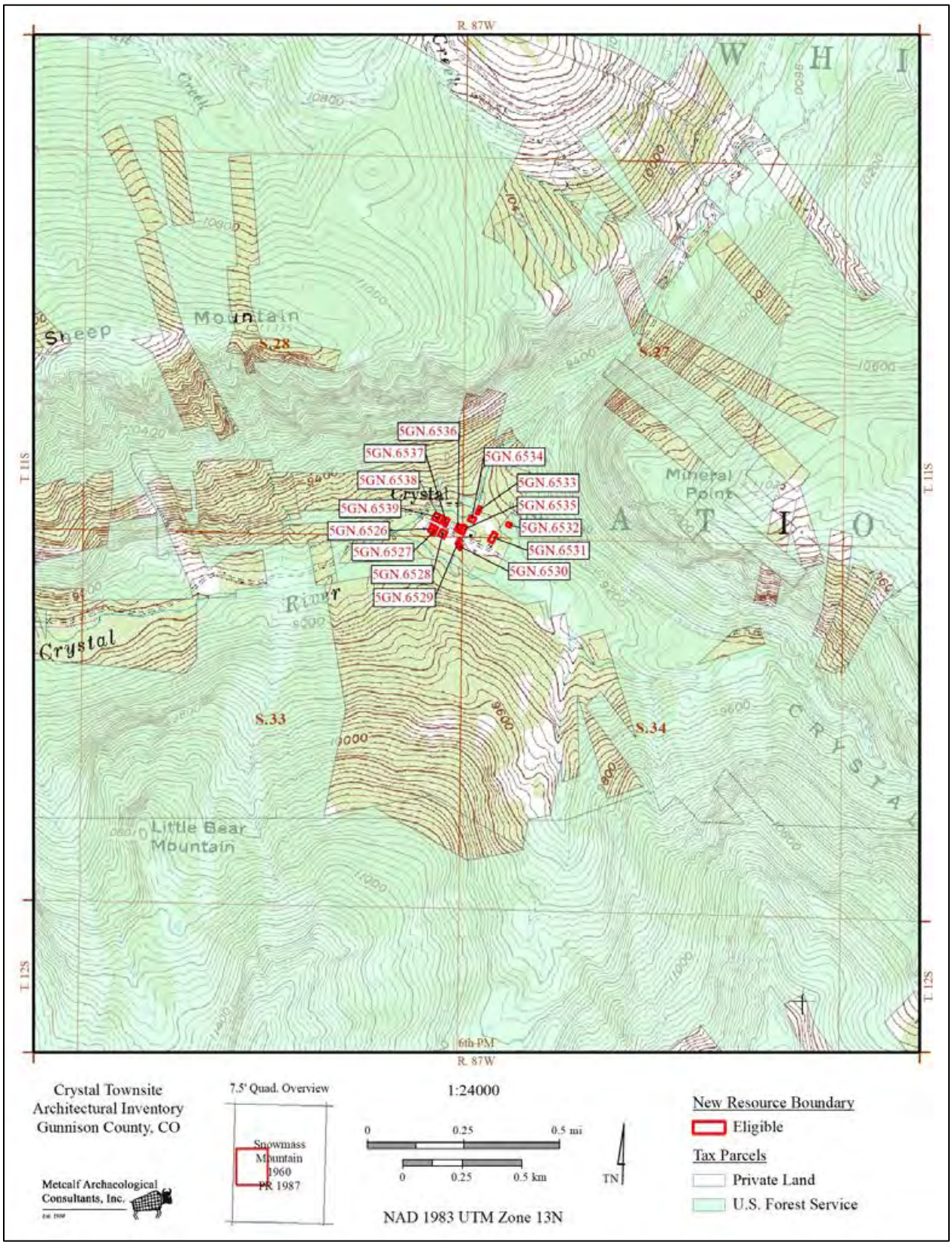
5GN6530 – Edgerton Cabin.
View of the interior of the cabin. View north-northeast. (Roll 19-260, image 669, 09/27/2019)

5GN6530 – Edgerton Cabin.
View of the interior of the cabin showing stovepipe and new roof. View northeast/up.
(Roll 19-260, image 670, 09/27/2019)

5GN6530 – Edgerton Cabin.
View of the interior of the cabin showing new roof. View south-southwest/up.
(Roll 19-260, image 672, 09/27/2019)

SITE SKETCH MAP

SITE LOCATION MAP



Gunnison County Register of Historic Landmarks Nomination Form

1. Address and Legal Description of Property.

3881 FSR 314

~~LOTS 8, BLOCK C OF JOHNSONS ADDITION TO THE TOWN OF CRYSTAL~~
ACCORDING TO THE PLAT
THEREOF RECORDED OCTOBER 5, 1892 AS RECEPTION NO. 063920.

2. Provide a boundary description, including all lots and blocks within the boundaries.

LOTS 8, BLOCK C OF JOHNSONS ADDITION TO THE TOWN OF CRYSTAL ACCORDING TO THE PLAT THEREOF RECORDED OCTOBER 5, 1892 AS RECEPTION NO. 063920.

3. Common name of Property Rosetta Cabin

SIGNIFICANCE (check appropriate categories and justify on next page)

Architectural significance:
- ◯ represents the work of important builder in our area
- ◯ possesses high artistic values
- ⊘ represents a significant type, period or method of construction

Historical significance:
- ◯ associated with significant persons
- ◯ associated with significant events or patterns
- ◯ contributes to an historic district

◯ Check here if this property is already registered on the State or National register and attach a copy of the nomination form for the state and/or National designation.

This landmark is being nominated for an Historic Landmark designation. I am the owner of the property described above, and hereby request placement of said property on the Gunnison County Register of Historic Properties. I have read Board of County Commissioners of Gunnison County Resolutions No. 93-32, 99-39, 05-28, and 05-35 as they may have been amended to date, (a copy of which is attached to this nomination form). I agree that if the nominated property is designated as a landmark, the property and I shall be subject to the provisions of Resolution 93-32, 99-39, 05-28, and 05-35, as they exist at the time of this nomination.

Treasure Mountain Ranch, Inc
Print Name of Property Owner(s)

PO Box 1508
Carbondale, CO 81623
Mailing Address

[signature]
Signature(s)

1/20/26
Date

901-240-5188
Telephone Number

[signature] 1-20-2026
Notary signature, date

(Seal)

DEBRA REDMOUNT
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 20174015023
MY COMMISSION EXPIRES 04/06/2029

County of Eagle

Nominating Person if other than Owner of Property:

Print Name

Mailing Address

Signature

Date

Telephone Number

NOMINATION JUSTIFICATION

Please state why the property should be listed on the Gunnison County Register of Historic Landmarks. Please address the areas of significance you have identified on the preceding page. Attach additional sheets if necessary.

Please see attached

Historic Building Nomination Form

Please provide the following information. If question is not applicable, write N/A.

1. Photographsof siteandbuildings. List # of Photos: 36 Please attach photos.
2. Other information? Please attach. ◯
3. Name of Builder/Architect _____
4. Describe architectural style and distinguishing features.
5. Date of Construction _____
6. Square footage _____ Number of stories _____
7. Building materials used:
8. Describe original and present uses:
9. Has the structure been moved from its original site? ____ If so, include information on where structure was moved from. Include date of relocation and reason for relocation.
10. Has the structure been altered? ____ If so, please describe. Include dates if possible.
11. Describe any associated buildings on the property.
12. Copies of research material used for nomination. Please attach. ◯
13. Attach a copy of the deed. Please attach. ◉
14. Provide a site plan with, at minimum, the following information:
    a) Dimensions of the site/lot
    b) Dimensions of the building(s) and setbacks from property fines
    c) Location(s) of other structures on the site.

    *Hand sketched or printed from County Mapping Website is acceptable.

Gunnison County Register of Historic Landmarks Nomination Form

1. Address and Legal Description of Property.

3881 FSR 314

~~LOTS 7&8, BLOCK D OF JOHNSONS ADDITION TO THE TOWN OF CRYSTAL~~ ACCORDING TO THE PLAT THEREOF RECORDED OCTOBER 5, 1892 AS RECEPTION NO. 063920.

2. Provide a boundary description, including all lots and blocks within the boundaries.

LOTS 7& 8, BLOCK D OF JOHNSONS ADDITION TO THE TOWN OF CRYSTAL ACCORDING TO THE PLAT THEREOF RECORDED OCTOBER 5, 1892 AS RECEPTION NO. 063920.

3. Common name of Property Melton Cabin

SIGNIFICANCE (check appropriate categories and justify on next page)

Architectural significance:

- ◯ represents the work of important builder in our area
- ◯ possesses high artistic values
- ⊘ represents a significant type, period or method of construction

Historical significance:

- ◯ associated with significant persons
- ◯ associated with significant events or patterns
- ◯ contributes to an historic district

◯ Check here if this property is already registered on the State or National register and attach a copy of the nomination form for the state and/or National designation.

This landmark is being nominated for an Historic Landmark designation. I am the owner of the property described above, and hereby request placement of said property on the Gunnison County Register of Historic Properties. I have read Board of County Commissioners of Gunnison County Resolutions No. 93-32, 99-39, 05-28, and 05-35 as they may have been amended to date, (a copy of which is attached to this nomination form). I agree that if the nominated property is designated as a landmark, the property and I shall be subject to the provisions of Resolution 93-32, 99-39, 05-28, and 05-35, as they exist at the time of this nomination.

Treasure Mountain Ranch, Inc
Print Name of Property Owner(s)

PO Box 1508
Carbondale, CO 81623
Mailing Address

Signature(s) 1/20/26 Date

901-290-5188
Telephone Number

Notary signature, date 1-20-2026

(Seal)

DEBRA REDMOUNT
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 20174015023
MY COMMISSION EXPIRES 04/06/2029

County of Eagle

Nominating Person if other than Owner of Property:

Print Name

Mailing Address

Signature Date

Telephone Number

NOMINATION JUSTIFICATION

Please state why the property should be listed on the Gunnison County Register of Historic Landmarks. Please address the areas of significance you have identified on the preceding page. Attach additional sheets if necessary.

Please see attached

Historic Building Nomination Form

Please provide the following information. If question is not applicable, write N/A.

1. Photographsof siteandbuildings. List # of Photos: 36 Please attach photos.
2. Other information? Please attach. ◯
3. Name of Builder/Architect _____
4. Describe architectural style and distinguishing features.
5. Date of Construction _____
6. Square footage _____ Number of stories _____
7. Building materials used:
8. Describe original and present uses:
9. Has the structure been moved from its original site? ____ If so, include information on where structure was moved from. Include date of relocation and reason for relocation.
10. Has the structure been altered? ____ If so, please describe. Include dates if possible.
11. Describe any associated buildings on the property.
12. Copies of research material used for nomination. Please attach. ◯
13. Attach a copy of the deed. Please attach. ◉
14. Provide a site plan with, at minimum, the following information:
    a) Dimensions of the site/lot
    b) Dimensions of the building(s) and setbacks from property fines
    c) Location(s) of other structures on the site.

    *Hand sketched or printed from County Mapping Website is acceptable.

Gunnison County Register of Historic Landmarks Nomination Form

1. Address and Legal Description of Property.

3881 FSR 314
~~LOTS 1&2, BLOCK 1 OF~~
EATONS ADDITION TO THE TOWN OF CRYSTAL ACCORDING TO THE PLAT THEREOF RECORDED OCTOBER 5, 1892 AS RECEPTION NO. 064410.

2. Provide a boundary description, including all lots and blocks within the boundaries.

LOTS 1&2, BLOCK 1 OF EATONS ADDITION TO THE TOWN OF CRYSTAL ACCORDING TO THE PLAT THEREOF RECORDED OCTOBER 5, 1892 AS RECEPTION NO. 064410

3. Common name of Property Crystal Club

SIGNIFICANCE (check appropriate categories and justify on next page)

Architectural significance:
- ◯ represents the work of important builder in our area
- ◯ possesses high artistic values
- ⊘ represents a significant type, period or method of construction

Historical significance:
- ◯ associated with significant persons
- ◯ associated with significant events or patterns
- ◯ contributes to an historic district

◯ Check here if this property is already registered on the State or National register and attach a copy of the nomination form for the state and/or National designation.

This landmark is being nominated for an Historic Landmark designation. I am the owner of the property described above, and hereby request placement of said property on the Gunnison County Register of Historic Properties. I have read Board of County Commissioners of Gunnison County Resolutions No. 93-32, 99-39, 05-28, and 05-35 as they may have been amended to date, (a copy of which is attached to this nomination form). I agree that if the nominated property is designated as a landmark, the property and I shall be subject to the provisions of Resolution 93-32, 99-39, 05-28, and 05-35, as they exist at the time of this nomination.

Treasure Mountain Ranch, Inc
Print Name of Property Owner(s)

PO Box 1508
Carbondale, CO 81623
Mailing Address

SLC
Signature(s)

1/20/26
Date

901-240-5188
Telephone Number

[signature]
Notary signature, 1-20-2026

(Seal)

DEBRA REDMOUNT
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 20174015023
MY COMMISSION EXPIRES 04/06/2029

County of Eagle

Nominating Person if other than Owner of Property:

Print Name

Mailing Address

Signature

Date

Telephone Number

NOMINATION JUSTIFICATION

Please state why the property should be listed on the Gunnison County Register of Historic Landmarks. Please address the areas of significance you have identified on the preceding page. Attach additional sheets if necessary.

Please see attached

Historic Building Nomination Form

Please provide the following information. If question is not applicable, write N/A.

1. Photographsof siteandbuildings. List # of Photos: 36 Please attach photos.

2. Other information? Please attach. ◯

3. Name of Builder/Architect _____

4. Describe architectural style and distinguishing features.

5. Date of Construction _____

6. Square footage _____ Number of stories _____

7. Building materials used:

8. Describe original and present uses:

9. Has the structure been moved from its original site? ____ If so, include information on where structure was moved from. Include date of relocation and reason for relocation.

10. Has the structure been altered? ____ If so, please describe. Include dates if possible.

11. Describe any associated buildings on the property.

12. Copies of research material used for nomination. Please attach. ◯

13. Attach a copy of the deed. Please attach. ◉

14. Provide a site plan with, at minimum, the following information:
    a) Dimensions of the site/lot
    b) Dimensions of the building(s) and setbacks from property fines
    c) Location(s) of other structures on the site.

    *Hand sketched or printed from County Mapping Website is acceptable.

Gunnison County Register of Historic Landmarks Nomination Form

1. Address and Legal Description of Property.

3881 FSR 314 HOME MS 7085

2. Provide a boundary description, including all lots and blocks within the boundaries.

Boundary of the Edgerton Cabin (5GN6530) is defined by the physical extent of the primary building and its associated building and features on its north, east, and south sides. In the northwest corner, the boundary is defined by a neighboring parcel. Today, the Edgerton Cabin is part of the greater, undivided ~400 Treasure Mountain Ranch/Crystal Mountain Ranch (Parcel # 2915-340-00-004) (Gunnison County Assessor 2019d).

3. Common name of Property EDGERTON CABIN

SIGNIFICANCE (check appropriate categories and justify on next page)

Architectural significance:

- ◯ represents the work of important builder in our area
- ◯ possesses high artistic values
- ⊘ represents a significant type, period or method of construction

Historical significance:

- ◯ associated with significant persons
- ◯ associated with significant events or patterns
- ◯ contributes to an historic district

◯ Check here if this property is already registered on the State or National register and attach a copy of the nomination form for the state and/or National designation.

This landmark is being nominated for an Historic Landmark designation. I am the owner of the property described above, and hereby request placement of said property on the Gunnison County Register of Historic Properties. I have read Board of County Commissioners of Gunnison County Resolutions No. 93-32, 99-39, 05-28, and 05-35 as they may have been amended to date, (a copy of which is attached to this nomination form). I agree that if the nominated property is designated as a landmark, the property and I shall be subject to the provisions of Resolution 93-32, 99-39, 05-28, and 05-35, as they exist at the time of this nomination.

Treasure Mountain Ranch, Inc
Print Name of Property Owner(s)

PO Box 1508
Carbondale, CO 81623
Mailing Address

SKG
Signature(s)

1/20/26
Date

901-240-5188
Telephone Number

Notary signature, date 1-20-2026

(Seal)

DEBRA REDMOUNT
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 20174015023
MY COMMISSION EXPIRES 04/06/2029

County of Eagle

Nominating Person if other than Owner of Property:

Print Name

Mailing Address

Signature

Date

Telephone Number

NOMINATION JUSTIFICATION

Please state why the property should be listed on the Gunnison County Register of Historic Landmarks. Please address the areas of significance you have identified on the preceding page. Attach additional sheets if necessary.

Please see attached

Historic Building Nomination Form

Please provide the following information. If question is not applicable, write N/A.

1. Photographsof siteandbuildings. List # of Photos: 36 Please attach photos.
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4. Describe architectural style and distinguishing features.
5. Date of Construction _____
6. Square footage _____ Number of stories _____
7. Building materials used:
8. Describe original and present uses:
9. Has the structure been moved from its original site? ____ If so, include information on where structure was moved from. Include date of relocation and reason for relocation.
10. Has the structure been altered? ____ If so, please describe. Include dates if possible.
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12. Copies of research material used for nomination. Please attach. ◯
13. Attach a copy of the deed. Please attach. ◉
14. Provide a site plan with, at minimum, the following information:
    a) Dimensions of the site/lot
    b) Dimensions of the building(s) and setbacks from property fines
    c) Location(s) of other structures on the site.

    *Hand sketched or printed from County Mapping Website is acceptable.

Gunnison County Register of Historic Landmarks Nomination Form

1. Address and Legal Description of Property.

3881 FSR 314

~~LOTS 1&2, BLOCK B OF JOHNSONS ADDITION TO THE TOWN OF CRYSTAL~~ ACCORDING TO THE PLAT THEREOF RECORDED OCTOBER 5, 1892 AS RECEPTION NO. 063920.

2. Provide a boundary description, including all lots and blocks within the boundaries.

LOTS 1&2, BLOCK B OF JOHNSONS ADDITION TO THE TOWN OF CRYSTAL ACCORDING TO THE PLAT THEREOF RECORDED OCTOBER 5, 1892 AS RECEPTION NO. 063920.

3. Common name of Property AA. Johnson General Store

SIGNIFICANCE (check appropriate categories and justify on next page)

Architectural significance:

- ◯ represents the work of important builder in our area
- ◯ possesses high artistic values
- ⊘ represents a significant type, period or method of construction

Historical significance:

- ◯ associated with significant persons
- ◯ associated with significant events or patterns
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Treasure Mountain Ranch, Inc
Print Name of Property Owner(s)

PO Box 1508
Carbondale, CO 81623
Mailing Address

[signature]
Signature(s)

1-20-26
Date

901-240-5188
Telephone Number

[signature], 1-20-2026
Notary signature, date

(Seal)

DEBRA REDMOUNT
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 20174015023
MY COMMISSION EXPIRES 04/06/2029

County of Eagle

Nominating Person if other than Owner of Property:

Print Name

Mailing Address

Signature

Date

Telephone Number

NOMINATION JUSTIFICATION

Please state why the property should be listed on the Gunnison County Register of Historic Landmarks. Please address the areas of significance you have identified on the preceding page. Attach additional sheets if necessary.

Please see attached

Historic Building Nomination Form

Please provide the following information. If question is not applicable, write N/A.

1. Photographsof siteandbuildings. List # of Photos: 36 Please attach photos.

2. Other information? Please attach. ◯

3. Name of Builder/Architect _____

4. Describe architectural style and distinguishing features.

5. Date of Construction _____

6. Square footage _____ Number of stories _____

7. Building materials used:

8. Describe original and present uses:

9. Has the structure been moved from its original site? ____ If so, include information on where structure was moved from. Include date of relocation and reason for relocation.

10. Has the structure been altered? ____ If so, please describe. Include dates if possible.

11. Describe any associated buildings on the property.

12. Copies of research material used for nomination. Please attach. ◯

13. Attach a copy of the deed. Please attach. ◉

14. Provide a site plan with, at minimum, the following information:
    a) Dimensions of the site/lot
    b) Dimensions of the building(s) and setbacks from property fines
    c) Location(s) of other structures on the site.

    *Hand sketched or printed from County Mapping Website is acceptable.

Gunnison County Register of Historic Landmarks Nomination Form

1. Address and Legal Description of Property.

3881 FSR 314
~~LOTS 4, BLOCK D OF~~
JOHNSONS ADDITION TO THE TOWN OF CRYSTAL ACCORDING TO THE PLAT THEREOF RECORDED OCTOBER 5, 1892 AS RECEPTION NO. 063920

2. Provide a boundary description, including all lots and blocks within the boundaries.

LOTS 4, BLOCK D OF JOHNSONS ADDITION TO THE TOWN OF CRYSTAL ACCORDING TO THE PLAT THEREOF RECORDED OCTOBER 5, 1892 AS RECEPTION NO. 063920

3. Common name of Property CLAYTON CABIN

SIGNIFICANCE (check appropriate categories and justify on next page)

Architectural significance:
- ◯ represents the work of important builder in our area
- ◯ possesses high artistic values
- ⊘ represents a significant type, period or method of construction

Historical significance:
- ◯ associated with significant persons
- ◯ associated with significant events or patterns
- ◯ contributes to an historic district

◯ Check here if this property is already registered on the State or National register and attach a copy of the nomination form for the state and/or National designation.

This landmark is being nominated for an Historic Landmark designation. I am the owner of the property described above, and hereby request placement of said property on the Gunnison County Register of Historic Properties. I have read Board of County Commissioners of Gunnison County Resolutions No. 93-32, 99-39, 05-28, and 05-35 as they may have been amended to date, (a copy of which is attached to this nomination form). I agree that if the nominated property is designated as a landmark, the property and I shall be subject to the provisions of Resolution 93-32, 99-39, 05-28, and 05-35, as they exist at the time of this nomination.

Treasure Mountain Ranch, Inc
Print Name of Property Owner(s)

PO Box 1508
Carbondale, CO 81623
Mailing Address

[signature] 1-20-26
Signature(s) Date

901-240-5188
Telephone Number

[signature], 1-20-2026
Notary signature, date

(Seal)

DEBRA REDMOUNT
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 20174015023
MY COMMISSION EXPIRES 04/06/2029

County of Eagle

Nominating Person if other than Owner of Property:

Print Name

Mailing Address

Signature Date

Telephone Number

NOMINATION JUSTIFICATION

Please state why the property should be listed on the Gunnison County Register of Historic Landmarks. Please address the areas of significance you have identified on the preceding page. Attach additional sheets if necessary.

Please see attached

Historic Building Nomination Form

Please provide the following information. If question is not applicable, write N/A.

1. Photographsof siteandbuildings. List # of Photos: 36 Please attach photos.

2. Other information? Please attach. ◯

3. Name of Builder/Architect _____

4. Describe architectural style and distinguishing features.

5. Date of Construction _____

6. Square footage _____ Number of stories _____

7. Building materials used:

8. Describe original and present uses:

9. Has the structure been moved from its original site? ____ If so, include information on where structure was moved from. Include date of relocation and reason for relocation.

10. Has the structure been altered? ____ If so, please describe. Include dates if possible.

11. Describe any associated buildings on the property.

12. Copies of research material used for nomination. Please attach. ◯

13. Attach a copy of the deed. Please attach. ◉

14. Provide a site plan with, at minimum, the following information:
    a) Dimensions of the site/lot
    b) Dimensions of the building(s) and setbacks from property fines
    c) Location(s) of other structures on the site.

    *Hand sketched or printed from County Mapping Website is acceptable.

Proof of Ownership: Deed

BOOK 490 PAGE 988

Recorded at 9:50 o'clock A M., December 19, 1975

Reception No. 309021 Marian L. Smith Recorder.

Helen G. Collins and Dorothy Tidwell

whose address is 6782 Cerritos Ave.

City of Long Beach and State of

California, for the consideration of Ten Dollars and

other valuable considerations ~~Dollars~~, in hand paid,

hereby sell(s) and quit claim(s) to Treasure Mountain Ranch, Inc., a Colorado corporation

whose address is Box 3098, City of Aspen

County of Pitkin, and State of Colorado, the following real property, in the County of Gunnison, and State of Colorado, to wit:

as set forth in Schedule A, attached hereto and made a part hereof.

STATE DOCUMENTARY FEE
DATE 12-19-75
$ 4.80

TO 447 CA (4-73)
(Individual)

TITLE INSURANCE AND TRUST
A TICOR COMPANY

STAPLE HERE

STATE OF CALIFORNIA
COUNTY OF Los Angeles } SS.

On December 1, 1975 before me, the undersigned, a Notary Public in and for said State, personally appeared Dorothy Tidwell

known to me to be the person whose name subscribed to the within instrument and acknowledged that she executed the same.

WITNESS my hand and official seal.

Signature Carol E. Devine

Carol E. Devine
Name (Typed or Printed)

OFFICIAL SEAL
CAROL E. DEVINE
NOTARY PUBLIC - CALIFORNIA
PRINCIPAL OFFICE IN
LOS ANGELES COUNTY
My Commission Expires May 6, 1978

(This area for official notarial seal)

with all its appurtenances

Signed this 1st day of December, 19 75.

Helen G. Collins
Helen G. Collins

Dorothy Tidwell
Dorothy Tidwell

Montana
~~CALIFORNIA~~
STATE OF ~~COLORADO~~,
County of Gallatin } ss.

The foregoing instrument was acknowledged before me this 9th day of Dec., 19 75, by Helen G. Collins and ~~Dorothy~~ Tidwell.

My commission expires Feb. 26, 1977
Witness my hand and official seal

Laurette E. Keig
Notary Public.

Statutory Acknowledgment.—If by natural person or persons here insert name or names; if by person acting in representative or official capacity or as attorney-in-fact, then insert name of person as executor, attorney-in-fact or other capacity or description; if by officer of corporation, then insert name of such officer or officers, as the president or other officers of such corporation, naming it.

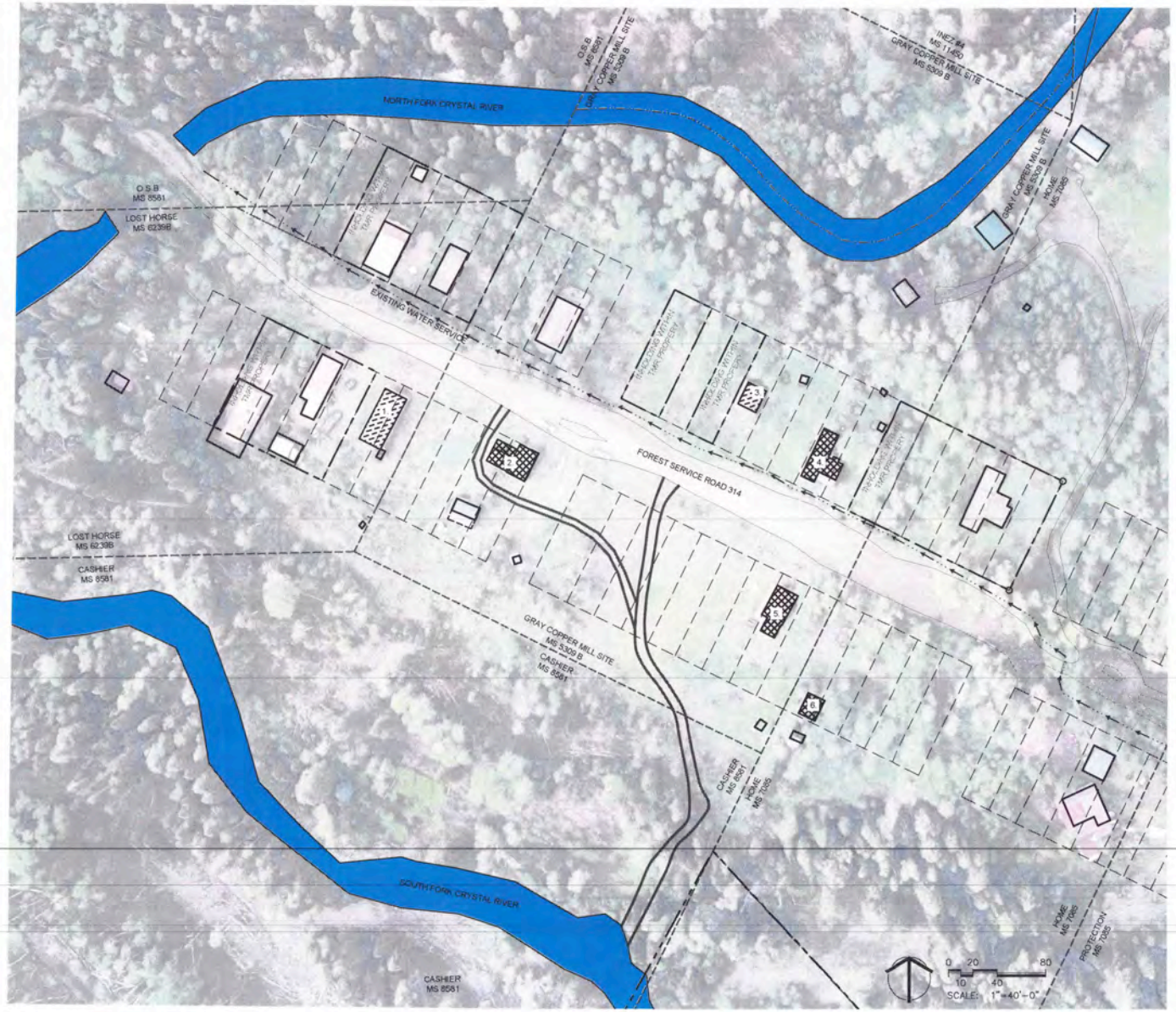
No. 898. QUIT CLAIM DEED—Short form—Sec. 118-1-13 as amended 1961. —11-74
—Bradford Publishing Co., 1824-46 Stout Street, Denver, Colorado

SCHEDULE A

Lot 1, Block A, Crystal townsite
Lots 1,2,3 and 4, Block B, Crystal townsite
Lots 1,2,3,4,5,6,7,8 and 9, Block C, Crystal townsite
Lots 1,2,4,5,6,7 and 8, Block D, Crystal townsite
Lots 7 and 8, Eaton's Addition, Block 1, Crystal townsite
Lots 1,3,4 and 5, Lost Horse Mill Site

The following Mill Sites in the Rock Creek Mining District:		
Mammoth Mill Site(surface rights only)	USMS	4186 B
Cleopatra Mill Site (surface rights only)	USMS	4187 B
Gray Copper Mill Site(surface rights only)	USMS	5309 B
Crystal Mill Site(surface rights only)	USMS	5708 B
F.G. Richardson Mill SiteUSMS	5710 B	
McVey Placer	USMS	15072
The following Lode Claims in the Rock Creek Mining District:		
Aspen	USMS	8633
Aspen No. 1	USMS	8633
Riverside	USMS	8633
Riverside No. 1	USMS	8633
Cashier(surface rights only)	USMS	8581
Old Solitary(surface rights only)	USMS	12808
Home	USMS	7086
Protection	USMS	7086
J. T. Johnson(surface rights only)	USMS	7655
Bear Mountain 1 to 26, inclusive (surface rights only)	USMS	13621
1/3 interest Lucky Boy	USMS	2858
Gray Copper	USMS	5309A
Fargo	USMS	5538
O.S.B.	USMS	8581
Lost Horse	USMS	6239A
Bullion Queen	USMS	12098
Crystal City	USMS	8581
Crystal City No. 2	USMS	8581
Crystal City No. 3	USMS	8581
Michigan	USMS	6239
Atlanta	USMS	7863
Spar	USMS	7863
Clark No. 3	USMS	3136
International	USMS	12098
New York	USMS	16366
Graham	USMS	16366
Black Queen	USMS	5783
Carlisle	USMS	2671A
Inez 1,2,3 and 4	USMS	11450

6-104: G.2. | Historic Cabin Exhibit



TMR STRUCTURES TO BE NOMINATED TO THE GUNNISON REGISTER OF HISTORIC PLACES:

1. Crystal Club Cabin, 1840 sqft (for use)

2. General Store, 1450 sqft (to retire from use)

3. Clayton Cabin, 570 sqft (for use)

4. Melton Cabin, 1099 sqft (to retire from use)

5. Rosetta Cabin, 1050 sqft (to retire from use)

6. Edgerton Cabin, 285 sqft (to retire from use)

BOUNDARY LINES

MINING CLAIM

PROPERTY BOUNDARY

CABIN TYPES

EXISTING STRUCTURES

HISTORIC TMR CABINS FOR CONTINUED USE

HISTORIC TMR CABINS TO BE RETIRED FROM USE

AGENDA ITEM or FINAL CONTRACT REVIEW SUBMITTAL FORM

Agenda Item: Public Hearing; Wildfire Code and Land Use Resolut

Action Requested: Board of County Commissioners' Signature

Parties to the Agreement:

Term Begins: **Term Ends:** **Grant Contract #:**

Summary:

Proposed wildfire code updates, as required by the State of Colorado, and associated amendments to the LUR

Fiscal Impact: $0

Submitted by: Crystal Lambert **Submitter's Email Address:** clambert@gunnisoncounty.org

Finance Review: ○ Required ◉ Not Required

Comments:

Reviewed by: Discharge Date:

County Attorney Review: ◉ Required ○ Not Required

Comments:
Legally sufficient. SO 2/24/26

Reveiwed by: GUNCOUNTY1\sobaid Discharge Date: 2/24/2026 Certificate of Insurance Required

Yes ○ No ◉

County Manager Review:

Comments:

Reveiwed by: GUNCOUNTY1\mbirnie Discharge Date: 2/25/2026

○ Consent Agenda ◉ Regular Agenda ○ Worksession Time Allotted: 60

Agenda Date: 3/3/2026

Revised April 2015

GUNNISON COUNTY
COMMUNITY & ECONOMIC DEVELOPMENT

Gunnison County Community & Economic Development Department
Phone: (970) 641-0360
Email: planning@gunnisoncounty.org
Website: www.GunnisonCounty.org

From: Crystal Lambert, Building and Environmental Health Official

To: Board of County Commissioners

Date: February 23, 2026

Re: Proposed adoption of updated wildfire code and map

Purpose

The State of Colorado adopted the Colorado Wildfire Resiliency Code ("CWRC:) on July 1, 2025 and jurisdictions have until April 1, 2026 to adopt a code for wildfire resilience that is no less stringent than the State CWRC.

The County's current wildfire code is the International Wildland Urban Interface Code ("IWUIC"), 2021 edition, which was implemented on January 1, 2023 and amended on November 7, 2023. There are some areas where the new State code is more stringent than the County's current wildfire code and adjustments will be necessary to meet the State's minimum code. There are also areas where the County's current wildfire code is more stringent or different than the State's new code, creating an opportunity to evaluate which provisions remain appropriate for Gunnison County.

Representatives from the local building construction industry, including building contracting, development and design, landscape architecture, and materials supply, along with fire districts, and West Region Wildfire Council were invited to participate in a stakeholder engagement group to discuss the new State Wildfire Resiliency Code and the County's current wildfire code to identify which items would be appropriate to retain from our current code and help decide recommended modifications to the State minimum code for Gunnison County.

Background

Wildfire in Colorado is becoming more frequent and growing in intensity and devastation. Twenty of the twenty largest wildfires in state history have occurred in the 21st century (since 2001) and four of the top five largest wildfires in state history have occurred in the last five years (2020 and 2025). Additionally, the top five fires that have destroyed the most homes have occurred in the last 13 years, since 2012.

Wildfire impacts extend beyond property loss and are shared with the entire community through environmental damage, public health issues and economic impacts. There can be an increased risk of flooding and erosion due to post wildfire flows with increased risk of mudslides. Damage to watersheds can threaten drinking water supplies and aquatic species. Smoke from wildfires causes health risks to vulnerable populations, including children, the elderly, and those with pre-existing heart or lung

conditions. Communities affected by wildfires can experience economic losses with decreased home values, loss of businesses and negative impacts to agriculture, wildlife, tourism and recreation. There can be substantial recovery costs for rebuilding efforts, including debris removal, erosion control, infrastructure and road repair.

The *2025 Gunnison County Community Wildfire Protection Plan ("CWPP")* provides comprehensive strategies to reduce wildfire risk and enhance preparedness so that our community can be ready to live with wildfire. https://www.gunnisoncounty.org/1112/Community-Wildfire-Protection-Plan The CWPP identifies building hardening and defensible space as key parcel-level strategies for community resilience.

In 2023, the Colorado State Legislature recognized that Colorado's wildfire risk is increasing, and more communities are at risk of wildfire. Senate Bill 23-166 established a wildfire code board with the mission to ensure that Colorado Communities are safer from and more resilient to wildfire by reducing the risk to people and property through the adoption of statewide codes and standards based on best practice approaches to hardening structures and reducing wildfire risk in the defensible space surrounding structures in the wild-land urban interface in Colorado. The Colorado Wildfire Code Board consists of 21 voting members representing both rural and urban communities, building code professionals, fire code professionals, investor-owned utilities, commercial building professionals, home building professionals, architect with experience in wildfire codes, fire marshal with experience in wildland fire behavior, land use planning, hazard mitigation, nonprofit home builder for affordable home ownership, and county and municipalities with experience in implementing codes for wildfire resiliency and 3 non-voting ex officio members from the Colorado Division of Fire Prevention and Control, Colorado State Forest Service and the Colorado Resiliency Office. Since October 2023, I have served as a voting member of the Board, enabling me to contribute Gunnison County's unique experience and rural perspective to the development of a code that works for all of Colorado. The Board met in person every month for over a year and a half and four advisory committees were created that met at least twice a month to focus on specific areas towards the creation of the Colorado Wildfire Resiliency Code. All meetings were posted and open to the public with public comment times at every meeting. Four public hearings were held around the state, in Sterling, Castle Rock, Montrose, and Glenwood Springs concerning adoption of the draft code and several hundred public comments, verbal and written, were received, heard and considered by the Board prior to adoption of the CWRC. Additional information about the Wildfire Resiliency Code Board, the Colorado Wildfire Resiliency Code and the State map can be found at the following website: https://dfpc.colorado.gov/WRCB

Overview of the Colorado Wildfire Resiliency Code

The CWRC defines the wildland-urban interface as "that geographic area where structures and other human development meets or intermingles with wildland or vegetative fuels."

A map has been developed and designed as a tool for the application of the CWRC. The map encompasses both the current and potential wildland-urban interface as defined by the CWRC. For the purpose of code application and relevancy, the map only illustrates three levels of fire intensity (low, moderate and high). Low (yellow on the map) fire intensity areas correspond to Class 1 code requirements for construction and site hardening and Moderate (orange) and High (red) fire intensity areas correspond to Class 2 code requirements. The following is a link to the map: https://experience.arcgis.com/experience/34c113129c044004bc672ca5493378de/page/Page

Jurisdictions can choose to adopt the State map or develop their own map. If a jurisdiction chooses to develop their own map it needs to be as stringent as the State map, including consideration of vegetative fuels, topography, local weather patterns, and fire behavior modeling data.

Adoption of the State map has several advantages, including elimination of local map maintenance and updating burden. The State map provides an accessible, printable and user-friendly online platform, and a ground-truthing process to verify or review a fire intensity classification.

The State map cannot be used for insurance purposes. Insurance companies use independent tools to assess risk and the Division of Insurance regulates all practices. The map is only used for the application of the Colorado Wildfire Resiliency Code. The insurance industry strongly supports building codes as a way to minimize and mitigate risk. Building codes can and do work to reduce risk during natural disasters and reduce risk of loss for individual property owners. Additional information about insurance and the Colorado Wildfire Resiliency Code can be found at the following link: https://doi.colorado.gov/wildfire-resiliency-building-codes-and-insurance

The CWRC applies to new construction of structures and defensible space around structures, both residential and commercial. It is not a retrofit code and does not apply to existing development. Additions to existing structures that increase the footprint by 500 square feet or more will need to comply with the code for the area of the addition only. The code requires installation of a compliant roof covering when an existing roof covering is replaced or when 25 percent or more of the roof's surface area is replaced. Similarly, compliant exterior wall materials are required when 25 percent or more of the total exterior wall surface area is replaced. When the exterior wall material requirements are triggered, the 0–5-foot immediate structure zone must also be brought into compliance for defensible space.

The Class 1 code requirements are the least stringent and apply to all properties within the mapped wildland-urban interface. A summary of the Class 1 requirements are as follows:

Class 1 Exterior Building Materials

Roof-Covering or assembly classified as Class A when tested in accordance with ASTM E108 (UL790).

- Flame and ember protection of roofs--For roof assemblies where the roof covering profile creates a space between the roof deck, the space shall resist the entry of flames and embers.
- Roof Valley Flashing--No. 26 galvanized steel gage corrosion-resistant metal installed over a minimum 36" wide underlayment consisting of one layer of cap sheet complying with ASTM D3909 running the full length of the valley.

Gutters and downspouts-shall be constructed of noncombustible material.
Ventilation Openings-For enclosed attics, enclosed rafter spaces, and underfloor spaces shall be either:

- Tested in accordance with ASTM E2886, **or**
- Noncombustible corrosion-resistant mesh with openings not to exceed 1/8"

Class 1 Site & Area Requirements

Structure Ignition Zone 1 (0-5'), Immediate Zone

This zone is designed to reduce or eliminate ember ignition and direct flame contact with the structure, decks, stairs, and attachments. The requirements apply to the area from 0 to 5 feet from the structure.

- Use noncombustible, hard surface materials in this zone, such as rock, gravel, sand, concrete, bare earth or stone/concrete pavers.

  Exception: Ignition-resistant plantings, per an approved list by the jurisdiction that is not less than that created by the Colorado State Forest Service, are allowed in the Immediate Zone.
- Remove all plantings including shrubs, slash, combustible mulch and other woody debris, with the exception of ignition-resistant vegetation.
- No planting of new trees in the immediate zone. Mature trees of no less than 10-inch diameter at 4.5 feet above ground level may be maintained. Tree crowns extending to within 10 feet of any structure shall be pruned to maintain a minimum clearance of 10 feet. Prune tree branches to a height of 6-10 feet from the ground or a third of the total height of the tree, whichever is less.

Site Signage

- Marking of Roads-Approved signs or other approved notices shall be provided and maintained for access roads and driveways to identify such roads and prohibit the obstruction thereof.
- Marking of fire protection equipment-Fire protection equipment and fire hydrants shall be clearly identified. (Don't disguise a hydrant as a shrub)
- Address markers-Buildings shall have a permanently posted address, which shall be placed at each driveway entrance and be visible from both directions of travel along the road.

Retaining Walls-Constructed with either noncombustible or ignition-resistant materials when any of the following conditions exist:

1. The wall is within 8 feet of a structure regulated by this code.
2. The wall is integral to the support of a structure.
3. The retaining wall is integral to the egress from a structure to a public way.

Fencing-Fencing within 8 feet of a structure shall be constructed with noncombustible or ignition-resistant materials. **Exception:** Vinyl fencing may be allowed.

The Class 2 code requirements apply to properties having a moderate or high fire hazard severity (orange or red on the State map). A summary of the Class 2 requirements are as follows:

<u>Class 2 Exterior Building Materials</u>

All the Class 1 items-Roof, gutters and downspouts, and ventilation openings.
Eaves and soffits shall be protected on the exposed underside by noncombustible, ignition-resistant, 1-hour fire-resistance-rated, 5/8" type X sheetrock, 2" nominal dimension lumber, or 1" nominal fire-retardant-treated wood.
Decks-Decking walking surface:

- Noncombustible materials
- Class A rated material

  Except: composite decking can be Class B rating
- Fire-retardant treated wood identified for exterior use
- Ignition-resistant building materials

Glazing-Either multilayered panels, tempered, or have a fire protection rating not less than 20 minutes.
Exterior Doors-Noncombustible materials, solid core wood at least 1 ¾" thick, or 20-minute fire-protection-rated
Exterior Walls shall be constructed with one of the following methods:

1. Assemblies with a minimum of 1-hour fire-resistance rating, rated for exposure on the exterior side.
2. Approved noncombustible materials
3. Heavy timber or log wall construction
4. Noncombustible materials
5. Fire-retardant treated wood labeled for exterior use
6. Ignition-resistant materials

Such materials shall extend from the top of the foundation to the underside of the eave or the underside of the roof sheathing.

Exceptions:

1. Exterior wall embellishments and architectural trim (exclusive of trim on exterior windows and doors) not to exceed 5 percent of the square footage of the exterior wall.
2. Roof or wall top cornice projections and similar assemblies.
3. Solid wood rafter tails and solid wood blocking installed between rafters having a minimum dimension of 2" nominal.

Exterior wall coverings-Coverings shall be limited to the following:

1. Noncombustible materials.
2. Fire-retardant-treated wood.
3. Ignition-resistant building materials.

Exception: where options 1 or 2 (in Section 404.3 are used, vinyl siding may be used as an exterior covering.

Flashing-A minimum of 6 inches of metal flashing or noncombustible material applied vertically between the wall sheathing and the exterior cladding shall be installed at the ground, decking, and roof intersections.

Detached Accessory Structures located less than 50 feet from a building containing habitable or occupiable space shall have exterior walls constructed in accordance with Sections 404.3-404.3.2.
Underfloor Enclosure- Buildings or structures shall have underfloor areas enclosed to the ground or comply with the exterior walls in accordance with Section 404.3 (exterior walls).
Appendages and Projections shall be constructed in accordance with Section 404.3 (exterior walls).
Vehicle Access Doors shall resist ember intrusion by preventing gaps larger than 1/8". Gaps between doors and door openings shall be controlled by one of the following:

- Weather stripping
- Door overlaps onto jambs and headers.
- Garage door jambs and headers covered with metal flashing.

Class 2 Site & Area Requirements

All the Class 1 requirements- 0-5' immediate zone, retaining walls, fencing, site signage

Structure Ignition Zone 2 (5-30 feet), Intermediate Zone
Designed to give an approaching fire less fuel, which will help reduce its intensity as it gets nearer to structures. The requirements apply to the area from 5 to 30 feet from the structure.

- Dead Material shall be removed from live vegetation
- Fuels Accumulation-Avoid large accumulations of surface fuels such as logs, branches, slash and combustible mulch.
- Trees-Tree crowns extending to within 10 feet of any structure shall be pruned to maintain a minimum clearance of 10 feet. Prune tree branches to a height of 6-10 feet from the ground or a third of the total height of the tree, whichever is less.
- Shrubs-Shrub groups within this zone shall be spaced to prevent structure ignition. Shrubs shall be at least 10 feet away from the edge of tree branches.

Structure Ignition Zone 3 (30-100 feet), Expanded Zone
Focuses on mitigation that keeps fire on the ground.

- Tree crowns within this zone shall be spaced at a minimum of 6-10 feet.

Background of wildfire codes in Gunnison County

In 2018 Gunnison County received a grant from the Community Planning Assistance for Wildfire ("CPAW") to help us understand our wildfire risk and provide specific recommendations to integrate wildfire-resiliency into the planning and development review process. The final recommendations from CPAW included adoption of the IWUIC, with amendments, definition of the WUI with the hazard assessment maps.

The CPAW team identified several challenges to addressing wildfire resiliency within land use planning in Gunnison County and many are still relevant today, such as existing developments without adequate wildfire safety and protection features (i.e. water supply, emergency access and neighborhood scale fuel mitigation), large transient demographic without knowledge of wildfire prevention and safety, such as evacuation routes, and a lack of voluntary engagement in wildfire mitigation practices. The CPAW team also identified a few opportunities that are still relevant today and have even become stronger since their assessment, such as our collaborative partnerships with local fire districts, the State Forest Service and the West Region Wildfire Council who provide assistance to further implementation of wildfire-ready and mitigation practices, such as fuel treatments, technical reviews on development applications, and assistance with on-site property assessments. Recently, the West Region Wildfire Council added an additional staff member who will work primarily in Gunnison County assisting County staff with implementation of the new wildfire resiliency code, property owners of both existing and new development with understand their wildfire risk and appropriate mitigation strategies and working with Emergency Management on implementation of the CWPP.

Comparison of the currently adopted IWUIC and the CWRC

Both the currently adopted IWUIC and the CWRC identify structure hardening and defensible space items depending on the wildfire hazard at the site.

The following items are areas where the County's IWUIC adoption is **more** stringent than the CWRC and the items are further described below:

- Water supply requirements-not included in the CWRC

- Deck construction-CWRC regulates the decking surface only
- Vent opening locations-IWUIC prohibits vent openings in soffits and eaves
- Structure Ignition Zone 1 (0-5 feet)-CWRC has an exception for ignition-resistant plantings
- Accessory structures-Exempt in the IWUIC only if ≥50 feet from a habitable structure
- Application for large parcels-CWRC exempts ≥35 acres parcels with only one residence

Water supply requirements are not part of the CWRC. The IWUIC encourages parcels to have adequate water supplies for fire-fighting efforts by potentially reducing the amount of defensible space or degree of structure hardening. Water supply standards are costly for rural parcels. The stakeholder engagement group unanimously felt that water supply requirements should not be included in the new wildfire resiliency code and should be a consideration for new subdivisions and developments.

The CWRC requires that only the deck walking surface be regulated. The IWUIC requires that decks be constructed of ignition-resistant materials. The stakeholder engagement group supported the idea of only requiring decking material to be addressed, especially considering the exterior wall and metal flashing requirements.

The CWRC does not restrict the location of vent openings. The IWUIC prohibits vent openings in eaves and soffits, which is often the most desirable location for builders and designers. The stakeholder engagement group was supportive of removing the restrictions on vent opening locations.

The immediate 0-to-5-foot zone around a structure is designed to reduce or eliminate ember ignition and direct flame contact with the structure, decks, stairs and attachments. The County's adoption of the IWUIC allows only noncombustible, hard surface materials in this zone (i.e. rock, gravel, sand, concrete, bare earth or stone/concrete pavers). The CWRC has the same requirements with an exception that allows for ignition-resistant plantings, identified by the Colorado State Forest Service, in this zone. The Colorado State Forest Service guide for ignition-resistant landscape plants provides a recommended list of landscape plants with attributes that decrease ignitability, such as low oil or resin and moisture content, when properly maintained. The Wildfire Resiliency Code Board considered the requirements of the Insurance Institute for Business and Home Safety ("IBHS") for their Wildfire prepare Home Technical Standards in determining the requirements of the CWRC for insurance coverage and reduction of risk for damage or loss of structures from fire and tried to align with those requirements as much as possible and this is one exception. The allowance of ignition-resistant plantings within the immediate zone is one item that does not align with the IBHS standards. Recent updates to the IBHS Wildfire Prepared Home Technical Standards include ensuring the immediate zone is a noncombustible zone because it is a critical element in effective wildfire mitigation as seen in recent major wildfire conflagration events. The stakeholder engagement group supported **not** including the exception to allow for ignition-resistant plantings in the immediate zone. Ignition-resistant plantings would be difficult for building inspectors to verify, and the County does not currently have a maintenance inspection program. Allowing specific plantings within this zone will likely not translate to future property owners who might see an opportunity for additional vegetation.

The CWRC exempts detached accessory structures no greater than 120 square feet when located at least 10 feet from a habitable structure. The IWUIC exempts those structures when they are located at least 50 feet from a habitable structure. The current building code adoptions in Gunnison County exempt accessory structures no greater than 200 square feet from needing a building permit. Applying

the less stringent separation distance threshold is in better alignment with the adopted building codes and would be more efficient and practical to implement. The stakeholder engagement group supported the less stringent CWRC requirement excepting accessory structures less than 120 square feet when located at least 10 feet from a habitable structure.

Senate Bill 23-166 which established the Wildfire Resiliency Code Board with the task of defining the WUI and adopting statewide codes for new construction in WUI excluded "any thirty-five acre parcel with only one residential structure on it that does not abut a residential or commercial area" from needing to adhere to the code. Many of the 35-acre developments in the County are within the mapped areas of the WUI and established in layouts that do not provide adequate separation distance between adjacent building sites/envelopes commensurate with their overall acreage. Exempting those parcels from the wildfire code requirements is counterproductive to the goals of the wildfire code in creating wildfire ready and resilient communities. The stakeholder engagement group was supportive of continuing to apply the wildfire code to all parcels in the WUI regardless of size.

The following items are areas where the County's IWUIC adoption is **less** stringent than the CWRC:

- Exterior wall embellishments and architectural trim-CWRC does not exempt window and door trim and allows only 5% of embellishments and other trim to be exempt
- Fencing-CWRC requires fencing within 8 feet of a structure be noncombustible or ignition-resistant
- Retaining walls-CWRC requires that retaining walls be noncombustible or ignition-resistant when within 8 feet or a structure, or integral to support of structures, or integral to egress
- Detached accessory structures (any size)-CWRC requires exterior wall material compliance when within 50 feet of a habitable or occupiable structure
- Ventilation openings-CWRC requires a mesh covering openings not to exceed 1/8" (versus ¼")
- Additions and alteration-CWRC trigger is when 500 square feet or more is added versus 50% of the existing area.

The exterior wall requirements that apply when a property is in a moderate or high wildfire hazard area will apply to all trim work except for up to 5% of the square footage of the exterior wall for decorative embellishments or architectural trim. Decorative embellishments are elements incorporated in design and construction for an ornamental or decorative purpose that are not integral to the structure or structural support. Architectural trim does not include door or window trim but could include corner trim or other pieces. For example, a typical house 40 feet by 20 feet could have about 2,000 square feet of wall surface area and 100 square feet (or 5%) of embellishments and trim could be exempt from the exterior wall materials requirement.

The adopted building code exempts fences less than 7 feet in height from building permitting and the *Gunnison County Land Use Resolution* requires that fences in residential areas be limited in height to 6 feet. This combination of code requirements explains one of the reasons why the County has no record of building permits for fences. The CWRC requires that fences within 8 feet of a regulated structure be constructed with noncombustible or ignition-resistant materials. This will be a big change for our community and will require public outreach and engagement to communicate and successfully implement the new requirement for fencing.

The exterior walls of detached accessory structures (greater than 120 square feet) need to comply with the requirements (when in moderate or high wildfire hazard areas) when the location is within 50 feet of a building containing habitable or occupiable space. This is similar to our current requirements except that occupiable space has been added. Habitable Space is space in a building for living, sleeping, eating or cooking and Occupiable Space means a room or enclosed space designed for human occupancy in which individuals congregate for amusement, education or similar purposes or in which occupants are engaged at labor. Occupiable Space includes most commercial buildings, including industrial shop spaces and even agricultural and similar uses where people are actively engaged in labor.

Additions that increase the footprint of a structure by 500 square feet or more will need to comply with the requirements, for the addition only. Currently, the requirements for additions are where the area of the addition is more than 50% of the existing area does the area of the addition need to comply. The CWRC trigger of 500 square feet could be more stringent in some cases and less stringent in others depending on the size of the existing structure.

Recommendations

At their December 18, 2025, meeting, the Gunnison County Planning Commission reviewed the Colorado Wildfire Resiliency Code and the proposed amendments to that code as recommended by the stakeholder engagement group and unanimously recommended adoption of the following items to the Gunnison County Board of County Commissioners:

1. **Adopt the Colorado Wildfire Resiliency Code and the State Wildfire Intensity Map, with the following local amendments:**

   a. **Apply wildfire resiliency requirements to thirty-five-acre or larger parcels.**
   Although Senate Bill 23-166 allows an exemption for certain 35-acre parcels, many large-parcel developments in Gunnison County are located within mapped wildland-urban interface areas and are configured in ways that do not provide meaningful separation between structures. Exempting these parcels based solely on size would undermine the intent of the wildfire code and increase long-term community risk. Applying the code uniformly within the mapped WUI ensures consistent wildfire mitigation regardless of parcel size.

   b. **Require the Structure Ignition Zone 1 (0–5 feet) to consist only of noncombustible, hard-surface materials, without an exception for ignition-resistant plantings.**
   Maintaining a fully noncombustible immediate zone is one of the most effective wildfire mitigation measures and aligns with current best practices, including recent updates to the Insurance Institute for Business and Home Safety (IBHS) Wildfire Prepared Home standards. Eliminating the planting exception improves enforceability, reduces future maintenance and compliance challenges, and avoids confusion for subsequent property owners.

2. **Adopt corresponding amendments to the Gunnison County Land Use Resolution (LUR) to align with the CWRC and State map adoption.**

These amendments ensure consistency between land use regulations and building code requirements and support efficient, coordinated implementation. A summary of the proposed LUR amendments is provided in Appendix A.

Replacement of the IWUIC with the CWRC, as amended, will result in a wildfire resiliency code that is simpler, more consistent with statewide standards, and easier for applicants and staff to understand and implement. Adoption of the State wildfire intensity map shifts the responsibility for map maintenance and updates to the State of Colorado while providing a transparent, user-friendly tool with an established ground-truthing process.

Senate Bill 25-142 provided amendments to Senate Bill 23-166, specifically providing an additional six months for jurisdictions to adopt a code as stringent as the CWRC for a total of nine months, or until April 1, 2026 and implementation within three months of that adoption date or July 1, 2026, whichever is sooner. Public comment received concerning the proposed CWRC adoption suggested providing time for designers to adjust to the new wildfire resiliency requirements. Compliance with a building code that has been adopted, even if not yet implemented, is acceptable for permit issuance. Within the three months following adoption of the wildfire code updates compliance with the current wildfire code or the new wildfire code will both be acceptable.

Next Steps

Two proposed resolutions are submitted for BOCC consideration:

1. Adoption of the Colorado Wildfire Resiliency Code, with amendments.
2. Amendments to the Gunnison County Land Use Resolution. The amendments align the LUR with the CWRC and State map adoption.

Please contact Crystal Lambert, Building and Environmental Health Official, with any questions. Thank you for your consideration.

TROUT CREEK
ENGINEERING

Gunnison County Commissioners 02/02/2026
RE: 2025 Colorado Wildfire Resiliency Code

Dear Commissioners,

Overall, I agree with the Colorado Wildfire Resiliency Code with all proposed Amendments. The one item that I would like for you to consider with this adoption is the "Effective Date", as this reflects all of mine, as well as other design professional's current and upcoming projects. I understand that we as a jurisdiction have until April 1, 2026, to "Adopt" this code or something that is no less stringent that the State CWRC. What had been explain to me, by Crystal Lambert, that it will be up to you as a Board to determine when this will become effective, as long as it is "effective" sometime within 3 months following adoption. I don't know if that is correct or not, however as a Design Professional who is in the middle of several projects it is unknown to any of us "when" to start designing using a new Wildfire Code and when to continue to use the 2021 I.W.U.I. code. There is no perfect time to just make that switch in our designs to not incur unnecessary design costs due to changes to the design documents provided to the County by our clients.

To get an understanding of how professional designers work is that we create the full design documents required which follow the "current" codes, then deliver those documents to our clients or client's representatives to submit for the required permits. Sometimes the clients or representatives will wait weeks or even months prior to submitting these documents to the County, in order to gain full cost estimations and budgets. So, as you can see this sometimes can cause a "Lag" between what is required by the current code and what the new code will require. So, again there is no great way for the design professional to know when they should "switch" their designs to a new code. This is why I liked it when the BOCC agreed that our County was not to adopt or change any codes but every 3 years effective Jan. 1 of that year. However, I fully understand this is a State Mandated requirement and does not apply to those timelines.

One potential idea that Crystal and I "briefly" discussed was if you were to extend the "effective date" for the full 3 months (or whatever is allowed) after your adoptions date AND within that 3 months allow for EITHER the 2021 I.W.U.I. Code OR the 2025 Colorado Wildfire Resilience Code to be accepted for the permit process. This would allow most if not all clients the appropriate time to submit under either code and would have less of a chance to incur unnecessary design change costs.

Thank you for your consideration on this matter

Bill Barvitski

Bill Barvitski
Trout Creek Engineering L.L.C.
970-642-4110 bill@troutcreekengineering.com

From: Pete Ferrell <pete.ferrell@gmail.com>
Sent: Monday, January 26, 2026 2:07 PM
To: Planning <Planning@gunnisoncounty.org>
Subject: Re: BOCC Meeting Jan. 27

[EXTERNAL SENDER - USE CAUTION]

Hi,

I will be unable to attend this meeting at such short notice, but I would like to encourage the county to get rid of any unnecessary additional regulations included in the county's current WUI code that are beyond the state requirements.

Our current WUI code has some provisions, and some zoning, that is ridiculously burdensome. I got into a yelling match - I think it was with Rachel Sabbato - about the WUI codes impacting the scrub brush that is 405 Sequoia Dr in Gunnison (please check out the zoning of that lot and consider whether it really needs to be upgraded to fire proof roof sheathing and a whole host of other expensive, unnecessary wildfire mitigation upgrades.) Because of the overly burdensome WUI codes, I was unable to come up with a financially viable spec house, and had to abandon what would have become 2 affordable houses (I was also planning to develop the adjacent lot) in the valley.

Our WUI codes are directly contributing to the outrageous cost of building around here. For a county government whose representatives consistently espouse their commitment to affordable housing, these burdensome regulations fly in the face of what the county says are its goals. The state has set wildfire regulations it feels are necessary. It is against the interest of the people of Gunnison County to adopt more burdensome regulations voluntarily.

Thanks for letting me contribute during this lengthy comment period.

-Peter Ferrell

BOARD OF COUNTY COMMISSIONERS
OF THE COUNTY OF GUNNISON, COLORADO
RESOLUTION NO: 26-___

A RESOLUTION ADOPTING THE "COLORADO WILDFIRE RESILIENCY CODE," WITH AMENDMENTS

WHEREAS, pursuant to C.R.S. § 30-28-201, *et. seq.*, the Board of County Commissioners of the County of Gunnison, Colorado (herein the "Board") previously adopted the 2021 edition of the "International Wildland-Urban Interface Code"; and

WHEREAS, pursuant to C.R.S. § 24-33.5-1236, et. seq., the Colorado Wildfire Resiliency Code was adopted on June 1, 2025 by the Colorado Wildfire Resiliency Code Board, Division of Fire Prevention and Control, Colorado Department of Public Safety; and

WHEREAS, pursuant to C.R.S. § 24-33.5-1237, *et. seq.*, Application of wildfire resiliency codes, (2)(a) "An adopting Governing Body shall adopt a code that meets or exceeds the minimum standards set forth in the codes within nine months of the board adopting the codes in accordance with section 24-33.5-1236 (4)(b)(II)(D)"; and

WHEREAS, the Board has reviewed the Colorado Wildfire Resiliency Code with proposed amendments; and

WHEREAS, the Board has determined that adoption of the Colorado Wildfire Resiliency Code with certain amendments establishes minimum requirements to safeguard the public safety, health, general welfare and property protection through mitigation of risk to life and structures from intrusion of fire from wildland fire exposures and fire exposures from adjacent structures and to mitigate structure fires from spreading to wildland fuels and provide safety to fire fighters and emergency responders during emergency operations; and

WHEREAS, the Gunnison County Planning Commission has reviewed the Colorado Wildfire Resiliency Code with the recommended amendments and has unanimously recommended adoption to the Board; and

WHEREAS, pursuant to C.R.S. § 30-28-204, the Board conducted a public hearing on the 3rd day of March, 2026 after notice was published in a newspaper of general circulation in the county at least fourteen days prior to said hearing;

NOW THEREFORE, BE IT RESOLVED by the Board of County Commissioners of Gunnison County, Colorado hereby adopts the following Colorado Wildfire Resiliency Code with amendments as included on the attached "Exhibit A" effective June 3, 2026.

The previously adopted 2021 edition of the "International Wildland-Urban Interface Code" is superseded, effective June 3, 2026, by this action.

INTRODUCED by Commissioner _____, seconded by Commissioner _____, and adopted on this ____ day of _____, 2026.

BOARD OF COUNTY COMMISSIONERS
OF GUNNISON COUNTY, COLORADO

_____

Laura Puckett Daniels, Commissioner

_____

Jonathan Houck, Commissioner

_____

Elizabeth Smith, Commissioner

ATTEST:

_____

Deputy County Clerk

COLORADO
Wildfire
Resiliency
Code Board

2025

Colorado Wildfire Resiliency Code

01 June 2025

COLORADO
Department of Public Safety

COLORADO
Division of Fire
Prevention & Control
Department of Public Safety

CWRC Version 1.0

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Attributions

ATTRIBUTIONS

Table of Contents

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Chapter 1 - Scope and Administration

PART 1 GENERAL PROVISIONS

SECTION 101 SCOPE AND GENERAL REQUIREMENTS

101.1 Title. These regulations shall be known as the Colorado Wildfire Resiliency Code as adopted by Gunnison County, hereinafter referred to as "this code."

101.2 Scope. The provisions of this code shall apply to the construction, alteration, movement, repair, maintenance and use of any building, structure or premises that contain *occupiable* and/or *habitable space*, or change in use resulting in an occupiable and/or habitable space, unless excepted, within the *wildland-urban interface* areas of Colorado, as designated in this code.

Buildings or conditions in existence at the time of the adoption of this code are allowed to have their use or occupancy continued, if such condition, use or occupancy was legal at the time of the adoption of this code, provided that such continued use does not constitute a distinct danger to life or property.

Buildings or structures moved into or within the jurisdiction shall comply with the provisions of this code for new buildings or structures.

101.2.1 Appendices. Provisions in the appendices shall not apply unless specifically adopted.

101.2.2 Factory-Built Structures (nonresidential, residential, and tiny homes). Structure hardening provisions of this code for factory-built structures as defined by sections 24-32-3302(9), (10), (11), and (35), C.R.S., are in accordance with Rules adopted by the Division of Housing in 8 CCR 1302-1, Rule 2 Codes and Standards.

101.2.3 HUD Code Homes. Homes built to the HUD Manufactured Home Construction and Safety Standards are exempt from structure hardening requirements on their first installation. Homes built to the HUD Manufactured Home Construction and Safety Standards which are moved into an applicable Wildfire Resiliency code area are subject to the provisions of this code as required by the authority having jurisdiction.

101.3 Purpose. The purpose of this code is to establish minimum regulations for the safeguarding of life and for property protection. Regulations in this code are intended to mitigate the risk to life and structures from intrusion of fire from wildland fire exposures and fire exposures from adjacent structures and to mitigate structure fires from spreading to wildland fuels. The extent of this regulation is intended to be tiered commensurate with the relative level of hazard present.

The unrestricted use of property in *wildland-urban interface* areas is a potential threat to life and property from fire and resulting erosion. Safeguards to prevent the occurrence of fires and to

provide adequate fire protection facilities to control the spread of fire in *wildland-urban interface* areas shall be in accordance with this code.

This code shall supplement the jurisdiction's building and fire codes, if such codes have been adopted, to provide for special regulations to mitigate the fire- and life-safety hazards of the *wildland-urban interface* areas.

101.4 Retroactivity. The provisions of the code shall apply to conditions arising after the adoption thereof, conditions not legally in existence at the adoption of this code and conditions that, in the opinion of the *code official*, constitute a distinct hazard to life or property.

> **Exception:** Provisions of this code that specifically apply to existing conditions are retroactive.

101.5 Additions or alterations. Additions or alterations shall be permitted to be made to any building or structure without requiring the existing building or structure to comply with all of the requirements of this code, provided that, when the work increases the footprint of the existing structure by 500 square feet or greater, the addition or alteration conforms to that required for a new building or structure.

> **Exception:** Provisions of this code that specifically apply to existing conditions are retroactive.

Additions or alterations shall not be made to an existing building or structure that will cause the existing building or structure to be in violation of any of the provisions of this code nor shall such additions or alterations cause the existing building or structure to become unsafe. An unsafe condition shall be deemed to have been created if an addition or alteration will cause the existing building or structure to become structurally unsafe or overloaded; will not provide adequate access in compliance with the provisions of this code or will obstruct existing exits or access; will create a fire hazard; will reduce required fire resistance or will otherwise create conditions dangerous to human life.

101.6 Roof coverings. The *roof covering* on buildings or structures in existence prior to adoption of this code that are replaced or have 25 percent or more of the surface area of the roof replaced, or where work to reconstruct, alter, or repair the *roof covering* effectively replaces such material, shall require the entirety of the *roof covering* to be replaced with a *roof covering* required for new construction specified in Sections 403.2 through 403.2.2.

> **Exception:** Existing *roof coverings* that are compliant with Section 403.2.

101.7 Exterior walls. The exterior walls of building or structures in existence prior to adoption of this code where 25 percent or more of the total exterior wall surface area is replaced, or where work to reconstruct, alter or repair the exterior walls effectively replaces the exterior wall material, shall require the entirety of the exterior wall surface area, including attachments, to be replaced with materials required for new construction specified in Section 404.3 through 404.3.2

and the immediate zone within 5 feet of the structure shall be made to comply with Section 503.1.

Exception: Existing exterior walls that are compliant with Section 404.3.

101.8 Maintenance. Buildings, structures, landscape materials, vegetation, *defensible space* or other devices or safeguards required by this code shall be maintained in conformance to the code edition under which installed. The owner or the owner's authorized agent shall be responsible for the maintenance of buildings, structures, landscape materials and vegetation.

SECTION 102—APPLICABILITY

102.1 General. Where there is a conflict between a general requirement and a specific requirement, the specific requirement shall govern. Where, in any specific case, different sections of this code, or any other adopted code, specify different materials, methods of construction or other requirements, the most restrictive shall govern.

102.2 Other laws. The provisions of this code shall not be deemed to nullify any provisions of local, state or federal law.

102.3 Application of references. References to chapter or section numbers, or to provisions not specifically identified by number, shall be construed to refer to such chapter, section or provision of this code.

102.4 Referenced codes and standards. The codes and standards referenced in this code are listed throughout this code. Such codes and standards shall be considered as part of the requirements of this code to the prescribed extent of each such reference and as further regulated in Sections 102.4.1 and 102.4.2.

102.4.1 Conflicts. Where conflicts occur between provisions of this code and the referenced codes and standards, the provisions of this code shall govern.

102.4.2 Provisions in referenced codes and standards. Where the extent of the reference to a referenced code or standard includes subject matter that is within the scope of this code, the provisions of this code, as applicable, shall take precedence over the provisions in the referenced standard.

102.5 Subjects not regulated by this code. Where applicable standards or requirements are not set forth in this code, or are contained within other laws, codes, regulations, ordinances or policies adopted by the authority having jurisdiction, compliance with applicable standards of other nationally recognized safety standards, as *approved*, shall be deemed as prima facie evidence of compliance with the intent of this code. Nothing herein shall derogate from the authority of the *code official* to determine compliance with codes or standards for those activities or installations within the code official's jurisdiction or responsibility.

102.6 Matters not provided for. Requirements that are essential for the public safety of an existing or proposed activity, building or structure, or for the safety of the occupants thereof,

which are not specifically provided for by this code, shall be determined by the *code official* consistent with the necessity to establish the minimum requirements to safeguard the public health, safety and general welfare.

102.7 Partial invalidity. In the event that any part or provision of this code is held to be illegal or void, this shall not have the effect of making void or illegal any of the other parts or provisions.

102.8 Existing conditions. The legal occupancy or use of any structure or condition existing on the date of adoption of this code shall be permitted to continue without change, except as is specifically covered in this code, the *International Fire Code* or the *International Property Maintenance Code*, or as is deemed necessary by the *code official* for the general safety and welfare of the occupants and the public.

102.9 Historic structures. A variance is authorized to be issued for the repair or rehabilitation of a historic structure or construction of a contributing structure upon a determination that the proposed repair or rehabilitation will not preclude the structure's continued designation as a historic structure, and the variance is the minimum necessary to preserve the historic character and design of the structure, within the spirit of this code.

Exception: Within wildfire hazard areas, historic structures that do not meet one or more of the following designations:

1. Listed or preliminarily determined to be eligible for listing in the National Register of Historic Places.
2. Determined as contributing to the historical significance of a registered historic district or a district preliminarily determined to qualify as an historic district.
3. Designated as historic under a state or local historic preservation program.

102.9.1 Historic preservation exemption. The authority having jurisdiction may establish a historic preservation exemption or exemptions in their jurisdiction that consists of the spirit and intent of this code.

102.10 Work exempt from permit under this code. Exemptions from code requirements shall not be deemed to grant authorization for any work to be done in any manner in violation of the provisions of this code or any other laws or ordinances of the jurisdiction. Compliance with this code shall not be required for the following:

1. Interior alterations of existing structures.
2. Additions that do not increase the footprint of a structure by more than 500 square feet.
3. The reconstruction, replacement, alteration, or repair of the exterior walls of an existing building, when less than 25 percent of the surface area of all exterior walls is affected.
4. The reconstruction, replacement, alteration, or repair of the exterior *roof covering* of an existing building, when less than 25 percent of the surface area of the exterior *roof covering* or an attachment thereto is affected.

5. Alterations or repairs to the exterior of an existing structure, or an attachment to it, when less than twenty-five percent of the exterior of the structure is affected by the alteration or repair.
6. Painting, staining and similar maintenance or restorative work.
7. One-story detached accessory, nonhabitable structures, such as tool and storage sheds, playhouses and similar uses, provided that the floor area does not exceed 120 square feet and the structure is located greater than or equal to 10 feet from the nearest adjacent occupiable structure.
8. *Accessory structures* and buildings of an accessory character classified as Utility and Miscellaneous Group U (including Agricultural Structures) located more than 50 feet from a structure containing *occupiable* or *habitable space*.
9. Fences located more than 8 feet from a habitable structure.

PART 2—ADMINISTRATION AND ENFORCEMENT

SECTION 103—CODE COMPLIANCE AGENCY

103.1 Creation of agency. The Building Office is hereby created and the official in charge thereof shall be known as the *code official*. The function of the agency shall be the implementation, administration and enforcement of the provisions of this code.

103.2 Deputies. In accordance with the prescribed procedures of this jurisdiction and with the concurrence of the appointing authority, the *code official* shall have the authority to appoint a deputy *code official*, other related technical officers, inspectors and other employees. Such employees shall have powers as delegated by the *code official*.

103.3 Board of Appeals. The Gunnison County Board of Appeals pursuant to C.R.S. Section 30-28-118 shall be the shall be the Gunnison County Board of Adjustment as described in the *Gunnison County Land Use Resolution Section 8-103: Appeals.*

SECTION 104—DUTIES AND POWERS OF THE CODE OFFICIAL

104.1 Powers and duties of the code official. The *code official* is hereby authorized to enforce the provisions of this code.

104.2 Determination of compliance. The *code official* shall have the authority to determine compliance with this code, to render interpretations of this code and to adopt policies and procedures in order to clarify the application of its provisions. Such interpretations, policies and procedures:

1. Shall be in compliance with the intent and purpose of this code.
2. Shall not have the effect of waiving requirements specifically provided for in this code.

104.2.1 Technical assistance. To determine compliance with this code, the *code official* is authorized to require the owner, the owner's authorized agent or the person in possession or control of the building or premises to provide a technical opinion and report.

104.2.1.1 Costs. A technical opinion and report shall be provided without charge to the jurisdiction.

104.2.1.2 Preparer qualifications. The technical opinion and report shall be prepared by a qualified engineer, specialist, laboratory or fire safety specialty organization acceptable to the *code official*. The *code official* is authorized to require design submittals to be prepared by, and bear the stamp of, a registered design professional.

104.2.1.3 Content. The technical opinion and report shall analyze the properties of the design, operation or use of the building or premises, the facilities and appurtenances situated thereon and fuel management to identify and propose necessary recommendations.

104.2.1.4 Tests. Where there is insufficient evidence of compliance with the provisions of this code, the *code official* shall have the authority to require tests as evidence of compliance. Test methods shall be as specified in this code or by other recognized test standards. In the absence of recognized test standards, the *code official* shall approve the testing procedures. Such tests shall be performed by a party acceptable to the *code official*.

104.2.2 Alternative materials, design and methods. The provisions of this code are not intended to prevent the installation of any material or to prohibit any design or method of construction not specifically prescribed by this code, provided that any such alternative has been *approved*.

104.2.2.1 Approval authority. An alternative material, design or method shall be *approved* where the *code official* finds that the proposed alternative is satisfactory and complies with Sections 104.2.2.2 through 104.2.2.7, as applicable.

104.2.2.2 Application and disposition. Where required, a request to use an alternative material, design or method of construction shall be submitted in writing to the *code official* for approval. Where the alternative material, design or method of construction is not approved, the *code official* shall respond in writing, stating the reasons the alternative was not approved.

104.2.2.3 Compliance with code intent. An alternative material, design or method of construction shall comply with the intent of the provisions of this code.

104.2.2.4 Equivalency criteria. An alternative material, design or method of construction shall, for the purpose intended, be not less than the equivalent of that prescribed in this code with respect to all of the following, as applicable:

1. Quality.
2. Strength.
3. Effectiveness.
4. Durability.
5. Safety, other than fire safety.
6. Fire safety.

104.2.2.5 Tests. Tests conducted to demonstrate equivalency in support of an alternative material, design or method of construction application shall be of a scale that is sufficient to predict performance of the end use configuration. Tests shall be performed by a party acceptable to the *code official.*

104.2.2.5.1 Fire tests. Tests conducted to demonstrate equivalent fire safety in support of an alternative material, design or method of construction application shall be of a scale that is sufficient to predict fire safety performance of the end use configuration. Tests shall be performed by a party acceptable to the *code official*.

104.2.2.6 Reports. Supporting data, where necessary to assist in the approval of materials or assemblies not specifically provided for in this code, shall comply with Sections 104.2.2.6.1 and 104.2.2.6.2.

104.2.2.6.1 Evaluation reports. Evaluation reports shall be issued by an *approved* agency and use of the evaluation report shall require approval by the *code official* for the installation. The alternate material, design or method of construction and product evaluated shall be within the scope of the *code official*'s recognition of the *approved* agency. Criteria used for the evaluation shall be identified within the report and, where required, provided to the *code official*.

104.2.2.6.2 Other reports. Reports not complying with Section 104.2.2.6.1 shall describe criteria, including but not limited to any referenced testing or analysis, used to determine compliance with code intent and justify code equivalence. The report shall be prepared by a qualified engineer, specialist, laboratory or fire safety specialty organization acceptable to the *code official*. The *code official* is authorized to require design submittals to be prepared by, and bear the stamp of, a registered design professional.

104.2.2.7 Peer review. The *code official* is authorized to require submittal of a peer review report in conjunction with a request to use an alternative material, design or

method of construction, prepared by a peer reviewer that is *approved* by the *code official*.

104.2.3 Modifications. Where there are practical difficulties involved in carrying out the provisions of this code, the *code official* shall have the authority to grant modifications for individual cases, provided that the *code official* shall first find that one or more special individual reasons make the strict letter of this code impractical, that the modification is in conformance with the intent and purpose of this code, and that such modification does not lessen health, life and fire safety requirements. The details of the written request and action granting modifications shall be recorded and entered into the files of the code enforcement agency.

104.3 Applications and permits. The *code official* is authorized to receive applications, review construction documents and issue permits for construction regulated by this code, issue permits for operations regulated by this code, inspect the premises for which such permits have been issued and enforce compliance with the provisions of this code.

104.4 Access to Property. For the purpose of inspecting and enforcing the provisions of this code and the terms and conditions of any permit issued under this code, the *code official* is authorized to enter upon private property at reasonable times and upon reasonable notice for the purpose of determining compliance with this code and to evaluate conditions relative to the permit application.

104.4.1 Authorization. The owner or occupant of the property having a permit under this code shall allow the *code official* access to the property to perform the required inspections. If access is denied, the *code official* shall apply to the Court with jurisdiction to seek authority to access the property.

104.5 Identification. The *code official* shall carry proper identification when inspecting structures or premises in the performance of duties under this code.

104.6 Notices and orders. The *code official* shall issue all necessary notices or orders to ensure compliance with this code.

104.7 Official records. The *code official* shall keep official records as required by Sections 104.7.1 through 104.7.5. Such official records shall be retained for not less than 5 years or for as long as the structure or activity to which such records relate remains in existence, unless otherwise provided by other regulations.

104.7.1 Approvals. A record of approvals shall be maintained by the *code official* and shall be available for public inspection during business hours in accordance with applicable laws.

104.7.2 Inspections. The *code official* shall keep a record of each inspection made, including notices and orders issued, showing the findings and disposition of each.

104.7.3 Code alternatives and modifications. Application for alternative materials, design and methods of construction and equipment in accordance with Section 104.2.2; modifications in accordance with Section 104.2.3; and documentation of the final decision of the *code official* for either shall be in writing and shall be retained in the official records.

104.7.4 Tests. The *code official* shall keep a record of tests conducted to comply with Sections 104.2.1.4 and 104.2.2.5.

104.7.5 Fees. The *code official* shall keep a record of fees collected and refunded in accordance with Section 106.

104.8 Liability. The *code official*, member of the board of appeals or employee charged with the enforcement of this code, while acting for the jurisdiction, in good faith and without malice in the discharge of the duties required by this code or other pertinent law or ordinance, shall not thereby be rendered personally liable, either civilly or criminally, and is hereby relieved from all personal liability for any damage accruing to persons or property as a result of an act or by reason of any act or omission in the discharge of official duties.

104.8.1 Legal defense. Any suit or criminal complaint instituted against any officer or employee because of an act performed by that officer or employee in the lawful discharge of duties and under the provisions of this code or other laws or ordinances implemented through the enforcement of this code shall be defended by legal representatives of the jurisdiction until final termination of the proceedings. The *code official* or any subordinate shall not be liable for costs in an action, suit or proceeding that is instituted in pursuance of the provisions of this code.

104.9 Approved materials and equipment. Materials, equipment and devices approved by the *code official* shall be constructed and installed in accordance with such approval.

104.9.1 Materials and equipment reuse. Materials, equipment and devices shall not be reused unless such elements are in good working order and *approved*.

104.10 Other agencies. When requested to do so by the *code official*, other officials of this jurisdiction shall assist and cooperate with the *code official* in the discharge of the duties required by this code.

SECTION 105—TEMPORARY USES, EQUIPMENT AND SYSTEMS

105.1 General. The *code official* is authorized to issue a permit for temporary uses, equipment and systems. Such permits shall be limited as to time of service, but shall not be permitted for more than 180 days. The *code official* is authorized to grant extensions for demonstrated cause.

105.2 Conformance. Temporary uses, equipment and systems shall conform to the requirements of this code as necessary to ensure health, safety and general welfare.

105.3 Temporary service utilities. The *code official* is authorized to give permission to temporarily supply service utilities.
105.4 Termination of approval. The *code official* is authorized to terminate such permit for temporary uses, equipment and systems and to order the same to be discontinued.

SECTION 106—FEES

106.1 General. Fees shall be in accordance with the fee schedule that is adopted and amended from time to time by the BOCC.

SECTION 107—STOP WORK ORDER

107.1 Authority. Where the *code official* finds any work regulated by this code being performed in a manner contrary to the provisions of this code or in a dangerous or unsafe manner, the *code official* is authorized to issue a stop work order.
107.2 Issuance. The stop work order shall be in writing and shall be given to the owner of the property, the owner's authorized agent or the person performing the work. Upon issuance of a stop work order, the cited work shall immediately cease. The stop work order shall state the reason for the order and the conditions under which the cited work is authorized to resume.
107.3 Emergencies. Where an emergency exists, the *code official* shall not be required to give a written notice prior to stopping the work.
107.4 Failure to comply. Any person who shall continue any work after having been served with a stop work order, except such work as that person is directed to perform to remove a violation or unsafe condition, shall be subject to fines established by the authority having jurisdiction.

SECTION 108—CONSTRUCTION DOCUMENTS

108.1 General. Plans, engineering calculations, diagrams and other data shall be submitted in the format as required by the jurisdiction. The construction documents shall be prepared and submitted where required by the statutes of the jurisdiction in which the project is to be constructed. Where special conditions exist, the code official is authorized to require additional documentation.
108.2 Site plan. In addition to the requirements for plans in the International Building Code, site plans shall include topography, landscape and vegetation details and locations of structures or building envelopes. The code official is authorized to waive or modify the requirement for a site plan where the application for permit is for alteration or repair or where otherwise warranted. Identify the fire intensity classification.
108.2.1 Defensible Space Site Plans. Defensible space site plans shall be prepared and submitted to the code official for review and approval as part of the site plans required for a permit.

Chapter 2 - Definitions

SECTION 201 GENERAL

201.1 Scope. Unless otherwise expressly stated, the following words and terms shall, for the purposes of this code, have the meanings shown in this chapter.

201.2 Interchangeability. Words stated in the present tense include the future; words stated in the masculine gender include the feminine and neuter; and the singular number includes the plural and the plural the singular.

201.3 Terms defined in other codes. Where terms are not defined in this code and are defined in other International Codes, such terms shall have the meanings ascribed to them as in those codes.

201.4 Terms not defined. Where terms are not defined through the methods authorized by this section, such terms shall have their ordinarily accepted meanings such as the context implies.

SECTION 202 DEFINITIONS

ACCESSORY STRUCTURE. A building or structure used to shelter or support any material, equipment, chattel or occupancy other than a habitable building.

AGRICULTURAL BUILDING. A structure designed and constructed to house farm implements, hay, grain, poultry, livestock or other horticultural products. This structure shall not be a place of human habitation or a place of employment where agricultural products are processed, treated or packaged, nor shall it be a place used by the public.

APPROVED. Acceptable to the *code official*.

BOCC. The Board of County Commissioners of Gunnison County, Colorado.

BUILDING. Any structure intended for supporting or sheltering any occupancy.

CLASS A TESTS. Class A Tests are applicable to *roof coverings* that are expected to be effective against severe fire exposure, afford a high degree of fire protection to the *roof deck*, do not slip from position, and are not expected to present a flying brand hazard.

CODE OFFICIAL. The official designated by the jurisdiction to interpret and enforce this code, or the *code official*'s authorized representative.

DEFENSIBLE SPACE. An area either natural or man-made, where material capable of allowing a fire to spread unchecked has been treated, cleared or modified to slow the rate and intensity of an advancing wildfire and to create an area for fire suppression operations to occur.

EMBELLISHMENTS. Elements incorporated in design and construction for ornamental or decorative purpose that are not integral to the structure or structural support.

FIRE INTENSITY CLASSIFICATION. The level of fire intensity identified for areas where significant fuel hazards and associated dangerous fire behavior may exist, based upon vegetative fuels, topography, weather conditions, and flame length value.

FIRE-RESISTANCE-RATED CONSTRUCTION. The use of materials and systems in the design and construction of a building or structure to safeguard against the spread of fire within a building or structure and the spread of fire to or from buildings or structures to the *wildland-urban interface* area.

FIRE-RETARDANT-TREATED WOOD. Fire-retardant-treated wood is any wood product that, when impregnated with chemicals by a pressure process or other means during manufacture, shall have, when tested in accordance with ASTM E84 or UL 723, a listed *flame spread index* of 25 or less. The ASTM E84 or UL723 test shall be continued for an additional 20-minute period and the flame front shall not progress more than 10.5 feet beyond the centerline of the burners at any time during the test.

FLAME SPREAD INDEX. A comparative measure, expressed as a dimensionless number, derived from visual measurements of the spread of flame versus time for a material tested in accordance with ASTM E84.

FUEL MODIFICATION. A method of modifying fuel load by reducing the amount of nonfire-resistive vegetation or altering the type of vegetation to reduce the fuel load.

HABITABLE SPACE. A space in a building for living, sleeping, eating or cooking.

HEAVY TIMBER CONSTRUCTION. As described in Section 602.4 of the 2024 *International Building Code*.

HOME IGNITION ZONE. Home Ignition Zone is the home and the area around the home (or structure). The HIZ takes into account both the potential of the structure to ignite and the quality of *defensible space* surrounding it.

IGNITION-RESISTANT BUILDING MATERIAL. A type of building material that resists ignition or sustained flaming combustion sufficiently so as to reduce losses from wildfire exposure of burning embers and small flames.

IGNITION-RESISTANT VEGETATION. Plants that are less likely to readily ignite from a flame or other ignition source and produce fewer embers. While they can still be damaged by fire, their foliage and stems don't significantly contribute to the intensity of the fire.

LOG WALL CONSTRUCTION. A type of construction in which exterior walls are constructed of solid wood members and where the smallest horizontal dimension of each solid wood member is not less than 6 inches. Log wall construction shall follow requirements of ICC 400.

MULTILAYERED GLAZED PANELS. Window or door assemblies that consist of two or more independently glazed panels installed parallel to each other, having a sealed air gap in between, within a frame designed to fill completely the window or door opening in which the assembly is intended to be installed.

NONCOMBUSTIBLE. As applied to building construction material means a material that, in the form in which it is used, is either one of the following:

1. Material of which no part will ignite and burn when subjected to fire.

2. Any material conforming to ASTM E136 shall be considered noncombustible within the meaning of this section.

3. For the purposes of this code, fire-rated gypsum board tested in accordance with ASTM C1396 with no less than a 1-hour fire-resistance-rating with fire exposure from the outside only is considered a noncombustible material.

OCCUPIABLE SPACE. A room or enclosed space designed for human occupancy in which individuals congregate for amusement, education or similar purposes or in which occupants are engaged at labor.

ROOF ASSEMBLY. A system designed to provide weather protection and resistance to design loads. The system consists of a *roof covering* and *roof deck* or a single component serving as both the *roof covering* and the *roof deck*. A *roof assembly* can include an underlayment, thermal barrier, ignition barrier, insulation or a vapor retarder.

ROOF COVERING. The covering applied to the *roof deck* for weather resistance, fire classification or appearance.

ROOF DECK. The flat or sloped surface not including its supporting members or vertical supports.

SLOPE. The variation of terrain from the horizontal; the number of feet rise or fall per 100 feet measured horizontally, expressed as a percentage.

STRUCTURE. That which is built or constructed.

STRUCTURE IGNITION ZONE. Structure Ignition Zone is the structure and the area around the structure (or home). The SIZ takes into account both the potential of the structure to ignite and the quality of *defensible space* surrounding it.

TREE CROWN. The primary and secondary branches growing out from the main stem, together with twigs and foliage.

WILDLAND-URBAN INTERFACE. That geographical area where structures and other human development meets or intermingles with wildland or vegetative fuels.

Chapter 3 - Wildfire Hazard Identification

SECTION 301 GENERAL

301.1 Scope. The provisions of this chapter provide methodology to establish and record wildfire hazard based on the findings of fact to be regulated by this code.

301.2 Objective. The objective of this chapter is to provide simple baseline criteria for determining *wildland-urban interface* areas based on the wildfire hazard.

SECTION 302 WILDLAND-URBAN INTERFACE AREA DESIGNATIONS

302.1 Declaration. The wildland-urban interface areas in Gunnison County are illustrated on the Colorado Wildfire Resiliency State Code Map maintained by the Division of Fire Prevention and Control and the Colorado State Forest Service.

SECTION 303 MAPPING AND APPLICABILITY

303.1 Mapping of Wildfire Hazard Areas. The wildland-urban interface areas and associated fire intensity classifications are identified on the Colorado Wildfire Resiliency State Code Map.

> **303.1.1 Map.** The map is based on a combination of factors including, but not limited to, vegetative fuels, topography, local weather patterns, and fire behavior modeling data.

303.2 Fire Intensity Classification. *Fire Intensity Classifications* are identified on the Colorado Wildfire Resiliency State Code Map. *Fire Intensity Classifications* are determined by expected wildfire behavior, including flame length and suppression difficulty and are separated into three levels: low, moderate, and high. The identified *fire intensity classification* establishes code requirements for construction and mitigation.

> **303.2.1 Low Fire Intensity Classification.** Low *Fire Intensity Classification* is identified in areas with light to medium surface fuels, such as grasses, shrubs, and scattered low-density vegetation. These fuels are often discontinuous, which limits flame propagation but can sustain burning under moderate weather conditions. Fires in this class may occur on gentle to moderate *slopes*, where topography begins to influence the rate of spread. Although flame lengths remain relatively small—typically less than two feet—limited spotting may occur, especially with wind. Trained firefighters with protective equipment and standard hand tools can usually suppress these fires through

direct attack, particularly on *slopes* under 30 percent. Mechanized equipment is typically unnecessary.

Key Characteristics Include:

1. **Fuels**: Light to medium surface fuels, including grasses, shrubs, and scattered vegetation (e.g., WNL, USL fuel types).
2. **Flame Length**: Less than 2 feet.
3. **Rate of Spread**: Low, increasing with *slopes* over 20 percent.
4. **Spotting**: Very short-range spotting is possible under windy conditions.
5. **Terrain Influence**: More active fire behavior on moderate *slopes* (20 to 30 percent).
6. **Suppression Difficulty**: Easily suppressed by trained firefighters using basic protective gear and hand tools. Direct attack is effective, and mechanized support is rarely needed.

303.2.2 Moderate Fire Intensity Classification. Moderate *Fire Intensity Classification* is identified in areas with moderate to heavy fuel loads, such as dense shrubs, small trees, and accumulated ground fuels. Fires in this class present continuous horizontal and vertical fuel arrangements, allowing flames to reach up to 8 feet in length. Fire behavior is notably influenced by moderate to steep *slopes*, often accelerating the spread. Short-range spotting becomes more common, complicating suppression efforts. Ground crews typically require mechanized support, such as engines and dozers, to establish control lines. Aircraft assistance may be necessary, particularly in inaccessible terrain. There is a significant increase in the potential for property damage and risk to life, especially in *wildland-urban interface* areas.

Key Characteristics Include:

1. **Fuels**: Moderate to heavy fuels, including dense shrublands, small trees, timber litter, and canopy fuels (e.g., USH, UIH fuel types).
2. **Flame Length**: Up to 8 feet.
3. **Rate of Spread**: Moderate to high, increasing significantly on *slopes* over 30 percent.
4. **Spotting**: Short-range spotting is common.
5. **Terrain Influence**: Steep *slopes* (30 percent or greater) increase fire spread and intensity.
6. **Suppression Difficulty**: Challenging for ground crews without support from engines, dozers, or aircraft. Dozers and plows are generally effective on moderate terrain.

303.2.3 High Fire Intensity Classification. High *Fire Intensity Classification* is identified in areas with heavy, continuous fuel loads, such as dense forest canopies, thick

understory growth, and heavy dead/downed material. Fires in this class frequently occur on steep *slopes*, often exceeding 40 percent, where topography dramatically increases the rate of spread and severity. Flame lengths can exceed 30 feet, and both short- and medium-range spotting are common, particularly in windy conditions. Direct suppression by ground crews is typically ineffective, requiring indirect attack strategies, such as backburns and aerial retardant drops. Fires in this class pose extreme risk to life, property, and firefighter safety, especially in rugged or remote areas.

Key Characteristics Include:

1. **Fuels**: Heavy fuels, including dense forests, urban core areas with heavy fuel loads, and canopy-dominated regions (e.g., WNH, USH, UCH fuel types).
2. **Flame Length**: Up to 30 feet or more.
3. **Rate of Spread**: Rapid, especially on *slopes* greater than 40 percent.
4. **Spotting**: Short-range spotting is common; medium-range spotting is possible under windy conditions.
5. **Terrain Influence**: *Slopes* over 40 percent amplify intensity and spread, creating dangerous conditions for suppression.
6. **Suppression Difficulty**: Direct attack by ground forces and dozers is generally ineffective. Indirect strategies (backburning, aerial support) are often necessary. These fires present significant danger to life, property, and responder safety.

303.3 Applicability of Code Provisions. The requirements of this code shall apply to all parcels located within designated Wildfire Hazard Areas and corresponding *fire intensity classifications* as identified on the Colorado Wildfire Resiliency State Code Map. The level of structure hardening, *defensible space*, and other mitigation measures required shall correspond to the applicable *fire intensity classification*—Low, Moderate, or High—as established by the board.

Structures and parcels identified with low *fire intensity classification* shall be constructed and maintained in accordance with the provisions for Class 1 structure hardening and site and area requirements.

Structures and parcels identified with moderate to high *fire intensity classifications* shall be constructed and maintained in accordance with the provisions for Class 2 structure hardening and site and area requirements.

SECTION 304 GROUND-TRUTHING

304.1 Purpose. This section establishes a process for owners or the owners authorized representative to request a ground-truthing review of their property's Wildfire Hazard or *fire intensity classification* as identified on state or locally adopted maps. The intent is to provide an opportunity to verify that mapping accurately reflects current, site-specific conditions.

304.2 Determination of Fire Intensity Classification and Code Requirements. As determined by the *code official,* the *fire intensity classification* and associated requirements shall be based on a review of the vegetative fuels on the parcel and within 300' of the parcel boundary, topography, local weather patterns, and fire behavior modeling data and in accordance with the following *fire intensity classifications*:

304.2.1 Low *Fire Intensity Classification* in accordance with Section 303.2.1

304.2.2 Moderate *Fire Intensity Classification* in accordance with Section 303.2.2

304.2.3 High *Fire Intensity Classification* in accordance with Section 303.2.3

This determination shall be made based on existing conditions or conditions that have been established by a development plan approved by the local jurisdiction. Technical documentation shall be submitted in support of such request by a qualified wildfire professional and in accordance with Section 104.2.

Chapter 4- Structure Hardening

SECTION 401 GENERAL

401.1 Scope. Exterior design and construction of new buildings and structures within the *wildland-urban interface* areas of Colorado shall be constructed in accordance with this chapter.

Exceptions:

1. Buildings of an accessory character classified as Group U occupancy (including *agricultural buildings*) of any size located at least 50 feet from a structure containing *occupiable* or *habitable space*.
2. One-story detached accessory, nonhabitable structures, such as tool and storage sheds, playhouses and similar uses, provided that the floor area does not exceed 120 square feet and the structure is located greater than or equal to 10 feet from the nearest adjacent occupiable structure.
3. The reconstruction, replacement, alteration, or repair of the exterior walls of an existing building, when less than 25 percent of the surface area of all exterior walls is affected.
4. The reconstruction, replacement, alteration, or repair of the exterior *roof covering* of an existing building, when less than 25 percent of the surface area of the exterior *roof covering* or an attachment thereto is affected.
5. Alterations or repairs to the exterior of an existing structure, or an attachment to it, when less than twenty-five percent of the exterior of the structure is affected by the alteration or repair.
6. Additions that do not increase the footprint of a structure by more than 500 square feet.

SECTION 402 BUILDING MATERIAL

402.1 Building material. Building materials shall comply with any one of the requirements in Section 402.2 through 402.4.

402.2 Noncombustible material. *Noncombustible* material shall comply with the definition of *noncombustible* materials in Section 202.

402.3 Fire-retardant-treated wood. *Fire-retardant-treated wood* shall be identified for exterior use and shall meet the requirements of Section 2303.2 of the 2024 *International Building Code*.

402.4 Ignition-resistant building material. Material shall be tested on the front and back faces in accordance with the extended ASTM E84 or UL 723 test, for a total test period of 30 minutes, or with the ASTM E2768 test. The materials shall bear identification showing the fire test results. Panel products shall be tested with a ripped or cut longitudinal gap of 1/8 inch. The materials, when tested in accordance with the test procedures set forth in ASTM E84 or UL 723

for a test period of 30 minutes, or with ASTM E2768, shall comply with Sections 402.4.1 through 402.4.3.3. Materials or products which melt, drip or delaminate to the extent that the flame front is interrupted are not permitted.

Exception: Materials composed of a combustible core and a noncombustible exterior covering made from either aluminum at a minimum 0.019 inch thickness or corrosion-resistant steel at a minimum 0.0149 inch thickness shall not be required to be tested with a ripped or cut longitudinal gap.

402.4.1 Flame spread. The material shall exhibit a *flame spread index* not exceeding 25.

402.4.2 Flame front. The material shall exhibit a flame front that does not progress more than 10 feet 6 inches beyond the centerline of the burner at any time during the test.

402.4.3 Weathering. *Ignition-resistant building materials* shall maintain their performance in accordance with this section under conditions of use. The materials shall meet the performance requirements for weathering (including exposure to temperature, moisture and ultraviolet radiation) contained in Sections 402.4.3.1 through 402.4.3.3, as applicable to the materials and conditions of use.

402.4.3.1 Evaluation requirements for weathering. Fire-retardant-treated wood, wood-plastic composite materials and plastic lumber materials shall be evaluated after weathering in accordance with Method A "Test Method for Accelerated Weathering of Fire-Retardant-Treated Wood for Fire Testing" in ASTM D2898.

402.4.3.2 Wood-plastic composite materials. Wood-plastic composite materials shall also demonstrate acceptable fire performance after weathering by the following procedure: first testing in accordance with ASTM E1354 at an incident heat flux of 50 kW/m2 in the horizontal orientation, then weathering in accordance with ASTM D7032 and then retesting in accordance with ASTM E1354 and exhibiting an increase of no more than 10 percent in peak rate of heat release when compared to the peak heat release rate of the nonweathered material.

402.4.3.3 Plastic lumber materials. Plastic lumber materials shall also demonstrate acceptable fire performance after weathering by the following procedure: first testing in accordance with ASTM E1354 at an incident heat flux of 50 kW/m2 in the horizontal orientation, then weathering in accordance with ASTM D6662 and then retesting in accordance with ASTM E1354 and exhibiting an increase of no more than 10 percent in peak rate of heat release when compared to the peak heat release rate of the nonweathered material.

SECTION 403 CLASS 1 STRUCTURE HARDENING

403.1 General. Class 1 structure hardening shall be in accordance with Sections 403.2 through 403.4.2 and shall apply to buildings and structures hereafter constructed, modified or relocated into or within areas of the *wildland-urban interface* having a low fire hazard severity.

403.2 Roofing. Roofs shall have a *roof covering* or *roof assembly* classified as Class A when tested in accordance with ASTM E108 or UL 790.

403.2.1 Flame and ember protection of roofs. For roof assemblies where the roof covering profile creates a space between the roof covering and roof deck, the space shall resist the entry of flames and embers by one or more of the following methods:

1. Firestopping with noncombustible material of the space between the roof covering and the roof deck.
2. Installation of one layer of cap sheet complying with ASTM D3909 over the combustible roof deck.
3. Installation of a listed Class A classified roof assembly.

403.2.2 Roof valley flashings. Valley flashings shall be not less than 0.019 inch (No. 26 galvanized sheet gage) corrosion-resistant metal installed over a minimum 36- inch-wide underlayment consisting of one layer of cap sheet complying with ASTM D3909 running the full length of the valley.

403.3 Gutters and downspouts. Gutters and downspouts shall be constructed of *noncombustible* material.

403.4 Ventilation Openings. Ventilation openings for enclosed attics, enclosed rafter spaces, and underfloor spaces shall be in accordance with Section 403.4.1 or Section 403.4.2 as applicable.

403.4.1 Performance Requirements. Ventilation openings shall be fully covered with listed vents, tested in accordance with ASTM E2886, to demonstrate compliance with all the following requirements:

1. There shall be no flaming ignition of the cotton material during the Ember Intrusion Test.
2. There shall be no flaming ignition during the Integrity Test portion of the Flame Intrusion Test.
3. The maximum temperature of the unexposed side of the vent shall not exceed 662°F (350°C).

403.4.2 Prescriptive Requirements. Ventilation openings for enclosed attics, enclosed rafter spaces, and underfloor spaces shall be covered with *noncombustible* corrosion-resistant mesh with openings not to exceed ⅛-inch.

SECTION 404 CLASS 2 STRUCTURE HARDENING

404.1 General. Class 2 structure hardening shall be in accordance with Sections 404.2 through 404.10.1 as well as the provisions of Class 1 structure hardening in Sections 403.2-403.4.2 and shall apply to buildings and structures hereafter constructed, modified or relocated into or within areas of the *wildland-urban interface* having a moderate or high fire hazard severity. See also Sections 101.6-101.7.

404.2 Protection of eaves. Eaves and soffits shall be protected on the exposed underside by *noncombustible material, ignition-resistant materials,* or by materials approved for not less than 1-hour *fire-resistance-rated construction*, *⅝-inch Type X drywall,* 2-inch nominal dimension lumber, or 1 inch nominal *fire-retardant-treated wood* or ¾ inch nominal fire-retardant-treated plywood, identified for exterior use and meeting the requirements of Section 2303.2 of the 2024 *International Building Code*. Fascias are required and shall be protected on the backside by *noncombustible material, ignition-resistant materials,* or by materials approved for not less than 1-hour *fire-resistance-rated construction, ⅝-inch Type X drywall,* or 2- inch nominal dimension lumber.

404.3 Exterior Walls. Exterior walls of buildings or structures shall be constructed with one of the following methods:

1. Exterior wall assemblies with a minimum of 1-hour fire-resistance rating, rated for exposure on the exterior side.
2. *Approved noncombustible materials.*
3. *Heavy timber* or *log wall construction.*
4. *Noncombustible* materials complying with Section 402.2 on the exterior side.
5. *Fire-retardant treated wood* complying with Section 402.3 on the exterior side. The *fire-retardant-treated wood* shall be labeled for exterior use and meet the requirements of Section 2303.2 of the 2024 *International Building Code*.
6. Ignition-resistant materials complying with Section 402.4 on the exterior side.

Such material shall extend from the top of the foundation to the underside of the eave or the underside of the roof sheathing.

Exceptions:

1. Exterior wall *embellishments* and architectural trim (exclusive of trim on exterior windows and doors) not to exceed 5 percent of the square footage of the exterior wall.
2. Roof or wall top cornice projections and similar assemblies.
3. Solid wood rafter tails and solid wood blocking installed between rafters having minimum dimension 2 inch nominal.

404.3.1 Exterior Wall Coverings. Exterior wall coverings shall be limited to the following:

1. *Noncombustible* materials.
2. *Fire-retardant-treated wood*.
3. *Ignition-resistant building materials*.

Exception: Where options 1 or 2 in section 404.3 are used, vinyl siding may be used as an exterior covering.

404.3.2 Flashing. A minimum of 6 inches of metal flashing or *noncombustible* material applied vertically between the wall sheathing and the exterior cladding shall be installed at the ground, decking, and roof intersections.

Combustible sheathing products exposed by the gap created at the base of the exterior walls, posts, or columns must be protected with *noncombustible material* or *ignition-resistant building materials* while still permitting drainage and moisture control from behind exterior cladding.

404.4 Underfloor enclosure. Buildings or structures shall have underfloor areas enclosed to the ground or comply with exterior walls in accordance with Section 404.3.

404.5 Decking. Unenclosed decks shall have the deck walking surface constructed of one of the following:

1. *Approved noncombustible* materials
2. Class A rated material

   Exception: Composite decking material with a minimum of Class B rating
3. *Fire-retardant-treated wood* identified for exterior use and meeting the requirements of Section 2303.2 of the 2024 *International Building Code*
4. *Ignition-resistant building materials* in accordance with Section 402.4.

404.6 Appendages and Projections. Appendages and projections shall be constructed in accordance with Section 404.3.

404.7 Exterior Glazing. Exterior windows, window walls and glazed doors, windows within exterior doors, and skylights shall be tempered glass, *multilayered glazed panels*, glass block or have a fire protection rating of not less than 20 minutes.

404.8 Exterior Doors. Exterior doors shall be *approved noncombustible* construction, solid core wood not less than 1 ¾-inches thick, or have a fire protection rating of not less than 20 minutes. Windows within doors and glazed doors shall be in accordance with Section 404.7.

Exception: Vehicle access doors.

404.9 Vehicle Access Door Perimeter Gap. Exterior vehicle access doors shall resist the intrusion of embers from entering by preventing gaps between doors and door openings, at the head, sill, and jamb of doors from exceeding ⅛ inch as approved by the AHJ.

Gaps between doors and door openings shall be controlled by one of the following methods:

1. Weather-stripping products made of materials that: (a) have been tested for tensile strength in accordance with ASTM D638 (Standard Test Method for Tensile Properties of Plastics) after exposure to ASTM G155 (Standard Practice for Operating Xenon Arc Light Apparatus for Exposure of Non-Metallic Materials) for a period of 2,000 hours, when the maximum allowable difference in tensile strength values between exposed and

non-exposed samples does not exceed 10 percent; and (b) exhibit a V-2 or better flammability rating when tested to UL 94 (Standards for Tests for Flammability of Plastic Materials for Parts in Devices and Appliances).

2. Door overlaps onto jambs and headers.
3. Garage door jambs and headers covered with metal flashing.

404.10 Detached Accessory Structures. Detached *accessory structures* located less than 50 feet from a building containing *habitable* or *occupiable space* shall have exterior walls constructed in accordance with Section 404.3 through 404.3.2.

404.10.1 Underfloor areas. Where the detached structure is located and constructed so that the structure or any portion thereof projects over a descending *slope* surface greater than 10 percent, the area below the structure shall have underfloor areas enclosed to within 6 inches of the ground, with exterior wall construction in accordance with Section 404.3 or underfloor protection in accordance with Section 404.4 or with ⅛-inch metal corrosion-resistant screen with a hardened zone within 5 feet.

Exception: The enclosure shall not be required where the underside of exposed floors and exposed structural columns, beams and supporting walls are protected as required for exterior 1-hour *fire-resistance-rated construction, heavy timber construction, noncombustible* materials on the exterior side, or *fire-retardant-treated wood* on the exterior side. The *fire-retardant-treated wood* shall be labeled for exterior use and meet the requirements of Section 2303.2 of the 2024 *International Building Code.*

Chapter 5- Site and Area Requirements

SECTION 501 GENERAL

501.1 Scope. The provisions of this chapter shall apply to parcels subject to this code.
501.2 Reference. As needed, the *code official* shall refer to the Home Ignition Zone (HIZ) Guide as developed by the Colorado State Forest Service.
Where conflicts occur between provisions of this code and the HIZ Guide, the provisions of this code shall govern. The provisions of this code, as applicable, shall take precedence over the provisions in the referenced standard.

SECTION 502 CLASS 1 REQUIREMENTS

502.1 Structure Ignition Zone 1 (0-5 feet): Immediate Zone

502.1.1 Objective. This zone is designed to reduce or eliminate ember ignition and direct flame contact with the structure, decks, stairs, and attachments.
502.1.2 Materials. Use *noncombustible*, hard surface materials in this zone, such as rock, gravel, sand, concrete, bare earth or stone/concrete pavers.

502.1.3 Plantings. Remove all plantings including shrubs, slash, combustible mulch and other woody debris, with the exception of ignition-resistant vegetation.
502.1.4 Trees. There shall be no planting of new trees in the immediate zone. Mature trees of no less than 10-inch diameter at 4.5 feet above ground level may be maintained.
Tree crowns extending to within 10 feet of any structure shall be pruned to maintain a minimum clearance of 10 feet.
Prune tree branches to a height of 6-10 feet from the ground or a third of the total height of the tree, whichever is less.

502.2 Site Signage

502.2.1 Marking of roads. *Approved* signs or other *approved* notices shall be provided and maintained for access roads and driveways to identify such roads and prohibit the obstruction thereof.
502.2.2 Marking of fire protection equipment. Fire protection equipment and fire hydrants shall be clearly identified in a manner *approved* by the *code official* to prevent obstruction.

502.2.3 Address markers. Buildings shall have a permanently posted address, which shall be placed at each driveway entrance and be visible from both directions of travel along the road. In all cases, the address shall be posted at the beginning of construction and shall be maintained thereafter, and the address shall be visible and legible from the road on which the address is located in a manner *approved* by the *code official*.

502.3 Retaining Walls

502.3.1 Retaining Walls. Retaining walls shall be constructed with either *noncombustible* or ignition-resistant materials when any of the following conditions exist:

1. The retaining wall is within 8 feet of a structure regulated by this code or up to the property line when the property line is less than 8 feet away from the structure.
2. The retaining wall is integral to the support of a structure regulated by this code.
3. The retaining wall is integral to the egress from a structure regulated by this code to a public way, easement, or private road.

502.4 Fencing

502.4.1 Fencing. Fencing within 8 feet of a structure regulated by this code or up to the property line when the property line is less than 8 feet away from the structure shall be constructed with *noncombustible* or ignition-resistant materials.

Exception: Vinyl fencing. Vinyl fencing may be allowed.

SECTION 503 CLASS 2 REQUIREMENTS

503.1 General. Class 2 site and area requirements shall be in accordance with Sections 503.2 through 503.3.2 and include all requirements of Class 1 in Sections 502.1 through 502.4.

503.2 Structure Ignition Zone 2 (5-30 feet) Intermediate Zone

503.2.1 Objective. This zone is designed to give an approaching fire less fuel, which will help reduce its intensity as it gets nearer to structures.

503.2.2 Dead Materials. Within the *fuel modification* area, hazardous dead plant material must be removed from live vegetation.

503.2.3 Fuels Accumulation. Avoid large accumulations of surface fuels such as logs, branches, slash and combustible mulch.

503.2.4 Trees. *Tree crowns* extending to within 10 feet of any structure shall be pruned to maintain a minimum clearance of 10 feet.

Prune tree branches to a height of 6-10 feet from the ground or a third of the total height of the tree, whichever is less.

503.2.4.1 Tree Spacing. *Tree crowns* within this zone shall be spaced to prevent structure ignition and promote fuel discontinuity to limit fire spread.

503.2.5 Shrubs. Shrub groups within this zone shall be spaced to prevent structure ignition. Shrubs shall be at least 10 feet away from the edge of tree branches.

503.3 Structure Ignition Zone 3 (30-100 feet) Expanded Zone

503.3.1 Objective. This zone focuses on mitigation that keeps fire on the ground.

503.3.2 Tree Spacing. *Tree crowns* within this zone shall be spaced at a minimum of 6-10 feet.

BOARD OF COUNTY COMMISSIONERS
OF THE COUNTY OF GUNNISON, COLORADO
RESOLUTION NO: 26-___

A RESOLUTION AMENDING THE GUNNISON COUNTY LAND USE RESOLUTION

WHEREAS, pursuant to the *Gunnison County Land Use Resolution ("the Resolution"),* Section 1-113*,* details a process for initiation, review and Board of County Commissioners action on proposed amendments to the *Resolution*; and

WHEREAS, pursuant to Section 1-113, the Community Development Department and Planning Commission have initiated and completed review of the proposed amendments as required by the *Resolution*; and

WHEREAS, Section 29-20-104(1)(a) of the Local Government Land Use Control Enabling Act grants Gunnison County the authority "to plan for and regulate the use of land by…[r]egulating development and activities in hazardous areas."; and

WHEREAS, the Planning Commission on December 18, 2025 meeting unanimously recommended adoption of the proposed amendments; and

WHEREAS, the Board of County Commissioners has conducted a duly noticed public hearing on these proposed amendments on March 3, 2026; and pursuant to Section 1-113 of the Resolution evaluated the proposed amendments using the following criteria:

1. Consistency of the proposed amendments with any comprehensive plan that may be adopted by Gunnison County
2. Changed conditions, including the economy of Gunnison County
3. Effect of the proposed amendments on the natural environment
4. Community needs
5. Development pattern
6. Changes in applicable law
7. Public health, safety and welfare
8. Compliance with any applicable intergovernmental agreements adopted by Gunnison County

NOW, THEREFORE, BE IT RESOLVED by the Board of County Commissioners of Gunnison County, Colorado that the Board hereby adopts the following amendments of the Gunnison County Land Use Resolution as included on the attached "Exhibit A".

THIS RESOLUTION AND THE APPROVAL GRANTED HEREBY SHALL NOT BE EFFECTIVE UNLESS AND UNTIL A COPY IS RECORDED IN THE Office of the Clerk and Recorder of Gunnison County.

INTRODUCED by Commissioner _____, seconded by Commissioner _____, and adopted on this ____ day of _____, 2026.

BOARD OF COUNTY COMMISSIONERS
OF GUNNISON COUNTY, COLORADO

Laura Puckett Daniels, Chairperson

Jonathan Houck, Commissioner

Elizabeth Smith, Commissioner

ATTEST:

Deputy County Clerk

Exhibit A: SUMMARY OF PROPOSED REVISIONS TO THE GUNNISON COUNTY LAND USE RESOLUTION TO ALIGN WITH THE ADOPTION OF THE COLORADO WILDFIRE RESILIENCY CODE

SECTION 1-112: USE OF MAPS, C.MAPS TO BE USED AS REFERENCES, 1.WILDFIRE HAZARD MAPS.

1. **WILDFIRE HAZARD MAPS**. ~~Wildfire Hazard Maps prepared by Community Planning Assistance for Wildfire (CPAW) and as they may be amended from time to time~~The Colorado Wildfire Resiliency State Code Map prepared and maintained by the Colorado Division of Fire Prevention and Control and the Colorado State Forest Service and available on the Colorado Wildfire Resiliency Code Board website.

ARTICLE 2:DEFINITIONS

FIRE INTENSITY CLASSIFICATION means the level of fire intensity identified for areas where significant fuel hazards and associated dangerous fire behavior may exist, based upon vegetative fuels, topography, weather conditions, and flame length value. The F~~f~~ire i~~I~~ntensity C~~c~~lassification for parcels in the WUI can be identified on the Colorado Wildfire Resiliency State Code Map prepared and maintained by the Colorado Division of Fire Prevention and Control and the Colorado State Forest Service and available on the Colorado Wildfire Resiliency Code Board website.

LOW FIRE INTENSITY CLASSIFICATION means areas with light to medium surface fuels, such as grasses, shrubs, and scattered low-density vegetation. These fuels are often discontinuous, which limits flame propagation but can sustain burning under moderate weather conditions. Fires in this class may occur on gentle to moderate slopes, where topography begins to influence the rate of spread. Although flame lengths remain relatively small-typically less than two feet-limited spotting may occur, especially with wind. Trained firefighters with protective equipment and standard hand tools can usually suppress these fire through direct attack, particularly on slopes under 30 percent. Mechanized equipment is typically unnecessary.

KEY CHARACTERISTICS INCLUDE:

- **FUELS:** Light to medium surface fuels, including grasses, shrubs, and scattered vegetation.
- **FLAME LENGTH:** Less than 2 feet.
- **RATE OF SPEAD:** Low, increasing with slopes over 20 percent.
    - **SPOTTING:** Very short-range spotting is possible under windy conditions.
    - **TERRAIN INFLUENCE:** More active fire behavior on moderate slopes (20 to 30percent)
    - **SUPPRESSION DIFFICULTY:** Easily suppressed by trained firefighters using basic protective gear and hand tools. Direct attack is effective, and mechanized support is rarely needed.

MODERATE FIRE INTENSITY CLASSIFICATION means areas with moderate to heavy fuel loads, such as dense shrubs, small trees, and accumulated ground fuels. Fire present continuous horizontal and vertical fuel arrangements, allowing flames to reach up to 8 feet in length. Fire behavior is notably influenced by moderate to steep slopes, often accelerating the spread. Short-range spotting becomes more common, complicating suppression efforts. Ground crews typically require mechanized support, such as engines and dozers, to establish control lines. Aircraft assistance may be necessary, particularly in inaccessible terrain. There is a significant increase in the potential for property damage and risk to life, especially in WUI areas.

KEY CHARACTERISTICS INCLUDE:

- **FUELS:** Moderate to heavy fuels, including dense shrublands, small trees, timber litter, and canopy fuels.
- **FLAME LENGTH:** Up to 8 feet.
- **RATE OF SPEAD:** Moderate to high, increasing significantly on slopes over 30 percent.
- **SPOTTING:** Short-range spotting is common.
- **TERRAIN INFLUENCE:** Steep slopes, 30 percent of greater, increases fire spread and intensity.
- **SUPPRESSION DIFFICULTY:** Challenging for ground crews without support from engines, dozers, or aircraft. Dozers and plows are generally effective on moderate terrain.

HIGH FIRE INTENSITY CLASSIFICATION means areas with heavy, continuous fuel loads, such as dense forest canopies, thick understory growth, and heavy dead/downed material. Fires frequently occur on steep slopes, often exceeding 40 percent, where topography dramatically increases the rate of spread and severity. Flame lengths can exceed 30 feet, and both short- and medium- range spotting are common, particularly in windy conditions. Direct suppression by ground crews is typically ineffective, requiring indirect attack strategies, such as backburns and aerial retardant drops. Fires in this class pose extreme risk to life, property, and firefighter safety, especially in rugged or remote areas.

KEY CHARACTERISTICS INCLUDE:

- **FUELS:** Heavy fuels, including dense forests, urban core areas with heavy fuel loads, and canopy-dominated regions.
- **FLAME LENGTH:** Up to 30 feet or more.
- **RATE OF SPEAD:** Rapid, on slopes over 40 percent.
- **SPOTTING:** Short-range spotting is common; medium range spotting is possible under windy conditions.
- **TERRAIN INFLUENCE:** Slopes over 40 percent amplify intensity and spread, creating dangerous conditions for suppression.
- **SUPPRESSION DIFFICULTY:** Direct attack by ground forces and dozers is generally ineffective. Indirect strategies (backburning, aerial support) are often necessary. These fire present a significant danger to life, property, and responder safety.

WILDFIRE HAZARD AREA means an area where potential wildfire phenomenon is so adverse to past, current or foreseeable construction or development that it constitutes a significant potential hazard to public health and safety or to property. Wildfire Hazard Areas contain low, moderate, and high Fire Intensity Classifications. Such areas may be shown on maps pursuant to Section 1-112: C: *Maps To Be Used As References* (also see FIRE INTENSITY CLASSIFICATION)

- ~~**LANDSCAPE-LEVEL WILDFIRE HAZARD** This scale represents the likelihood (probability) of a fire occurring and the intensity of the fire at the landscape level based on the inherent landscape characteristics, including broad existing vegetation, biophysical settings, fire regimes, and fire histories. The landscape-level hazard assessment is delineated into the following rankings:~~
  - ~~MODERATE~~

- ~~HIGH~~
- ~~VERY HIGH~~

~~The factors influencing these rankings can be used to determine the potential landscape-level exposure that a development will be subject to. The ranking at this scale is difficult to change at the local/parcel level. Mitigation affecting change at this scale is typically done by large-scale disturbances such as insect mortality, fires, or landscape-level mitigation.~~

- ~~**LOCAL-LEVEL WILDFIRE HAZARD** This scale is based on an extreme event (worst fire days). This does not show the likelihood of a fire occurring but does show where fires are likely to burn at high intensity. For example, a fire that starts in an area where the local hazard is high can spread fast and burn at high intensity creating significant wildfire exposure to any structures in the area. The same rankings used at the landscape scale are used at this local scale:~~
  - ~~MODERATE~~
  - ~~HIGH~~
  - ~~VERY HIGH~~

WILDLAND URBAN INTERFACE (WUI) means ~~any developed area where conditions affecting the combustibility of both wildland and built fuels allow for the ignition and spread of fire through the combined fuel complex~~that geographic area where structures and other human development meets or intermingles with wildland or vegetative fuels. The WUI is illustrated in the Colorado Wildfire Resiliency State Code Map prepared and maintained by the Colorado Division of Fire Prevention and Control and the Colorado State Forest Service and available on the Colorado Wildfire Resiliency Code Board website~~CPAW map titled, "Gunnison County Wildland Urban Interface."~~

~~**WUI Intermix**: Areas with ≥1 house per acre and ≥50 percent cover of wildland vegetation. These areas have a potential for exposure to radiant and convective heat, as well as airborne embers.~~

- ~~**WUI Interface**: Areas with ≥1 house per acre and ≤50 percent cover of vegetation and within 1.5 mi of area with >= 75% wildland vegetation.~~
- ~~**Non- WUI Vegetated** (no housing): Areas with ≥50 percent cover of wildland vegetation and no houses (e.g., protected areas, steep slopes, mountain tops).~~

SECTION 5-104: ADMINISTRATIVE REVIEW PROJECT APPLICATION, E. ADDITIONAL SUBMITTALS BASED UPON INFORMATION AVAILABLE ON MAPS USED BY THE COUNTY, 3. LOCATION OF SITE WITHIN WILDFIRE HAZARD AREA:

3. **LOCATION OF SITE WITHIN WILDFIRE HAZARD AREA.** As applicable, an application proposing a land use change on a parcel located within a ~~w~~Wildfire ~~h~~Hazard ~~a~~Area as identified on the Colorado Wildfire Resiliency Code map prepared and maintained by the Colorado Division of Fire Prevention and Control and the Colorado State Forest Service, pursuant to Section 11-105: *Development in Areas Subject to Wildfire Hazards.*

SECTION 6-104: MINOR IMPACT APPLICATION, F. ADDITIONAL SUBMITTALS BASED UPON INFORMATION AVAILABLE ON MAPS USED BY THE COUNTY, 3. LOCATION OF SITE WITHIN WILDFIRE HAZARD AREA:

3. **LOCATION OF SITE WITHIN WILDFIRE HAZARD AREA.** As applicable, an application proposing a land use change on a parcel located within a Wildfire ~~h~~Hazard ~~a~~Area as identified on the Colorado Wildfire Resiliency State Code map prepared and maintained by the Colorado

Exhibit A: SUMMARY OF PROPOSED REVISIONS TO THE GUNNISON COUNTY LAND USE RESOLUTION TO ALIGN WITH THE ADOPTION OF THE COLORADO WILDFIRE RESILIENCY CODE

Division of Fire Prevention and Control and the Colorado State Forest Service, pursuant to Section 11-105: *Development in Areas Subject to Wildfire Hazards.*

SECTION 7-201: SKETCH PLAN APPLICATION FOR MAJOR IMPACT PROJECTS, I.MAPS AND SITE PLAN SHEETS, 2.NATURAL FEATURES, d.WILDFIRE HAZARD MAPS:

d. WILDFIRE HAZARD MAPS. Map of the area wildfire hazards and identification of the fire intensity classification(s) as identified on the ~~Wildfire Area Hazard Maps~~ Colorado Wildfire Resiliency State Code Map prepared and maintained by the Colorado Division of Fire Prevention and Control and the Colorado State Forest Service and available on the Colorado Wildfire Resiliency Code Board website~~prepared by by Community Planning Assistance for Wildfire (CPAW).~~.

SECTION 7-301: PRELIMINARY PLAN APPLICATION FOR MAJOR IMPACT PROJECTS, J. GEOLOGIC HAZARD AREAS, 3. WILDFIRE HAZARD AND FIRE PROTECTION:

3. **WILDFIRE HAZARD AND FIRE PROTECTION.** When a land use change is proposed on a parcel located in a Wildfire Hazard Area as identified on the Colorado Wildfire Resiliency State Code map prepared and maintained by the Colorado Division of Fire Prevention and Control and the Colorado State Forest Service ~~T~~the narrative, map and layout design of the Preliminary Plan shall address and comply with the requirements of Section 11-105: *Development in Areas Subject to Wildfire Hazard* and Section 12-107: *Fire Protection*, and include measures to minimize the potential that the proposed uses will generate or increase wildfire

SECTION 11-104: DEVELOPMENT SUBJECT TO GEOLOGIC HAZARDS, G. STANDARDS APPLICABLE TO DEVELOPMENT IN PARTICULAR GEOLOGIC HAZARD AREAS, 6. DEVELOPMENT ON SLOPES GREATER THAN 30 PERCENT, e. DEVELOPMENT PROHIBITED:

e. DEVELOPMENT PROHIBITED. Development shall be prohibited on any slope in excess of 30 percent that is also located in an area that is determined to be a ~~very high~~ wildfire hazard area with a H~~h~~igh Fire Intensity Classification, pursuant to Section 11-104: C: *Applicability.*

SECTION 11-105: DEVELOPMENT IN AREAS SUBJECT TO WILDFIRE HAZARDS, C. MAPS INCORPORATED:

C. MAPS INCORPORATED. The Colorado Wildfire Resiliency State Code Map prepared and maintained by the Colorado Division of Fire Prevention and Control and the Colorado State Forest Service and available on the Colorado Wildfire Resiliency Code Board website~~The Gunnison County Wildfire Hazard Maps, prepared by the Community Planning Assistance for Wildfire, and Gunnison County GIS~~, shall be used as references for determining when parcels are located within wildfire hazard areas, pursuant to Section 1-112: *Use of Maps.* Where areas have not been mapped, review and analysis by the Colorado Forest Service shall determine the status of wildfire hazards. ~~Copies of the maps are available on www.gunnisoncounty.org.~~

SECTION 11-105: DEVELOPMENT IN AREAS SUBJECT TO WILDFIRE HAZARDS, F. STANDARDS, 2. PROHIBITED LOCATIONS FOR DEVELOPMENT & 3. DEMONSTRATION OF COMPLIANCE:

2. **PROHIBITED LOCATIONS FOR DEVELOPMENT**. Development shall not be located in any area designated as having ~~very~~ H~~h~~igh Fire Intensity Classification ~~wildfire hazard~~ that also has

slopes greater than 30 percent. Development shall also not be located in a fire chimney, as identified by the Colorado State Forest Service.

3. **DEMONSTRATE COMPLIANCE WITH THE COLORADO WILDFIRE RESILIENCY CODE~~*INTERNATIONAL WILDLAND URBAN INTERFACE CODE* (IWUIC)~~, AS ADOPTED AND AMENDED BY GUNNISON COUNTY.** All land use change applications shall comply with the standards set forth in the County-adopted version of the ~~*International Wildland Urban Interface Code*~~*Colorado Wildfire Resiliency Code*.

SECTION 11-105: DEVELOPMENT IN AREAS SUBJECT TO WILDFIRE HAZARDS, F. STANDARDS, 5. WILDFIRE PREVENTION STANDARDS TO BE ADDRESSED IN PROTECTIVE COVENENTS:

5. **WILDFIRE PREVENTION STANDARDS TO BE ADDRESSED IN PROTECTIVE COVENANTS**. Development shall comply with the following standards. Assurances as to compliance with these standards shall be addressed in a recorded, permanent protective covenant enforceable by the County.

   a. **FUEL MODIFICATIONS**. If the proposed development includes areas that are within a wildfire hazard area containing low, moderate or high Fire Intensity Classifications as mapped on the Colorado Wildfire Resiliency State Code Map~~Gunnison County Wildfire Hazard Maps~~, that can be reduced to lower hazard ratings through thinning, clumping, reduction of ~~"~~ladder~~"~~ fuels (vegetation that may allow a fire to burn from ground level to lower tree branches), removal of hanging limbs near chimneys, creation of defensible space around structures, or other such modifications, then such modifications shall be accomplished and maintained by the applicant and or applicable homeowner's association.

   b. **FUEL BREAKS**. Practical fuel break systems shall be installed as needed in locations that are approved by the Colorado State Forest Service.

   c. ~~IGNITIION~~IGNITION **RESISTANT CONSTRUCTION MATERIALS.** If the proposed development includes areas that are within a wildfire hazard area containing low, moderate or high Fire Intensity Classifications as mapped on the Colorado Wildfire Resiliency State Code Map ~~Gunnison County Wildfire Hazard Maps~~, construction materials that are ignition resistant shall be allowed and encouraged within the protective covenants.

SECTION 12-105: WATER SUPPLY, D. CALCULATION OF ADEQUACY OF SUPPLY, 6. ADEQUATE AND RELIABLE WATER SUPPLY:

Delete reference to the IWUIC

SECTION 12-107: FIRE PROTECTION, C. SIGNAGE AND ADDRESSING & D. FIRE SUPPRESSION:

C. **SIGNAGE AND ADDRESSING.** All sites for proposed land use changes shall be signed and marked with address markers in accordance with the standards of the ~~IWUIC~~County's adoption of the Colorado Wildfire Resiliency Code and the International Building Code.

D. **FIRE SUPPRESSION.** All development shall comply with the standards of ~~the International Wildland Urban Interface Code including~~ NFPA 1141 and 1142.

SECTION 13-111: LANDSCAPING AND BUFFERING, E. LANDSCAPING PLAN & I. LANDSCAPE ADJACENT TO BUILDINGS:

E. **LANDSCAPING PLAN.** Applicants for a land use change shall prepare a landscaping plan if the land use change is a residential development that is classified as a Major Impact Project, or any

multiple-family residential development, mobile home community or recreational vehicle park, or commercial, industrial or other non-residential use that is classified as either a Minor or Major Impact Project, pursuant to Section 3-111: *Classification of Impact*. Information is available from the Colorado State Forest Service to assist in designing a landscaping plan that minimizes the potential for wildfire hazard. The landscaping plan shall comply with the standards of the Gunnison County adopted ~~International Wildland Urban Interface Code~~Colorado Wildfire Resiliency Code. The plan shall indicate the type and location of vegetation to be included on the site. The plan shall also contain a planting schedule and a plan for maintenance of all landscaping to be installed.

I. **LANDSCAPE ADJACENT TO BUILDINGS**. Landscape elements may be located adjacent to buildings except that when sites that are designated as wildfire hazard areas, landscaping must be designed considering the need for defensible space as recommended by the Colorado Forest Service and in compliance with the County's adoption of the Colorado Wildfire Resiliency Code.

AGENDA ITEM or FINAL CONTRACT REVIEW SUBMITTAL FORM

Agenda Item: Gunnison Basin Sage-grouse Strategic Committee Pub

Action Requested: Motion

Parties to the Agreement:

Term Begins: **Term Ends:** **Grant Contract #:**

Summary:

Boards and Commissions appointment for the Gunnison County Sage-grouse Strategic Committee Public At-Large Alternate position for Steffanie Chain

Fiscal Impact:

Submitted by: Holly Perry **Submitter's Email Address:** hperry@gunnisoncounty.org

Finance Review: ○ Required ◉ Not Required

Comments:

Reviewed by: Discharge Date:

County Attorney Review: ○ Required ◉ Not Required

Comments:

Reveiwed by: Discharge Date: Certificate of Insurance Required

Yes ○ No ○

County Manager Review:

Comments:

Reveiwed by: GUNCOUNTY1\Hperry Discharge Date: 2/26/2026

○ Consent Agenda ◉ Regular Agenda ○ Worksession Time Allotted: 5

Agenda Date: 3/3/2026

Revised April 2015

From: noreply@civicplus.com
To: BOCC
Subject: Online Form Submittal: Boards and Commissions Application
Date: Friday, January 30, 2026 7:31:26 AM

[EXTERNAL SENDER - USE CAUTION]

Boards and Commissions Application

Board/Commission or position applying for:	Gunnison Basin Sage-grouse Strategic Committee
First and Last Name	steffanie chain
Address	[redacted]
City	almont
Phone	[redacted]
Email Address	[redacted]
Why would you like to serve on this Board or Commission?	Im interested in the bird. They are all around my house. Id like to understand how to help them increase their numbers. And Im semi retired and would like to give back to my community.
Additional Comments	*Field not completed.*

AGENDA ITEM or FINAL CONTRACT REVIEW SUBMITTAL FORM

Agenda Item: Correspondence; Draft Environmental Impact Stateme

Action Requested:

Parties to the Agreement:

Term Begins: **Term Ends:** **Grant Contract #:**

Summary:

Comment Letter for Draft EIS for Post 2026 Operational Guidelines

Fiscal Impact:

Submitted by: Holly Perry **Submitter's Email Address:** hperry@gunnisoncounty.org

Finance Review: ○ Required ◉ Not Required

Comments:

Reviewed by: Discharge Date:

County Attorney Review: ○ Required ◉ Not Required

Comments:

Reveiwed by: Discharge Date: Certificate of Insurance Required

Yes ○ No ○

County Manager Review:

Comments:

Reveiwed by: GUNCOUNTY1\mbirnie Discharge Date: 2/25/2026

○ Consent Agenda ◉ Regular Agenda ○ Worksession Time Allotted: 5

Agenda Date: 3/3/2026

Revised April 2015

GUNNISON COUNTY
COUNTY COMMISSIONERS

Gunnison County Board of County Commissioners
Phone: (970) 641-0248
Email: bocc@gunnisoncounty.org
Website: www.GunnisonCounty.org

March 3, 2026

Sent via electronic mail: crbpost2026@usbr.gov

U.S. Bureau of Reclamation
Attn: BCOO-1000
P.O. Box 61470
Boulder City, NV 89006

RE: Draft EIS Comments regarding Post-2026 Operational Guidelines and Strategies for Lake Powell and Lake Mead

Dear Acting Commissioner Cameron:

Please accept the comments of the Board of County Commissioners of Gunnison County (Gunnison County) in response to Reclamation's Draft Environmental Impact Statement (DEIS) for Post-2026 Operational Guidelines and Strategies for Lake Powell and Lake Mead.

Like many Upper Basin communities and water users, we seek operational guidelines that restore system balance and provide long-term security for water users across the basin. Unfortunately, the 2007 Interim Operating Guidelines and subsequent emergency actions perpetuated structural imbalances and overuse instead of promoting lasting stability. Given climate-driven aridification and declining average flows, bold but lawful structural reforms are now required.

We contend that necessary reforms must be implemented in a manner consistent with the 1922 Colorado River Compact, the 1948 Upper Colorado River Basin Compact, and the broader Law of the River.

With this assertion in mind, we support and agree with the Colorado River Water Conservation District's comments and specific recommendations. We ask that you incorporate their suggestions for further analysis and revisions during the development of the Final EIS.

Additionally, we emphasize the following points that are essential to the development of operating guidelines that achieve a long-term balance between supply and demand across the Colorado River Basin.

Reclamation Must Prioritize Hydrologic Reality Over Predictability: The DEIS places undue emphasis on "predictability" for water users. Predictability cannot be achieved under future hydrologic conditions unless demands are permanently adjusted to align with reduced supply.

Flows in the Colorado River have declined approximately 20% over the past two decades and reservoir elevations remain critically low. The DEIS' focus on predictability disproportionately favors Lower Basin users who rely on reservoir releases, while Upper Basin communities live with hydrologic variability and limited storage buffering.

The proposed federal action must focus on restoring long-term structural balance across the basin and performing under all ranges of hydrology, including critically dry conditions.

The Final EIS Must Evaluate and Adjust the Scale of Upper Basin Conservation: Several alternatives rely on assumed Upper Basin conservation volumes of up to 500,000 acre-feet annually. However, the DEIS does not analyze the reasonably foreseeable environmental and socioeconomic impacts required to achieve conservation at that scale.

In Upper Basin communities, conservation at these levels would likely require significant and sustained reductions in irrigated acreage and municipal uses and decreased economic activity.

Such reductions would have direct and potentially permanent impacts on:

- Agricultural economies and employment
- Rural tax bases and county revenues
- Habitat for aquatic and terrestrial species
- Community stability and small business viability

These impacts must be analyzed programmatically and cumulatively under NEPA. Furthermore, the modeled conservation volumes exceed demonstrated program performance to date. The Final EIS should evaluate how alternative outcomes are impacted utilizing real world conservation program amounts.

Upper Basin Shortages Must Be Explicitly Disclosed: The DEIS repeatedly quantifies Lower Basin shortages in the main body of the document while relegating Upper Basin shortages to Appendix I.

Failure to clearly disclose these shortages in the main body of the EIS creates a misleading narrative regarding risk distribution across basins.

Lower Basin Water Use Must Account for System Losses: Approximately 1.5 million acre-feet annually represents system losses, including evaporation and transit losses. These losses are an integral part of Lower Basin consumptive use and should not be classified as "shortages." Failure to account for these losses contributed to storage decline under the 2007 Interim Guidelines. No basin or contractor should be permitted to deplete water beyond legal apportionments unless Lake Powell is in full or flood-control conditions.

Lower Basin conservation water must be subject to realistic, recurring evaporation and transit loss accounting. One-time assessments are insufficient.

At Least One Alternative Must Perform Under Critically Dry Hydrology and Hydrology Must Drive Post-2026 Operations: None of the DEIS alternatives perform adequately under critically dry hydrology. Given declining natural flows at Lees Ferry and current reservoir elevations, at least one alternative must achieve performance metrics at least 90% of the time under critically dry conditions.

Additionally, operating regimes based solely on comparative reservoir elevations have failed to protect storage at Lake Powell. The Draft EIS must model realistic operations and its effects instead of allowing reservoirs to drop below critical elevations. This is critical for the public to understand and evaluate impacts of likely operations given current reservoir levels and hydrologic conditions.

Interbasin Transactions Must Not Be Allowed: The interstate compacts were designed to provide legal certainty and prevent interstate water marketing across basins. Interstate marketing mechanisms threaten Upper Basin water security, economic stability, and legal clarity. Colorado law also reflects a long-standing

public policy limiting interstate export of waters of the state. We will not support any mechanism authorizing interstate or interbasin water marketing between the Upper and Lower Colorado River Basins.

Alternatives Must Contain Clearly Defined and Modeled Actions: The Basic Coordination Alternative includes non-specific actions above Lake Powell (i.e., in the Upper Basin) regarding additional reductions for infrastructure protection without modeling or clearly defining those triggers. These additional and unspecified actions must be disclosed and modeled to allow decision-makers and the public an opportunity to fully understand and assess the impact of these actions.

Similarly, the Supply Driven Alternative includes undefined "Gap Water," with modeling assumptions that do not exclude Lower Basin system loses. The concept of "Gap Water" must be fully defined with disclosure on how often it is introduced to the system and the range of its magnitude.

Upper Basin Conservation Water and CRSP Upper Initial Units Water Must Remain in Lake Powell: If Upper Basin conservation is included, conserved water must be operationally neutral with respect to Lake Powell releases and Lower Basin shortage determinations. Conserved water should only be released at the direction of the Upper Colorado River Commission for Compact compliance or meaningful reservoir recovery.

Releases from CRSP Upper Initial Units for infrastructure protection must remain operationally neutral and remain in Lake Powell until sufficient system recovery occurs. Repeated modeled releases raise feasibility and NEPA concerns that must be analyzed.

In conclusion, Upper Basin communities bear hydrologic variability at the source of the Colorado River system. Our economies, agricultural base, infrastructure, and public services depend on legally consistent and hydrologically realistic operations.

We respectfully urge Reclamation to revise the DEIS to:

- Restore structural supply-demand balance;
- Fully analyze Upper Basin conservation impacts;
- Properly account for Lower Basin system losses;
- Ensure transparency in modeling;
- Include alternatives that perform under critically dry hydrology; and
- Honor the compacts and federal law.

Thank you for your full and fair consideration of these comments.

Sincerely,

Gunnison County Board of Commissioners

_____	_____	_____
Laura Puckett Daniels, Chairperson	Jonathan Houck, Commissioner	Liz Smith, Commissioner

AGENDA ITEM or FINAL CONTRACT REVIEW SUBMITTAL FORM

Agenda Item: A Resolution Supporting Colorado Communities for C

Action Requested: Board of County Commissioners' Signature

Parties to the Agreement:

Term Begins: **Term Ends:** **Grant Contract #:**

Summary:

A Resolution Supporting Colorado Communities for Climate Action and Joining as a Member

Fiscal Impact: n/a

Submitted by: Holly Perry **Submitter's Email Address:** hperry@gunnisoncounty.org

Finance Review: ○ Required ◉ Not Required

Comments:

Reviewed by: Discharge Date:

County Attorney Review: ◉ Required ○ Not Required

Comments:
Legally sufficient. SO 2/26/26

Reveiwed by: GUNCOUNTY1\sobaid Discharge Date: 2/26/2026 Certificate of Insurance Required

Yes ○ No ◉

County Manager Review:

Comments:

Reveiwed by: GUNCOUNTY1\Hperry Discharge Date: 2/26/2026

○ Consent Agenda ◉ Regular Agenda ○ Worksession Time Allotted: 5

Agenda Date: 3/3/2026

Revised April 2015

BOARD OF COUNTY COMMISSIONERS
OF THE COUNTY OF GUNNISON, COLORADO

RESOLUTION NO. 2026-_____

A RESOLUTION SUPPORTING COLORADO COMMUNITIES FOR CLIMATE ACTION AND JOINING AS A MEMBER

WHEREAS, Colorado Communities for Climate Action ("CC4CA") is a coalition of Colorado municipalities and counties advocating for Federal and State policies to protect the climate, reduce air pollution and support clean energy; and

WHEREAS, on January 27, 2026, at a work session of the Board of County Commissioner of the County of Gunnison, Colorado ("Board"), the Board held a discussion about CC4CA with representatives of the coalition; and

WHEREAS, CC4CA has a Policy Statement, attached hereto as Appendix A; and

WHEREAS, the Board supports the goals of CC4CA and desires to join CC4CA as a member;

NOW, THEREFORE, BE IT RESOLVED by the Board of County Commissioners of the County of Gunnison, Colorado, that:

1. Gunnison County joins CC4CA as a member.

INTRODUCED by Commissioner_____, seconded by Commissioner _____, and adopted this ____ day of _____, 2026.

BOARD OF COUNTY COMMISSIONERS
OF THE COUNTY OF GUNNISON, COLORADO

By _____
Laura Puckett Daniels, Chairperson

By _____
Elizabeth Smith, Vice Chairperson

By _____
Jonathan Houck, Commissioner

ATTEST [seal]:

_____
Deputy County Clerk

CC4CA Policy Statement
Effective July 1, 2023
Adopted by the Board of Directors June 9, 2023

Colorado Communities for Climate Action is a coalition of local governments advocating for stronger state and federal climate policy. CC4CA's policy positions reflect unanimous agreement among the coalition members on steps that should be taken at the state and federal level, often in partnership with local governments, to enable Colorado and its communities to lead in protecting the climate.

CC4CA generally focuses on legislative, regulatory, and administrative action, supporting efforts that advance the general policy principles and the detailed policy positions described below, and opposing efforts that would weaken or undermine these principles and positions.

General Policy Principles

The following general principles guide Colorado Communities for Climate Action's specific policy positions. CC4CA supports:

- Collaboration between state and federal government agencies and Colorado's local governments to advance local climate protection and resilience.
- State and federal programs to reduce greenhouse gas pollution, including adequate and ongoing funding of those programs.
- Analyses, financial incentives, infrastructure, fiscal tools and enabling policies for the development and deployment of clean energy technologies.
- Locally driven and designed programs to support communities impacted by the clean energy transformation.
- Centering equity in decision-making by prioritizing policies that address systemic environmental and governance inequities based on race and socioeconomic status and that justly transition and grow the clean energy economy.

Policy Positions

Colorado Communities for Climate Action supports policies that:

Statewide Climate Strategies

1. Reduce statewide greenhouse gas emissions consistent with or greater than the State of Colorado's adopted, codified goals.

2. Secure accurate, actionable, useful, and regular state greenhouse gas inventories and forecasts for Colorado which are made accessible to local governments and incorporate alignment between state and local inventory data to the extent possible.

3. Adopt a comprehensive market-based approach to reduce Colorado's greenhouse gas emissions that ensures the benefits accrue justly and equitably to impacted communities.

4. Treat the environmental and health costs associated with the use of fossil fuels as an important priority in making and implementing climate-related policy.

Local Climate Strategies

5. Remove barriers and promote opportunities that allow counties and municipalities to maximize deployment of local clean energy and climate-related strategies, including resilience-oriented strategies, while promoting affordable, accessible, and equitable delivery of reliable clean energy.

6. Enable local governments to obtain the energy use and other data from utilities and state agencies that they need to effectively administer climate and clean energy programs.

7. Support well-designed public processes for evaluating retail and wholesale energy choice options for communities, informed by a broad variety of stakeholders.

8. Provide cost-effective and equitable policies, strategies, and practices that enable and accelerate energy efficiency in buildings, beneficial electrification, reducing building related GHG emissions, and improving quality of life.

Energy Generation, Transmission, and Distribution

9. Modernize energy infrastructure to strengthen grid reliability, enhance resilience (community-based and otherwise), improve transmission, and more fully integrate renewable energy, distributed generation, and energy storage resources.

10. Retire or discontinue the use of fossil fuel power plants while ensuring grid reliability.

11. Discourage construction of new fossil fuel power plants.

12. Expand the ability of electric cooperatives and municipal electric utilities to independently purchase local renewable electricity and take other steps to reduce greenhouse gas pollution.

Energy Efficiency

13. Expand demand side savings from efficiency and conservation for all energy types.

14. Support ongoing and sustainable funding for weatherization, beneficial electrification, and renewable energy assistance to low-income households.

15. Provide counties and statutory cities and towns with the same authority held by home rule cities to implement local energy conservation policies and programs.

Transportation

16. Ensure effective implementation of Colorado's vehicle emissions standards, GHG-related regulations, state and regional transportation-related plans, and other regulatory and programmatic activities designed to reduce greenhouse gas emissions from mobile sources.

17. Increase funding and policy incentives for multimodal transportation and mobility options, based on efficient use of resources.

Land Use

18. Encourage adoption, funding, and implementation of statewide policies that enable and incentivize local governments to enact land use, zoning, and planning policies that help reduce greenhouse gas emissions and improve resilience.

19. Encourage adoption and implementation of practices in the agriculture and forest sectors that durably reduce greenhouse gases, increase resilience, improve water

conservation, support ecosystem health, and promote a sustainable, low-carbon agriculture and forestry economy in Colorado.

Resilience

20. Proactively improve the resilience and adaptability of Colorado communities in the face of natural disasters and other challenges associated with climate change, including ensuring that disaster stabilization and recovery efforts result in reduced greenhouse gas pollution and improved resilience to future disasters.

21. Reduce greenhouse gas emissions associated with water management, and increase water resilience, through water conservation, efficiency, reuse, adaptation, low impact development strategies, and other approaches.

Fuel Sources

22. Eliminate emissions from and achieve comprehensive, high accuracy monitoring of fossil fuel extractive industry activities.

23. Secure appropriate guardrails on the development/use of alternative energy technologies, such as hydrogen and biomass, based on their life cycle greenhouse gas emissions impacts, environmental and social impacts, and cost.

Waste

24. Ensure that CDPHE has adequate authority and resources to implement plans and policies for meeting Colorado's statewide and regional solid waste diversion goals.

25. Secure high levels of circular economy activities like reuse, recycling, composting, and reducing the carbon intensiveness of materials and products, including reducing and eliminating use of disposable/single-use products and construction and demolition waste.

26. Achieve significant greenhouse gas emissions reductions from solid waste, water treatment, and wastewater processing.

General

27. Support ongoing and sustainable funding for programs that assist communities in the transition from fossil fuel-dominated economies.

28. Support exploration and deployment of well-regulated carbon management technologies and practices that: a) retain currently sequestered carbon, capture greenhouse gases before they are emitted, remove greenhouse gases from the atmosphere, and use or sequester this carbon; and b) incorporate appropriate

guardrails on lifecycle greenhouse gas emissions, environmental and social impacts, and cost.

29. Encourage investments that achieve climate-positive solutions, including policies that encourage entities investing public dollars to consider partial or full divestment in fossil fuel extraction and use as part of their investment strategies.

30. Maintain protections and authorities currently provided under environmental laws like the National Environmental Policy Act, Clean Air Act, and Clean Water Act, and ensure that these laws are fully implemented and can be improved through stakeholder input when appropriate.

AGENDA ITEM or FINAL CONTRACT REVIEW SUBMITTAL FORM

Agenda Item: Lot Cluster; LUC-25-00025; Matt and Dana Wise

Action Requested: Board of County Commissioners' Signature

Parties to the Agreement:

Term Begins: **Term Ends:** **Grant Contract #:**

Summary:

The Applicants, Matt and Dana Wise, request a lot cluster of parcel # 3689-340-02-054 and parcel # 3689-340-02-009. The parcels are legally described as Lots 6 through 10, Block 2, Townsite of White Pine.

Fiscal Impact:

Submitted by: Caroline Danielson **Submitter's Email Address:** cdanielson@gunnisoncounty.org

Finance Review: ○ Required ◉ Not Required

Comments:

Reviewed by: Discharge Date:

County Attorney Review: ◉ Required ○ Not Required

Comments:
Legally sufficient. SO 2/24/26

Reveiwed by: GUNCOUNTY1\sobaid Discharge Date: 2/24/2026 Certificate of Insurance Required

Yes ○ No ◉

County Manager Review:

Comments:

Reveiwed by: GUNCOUNTY1\mbirnie Discharge Date: 2/25/2026

○ Consent Agenda ◉ Regular Agenda ○ Worksession Time Allotted: 5

Agenda Date: 3/3/2026

Revised April 2015

GUNNISON COUNTY
COMMUNITY & ECONOMIC DEVELOPMENT

Caroline Danielson, *Planner I*
(970) 641-7981
cdanielson@gunnisoncounty.org
www.GunnisonCounty.org

To: Board of County Commissioners
RE: LUC-25-00025 | Lot Cluster | Matt and Dana Wise
Memo Date: February 23, 2026
Meeting Date: March 3, 2026

The Applicants, Matt and Dana Wise, request a lot cluster of parcel # 3689-340-02-054 and parcel # 3689-340-02-009, as shown in Exhibit A. *Site Plan.* The parcels are legally described as Lots 6 through 10, Block 2, Townsite of White Pine. On the Gunnison County Assessor's Property Record Search, Lots 6 and 7 are shown as one parcel and Lots 8-10 are shown as one parcel. However, the lots have not been legally clustered and could, as they stand currently, be separately conveyed. The parcels are currently vacant, and the Applicant intends to construct an OWTS and single-family residence across the parcels. The Applicant desires to use the parcels as a single property.

The application was reviewed by the County Attorney's Office on September 17, 2025 for legal sufficiency. Staff has reviewed the lot cluster application for compliance with the applicable standards of Land Use Resolution (LUR) Section 5-103 *Standards of Approval of Administrative Review Projects.*

SECTION 5-103: *STANDARDS FOR APPROVAL OF ADMINISTRATIVE REVIEW PROJECTS*

1. COMPLY WITH APPLICABLE STANDARDS. The land use change shall comply with all applicable standards and other provisions of this Resolution. **No non-conformities will be created. The clustered lots would not meet the minimum lot size of one acre outlined in the Gunnison County OWTS Regulations. With this, the Applicant would need a variance granted by the Environmental Health Board prior to OWTS permit issuance.**
2. COMPATIBILITY WITH COMMUNITY CHARACTER. The proposed land use change shall be compatible with, or an enhancement of, the character of existing land uses in the area, and shall not adversely impact the future development of the surrounding area. **Surrounding lots range from ~6,250 to ~53,317 square feet, with the majority of the lots in White Pine being less than 1 acre. The resultant clustered Lots 6-10 would be 29,036 square feet. With this, the clustering of the Wise's lots would be compatible with the character of the surrounding area. Additionally, clustering the lots would reduce density in an area that is far from existing municipalities, transit, public utilities, and community services.**

The application was found to comply with the standards of LUR Section 104. M: *Application Form for Lot Cluster*.

Thank you,
Caroline Danielson

Caroline Danielson, *Planner I*
(970) 641-7981
cdanielson@gunnisoncounty.org
www.GunnisonCounty.org

Exhibits

You may review the entire application at https://permitdb.gunnisoncounty.org/citizenaccess, click "Projects", search by application number LUC-25-00025. Click on "Attachments".

A. Site Plan
B. Lot Cluster Agreement

COUNTY ROAD 888 , WHITE PINE - UPPER TOMICHI
Actual Value **$27,880**
Account # **R009592**
Parcel # **368934002054**
Owners **WISE MATT, WISE DANA**
Legal **LOTS 6 & 7, BLOCK 2, WHITE PINE**

COUNTY ROAD 888 , WHITE PINE - UPPER T
Actual Value **$36,880**
Account # **R009593**
Parcel # **368934002009**
Owners **WISE MATT, WISE DANA**
Legal **LOTS 8-10, BLOCK 2, WHITE PINE**

LOT CLUSTER AGREEMENT AND DECLARATION

Date of Meeting_____(filled in by staff)

THIS LOT CLUSTER AGREEMENT AND DECLARATION is made between the Board of County Commissioners of the County of Gunnison, Colorado (hereinafter "Gunnison County")

and Matt Wise _____ _____
(Owner) **(Owner)**

Dana Wise _____ _____
(Owner) **(Owner)**

RECITALS:

Legal Description: Complete – please attach if too long

LOTS 6 & 7, & LOTS 8-10, BLOCK 2, WHITE PINE - TBD CR 888, Whitepine, CO 81248

and any adjacent street or alley that is or may be vacated.,
County of Gunnison
State of Colorado

This *Lot Cluster Agreement and Declaration* is made for good, valuable and sufficient consideration, including the creation of a single parcel by the clustering of the above described properties.

NOW, THEREFORE, it is agreed that:

1. Gunnison County, Colorado and Owner, on behalf of themselves, their respective heirs, successors, personal representatives and assigns, hereby declare that the real property described above shall hereafter be and is combined into one parcel to be maintained as one new integrated parcel and single building lot and further declare that no portion of such new parcel constituting less than the entire new parcel may be conveyed, mortgaged or encumbered or otherwise transferred without prior compliance with applicable subdivision requirements including but not limited to the *Gunnison County Land Use Resolution*.

2. This *Lot Cluster Agreement and Declaration* does not independently change or amend any fee, assessment or charge regarding any service to such real property.

3. This *Lot Cluster Agreement and Declaration* is made for the benefit of Gunnison County, Colorado, and shall run with the land in perpetuity. Nothing in this *Lot Cluster Agreement and Declaration* is or shall be construed to be a waiver of applicable County Building, Sewage Disposal System, Land Use Change or other permit requirements.

4. This *Lot Cluster Agreement and Declaration* shall not have effect until it is recorded, at the cost of the Applicant, with the Clerk and Recorder of Gunnison County, Colorado.

5. The lot cluster approved by recordation of this *Lot Cluster Agreement and Declaration* does not result in a guarantee of approval of an Individual Septic System Permit application or approval of a variance from the *Gunnison County Individual Sewage Disposal System Regulations*.

6. Approval of this lot cluster is subject to the terms of the utility companies potentially affected by this action. The companies' comments are attached to, and are hereby incorporated as part of this *Lot Cluster Agreement and Declaration*.

Date: 8-28-25 Matt Wise
Owner

Date: 8/28/25 Dana Wise
Owner

Date: _____
Owner

Date: _____
Mortgage or Lien Holder

STATE OF Washington)
)ss
COUNTY OF Kittitas)

The foregoing instrument was acknowledged before me this 28 day of August 2025 by Matt and Dana Wise **(Owner/s).**

Witness my hand and official seal.

My Commission expires: October 17, 2026

Notary Public

NOTARY PUBLIC
STATE OF WASHINGTON
TAYLOR LINSLEY
MY COMMISSION EXPIRES
OCTOBER 17, 2026
COMMISSION # 1955931

Address:

STATE OF _____)
)ss
COUNTY OF _____)

The foregoing instrument was acknowledged before me this _____ day of _____20___ by _____ **(Mortgage/Lien Holder).**

Witness my hand and official seal.

My Commission expires: _____

_____
Notary Public

Address:

Date: _____

_____ Chairperson

_____ Vice-Chairperson

_____ Commissioner

Board of County Commissioners
Gunnison County, Colorado

Attest:

_____
Gunnison County Clerk and Recorder

AGENDA ITEM or FINAL CONTRACT REVIEW SUBMITTAL FORM

Agenda Item: Boundary Line Adjustment; LUC-24-00011; Hartman Ca

Action Requested: Board of County Commissioners' Signature

Parties to the Agreement:

Term Begins: **Term Ends:** **Grant Contract #:**

Summary:

The Applicant requests a boundary line adjustment with the purpose of transferring 0.39 acres from Parcel 2 to Parcel 1 to include Hartman Castle within Parcel 1.

Fiscal Impact:

Submitted by: Rachael Blondy **Submitter's Email Address:** rblondy@gunnisoncounty.org

Finance Review: ○ Required ◉ Not Required

Comments:

Reviewed by: Discharge Date:

County Attorney Review: ◉ Required ○ Not Required

Comments:
Legally sufficient. SO 2/24/26

Reveiwed by: GUNCOUNTY1\sobaid Discharge Date: 2/24/2026 Certificate of Insurance Required

Yes ○ No ◉

County Manager Review:

Comments:

Reveiwed by: GUNCOUNTY1\mbirnie Discharge Date: 2/25/2026

○ Consent Agenda ◉ Regular Agenda ○ Worksession Time Allotted: 5

Agenda Date: 3/3/2026

Revised April 2015

GUNNISON COUNTY
COMMUNITY & ECONOMIC DEVELOPMENT

Rachael Blondy, *Planner II*
(970) 641-7932
rblondy@gunnisoncounty.org
www.GunnisonCounty.org

To: Gunnison County Board of County Commissioners
RE: LUC-24-00011 | Boundary Line Adjustment | Hartman Castle
Meeting Date: March 3, 2026

The Applicant, Dave Taylor, requests approval of a Boundary Line Adjustment (BLA) between two parcels to the south of the City of Gunnison and to the west of County Road 50. Both parcels can be found under Parcel 3787-110-00-015, but recorded deeds confirm two parcels exist. The purpose of the BLA is to transfer 0.39 acres of land from Parcel 2 to Parcel 1, so that the property boundary of Parcel 1 encapsulates Hartman Castle. The Hartman Castle Preservation Corporation is going through a historical designation process, which includes an application for a grant to purchase Parcel 1 from the Applicant. The parcels will have legal access off County Road 50, with an access easement through Parcel 1 to Parcel 2. Both parcels are developed.

1. Parcel 1 - 2.99 acres to 3.38 acres
2. Parcel 2 - 2.84 acres to 2.45 acres

Staff reviewed the application, which complies with all applicable standards found in Land Use Resolution Section 5-103 and was found to comply with the standards of Section 5-103:A.3.a and Section 5-104.L.

Section 5-103:A STANDARDS FOR APPROVAL OF ADMINISTRATIVE REVIEW PROJECTS

1. *COMPLY WITH APPLICABLE STANDARDS* – No conformities will be created.
2. *COMPATIBILITY WITH COMMUNITY CHARACTER* – The resulting lots are similar to the surrounding parcels.

Section 5-103:A.3.a ADDITIONAL STANDARDS APPLICABLE TO BOUNDARY LINE ADJUSTMENTS

1. *INSUBSTANTIAL CHANGE* – *Parcel 1: Increased by 13.04%*
   Parcel 2: Decreased by 13.73%
2. *NOT CREATE ADDITIONAL LOTS* – The BLA will not create additional lots.
3. *MINIMUM LOT SIZE* – Both resulting parcels will be above 1 acre.

Section 5-104:L APPLICATION FORM FOR BOUNDARY LINE

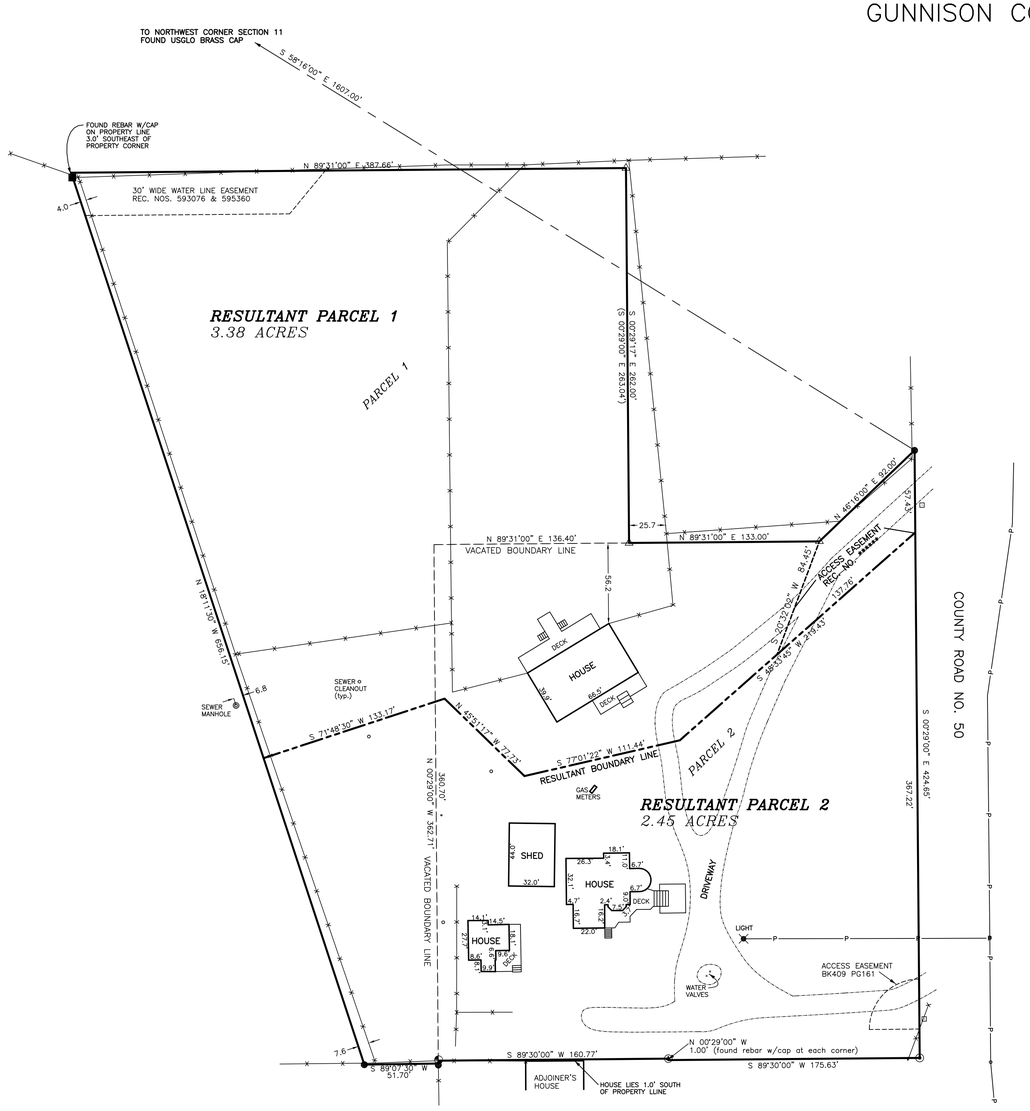
1. *CONSENT OF ALL LANDOWNERS AND MORTGAGE HOLDERS* – Notarized written consent from the landowner is found on the plat.
2. *SURVEY PLAT* – The BLA plat meets all standards listed in this section.

Exhibits

You may review the entire application at https://permitdb.gunnisoncounty.org/citizenaccess, click "Projects", search by application number LUC-24-00011, Click on "Attachments".

A. Plat
B. Access Easement

BOUNDARY LINE ADJUSTMENT – TAYLOR PROPERTY
TWO PARCELS THE WITHIN SE1/4NW1/4NW1/4 OF SECTION 11, TOWNSHIP 49 NORTH, RANGE 1 WEST, N.M.P.M. GUNNISON COUNTY, COLORADO



ATTORNEY'S OPINION

I, Daniel P. Spivey, being an attorney-at-law duly licensed to practice before courts of record in the State of Colorado, do hereby certify that I have examined the title to all lands herein shown on this plat and title to such lands is in David A. Taylor and Susan M. Taylor, free and clear of all liens, taxes and encumbrances, except as follows:

1. Any lien, or right to a lien, for services, labor or material heretofore or hereafter furnished, imposed by law and not shown by the public records.
2. Any and all unpaid taxes and assessments.
3. (a) Unpatented mining claims; (b) reservations or exceptions in patents or in Acts authorizing the issuance thereof; (c) water rights, claims or title to water, whether or not the matters excepted under (a), (b), or (c) are shown by the public records.
4. Any and all matters not of the public record and not otherwise shown or otherwise identified on this plat.
5. Right of the proprietor of a vein or lode to extract and remove his ore therefrom, should the same be found to penetrate or intersect the premises hereby granted, and a right of way for ditches or canals constructed by the authority of the United States, as reserved in United States Patent recorded April 02, 1895 in Book 115 at Page 149.
6. Terms, conditions, provisions, burdens and obligations as set forth in easement and right of way for access purposes recorded April 03, 1969 in Book 409 at Page 161.
7. Terms, conditions and provisions of Resolution No. 38, Series 1994 recorded December 07, 1994 in Book 756 at Page 894.
8. Terms, conditions, provisions, burdens and obligations as set forth in Grant of Perpetual Easement recorded August 20, 2009 under Reception No. 593076 and in Grant of Perpetual Easement November 25, 2009 under Reception No. 595360.
9. Terms, conditions and provisions of Certificate of Administrative Review recorded April 22, 2024 under Reception No. 696026.
10. Terms, conditions and provisions of Certificate of Setback Variance Approval recorded July 23, 2024 under Reception No. 697352.
11. Terms, conditions and provisions of Certificate of Minor Impact Approval recorded July 23, 2024 under Reception No. 697351.
12. All matters shown on this plat.

_____
Daniel P. Spivey, Attorney-at-law
Supreme Court Registration No. 41504
For and on behalf of Law of the Rockies, LLC
525 N. Main St., Gunnison, CO 81230

SURVEYOR'S CERTIFICATE

I, Timothy E. Pearson, a registered land surveyor in the State of Colorado, certify that this plat and the survey referred to herein were made under my direction and control and that both are true and correct to the best of my knowledge.

Dated this _____ day of _____, A.D. 20___.

_____
Timothy E. Pearson
Colorado L.S. No. 34979

DEDICATION

Know all men by these presents, that the undersigned, being all of the Owner(s), Mortgagee(s) and Lien–holder(s) of certain lands in Gunnison County, Colorado, described as follows:

Township 49 North, Range 1 West, N.M.P.M.

Section 11: Two parcels of land located in the SE1/4NW1/4NW1/4 of said Section 11, more particularly described as follows:

Parcel No.1:

Beginning at a point from whence the NW corner of said Section 11 bears N 58°16' W 1607.0 feet;
thence S 46°16' W 92.0 feet;
thence S 89°31' W 133.0 feet to the true point of beginning;
thence around said tract S 89°31' W 136.4 feet;
thence S 0°29' E 362.71 feet;
thence S 89°07.5' W 51.7 feet;
thence N 18°11.5' W 656.15 feet;
thence N 89°31' E 387.66 feet;
thence S 0°29' E 263.04 feet to the point of beginning,

County of Gunnison,
State of Colorado.

Parcel No.2:

Beginning at a point from whence the NW corner of said Section 11 bears N 58°16' W 1607.0 feet;
thence S 0°29' E 424.65 feet;
thence S 89°30' W 175.63 feet;
thence N 0°29' W 1.0 feet
thence S 89°30' W 160.77 feet;
thence N 0°29' W 360.70 feet;
thence N 89°31' E 269.4 feet;
thence N 46°16' E 92 feet to the point of beginning,

County of Gunnison,
State of Colorado.

in Gunnison County, Colorado, under the name of BOUNDARY LINE ADJUSTMENT – TAYLOR PROPERTY, in Gunnison County, Colorado, have laid out, platted and/or subdivided the same as shown on this plat and do hereby dedicate and convey to the owners of lots, tracts, or parcels within this subdivision and their guests, but not to the public at large, the common right to use streets, alleys, roads and other public areas as shown hereon and hereby dedicate those portions of land labeled as easements for the installation and maintenance of public utilities as shown hereon.

Executed this _____ day of _____, 2026.

OWNERS:

By_____
David A. Taylor

By_____
Susan M. Taylor

STATE OF COLORADO)
) ss.
COUNTY OF GUNNISON)

The foregoing instrument was acknowledged and executed before me this _____ day of _____ 2026, by David A. Taylor and Susan M. Taylor.

Witness my hand and official seal. _____
Notary Public

BOARD OF COUNTY COMMISSIONERS APPROVAL

The within plat of the boundary line adjustment, BOUNDARY LINE ADJUSTMENT – TAYLOR PROPERTY, is approved this _____ of _____, A.D. 2026.

_____
Chairperson, Gunnison County Board of Commissioners

ATTEST:

_____
County Clerk

GUNNISON COUNTY CLERK AND RECORDER'S ACCEPTANCE

This plat was accepted for deposit in the office of the Clerk and Recorder of Gunnison County, Colorado on this _____ day of _____, 2026, Deposit Number _____
Time _____, Date _____.

_____
Gunnison County Clerk and Recorder

N

50 0 50 100
Scale: 1" = 50'

GENERAL NOTES:

1. Property located by field measurments from the northwest corner of Section 11, as marked by a USGLO brass cap. Basis of bearings is astronomic north as determined by solar observations.
2. Parcel No.1 as described does not mathematically close by 1.04 feet. Record bearing and distance are shown in parentheses where they differ from calculated bearing and distance along the closing closing leg of this parcel.

LEGEND

- ■ Found rebar with aluminum cap stamped "LS 1776"
- ⊙ Found rebar with no cap
- ⊛ Found rebar with plastic cap stamped "LS 2816"
- △ Found steel stake with steel cap stamped "LS 11250" or with no cap
- ⚽ Found rebar with plastic cap stamped "LS 33647"
- ● Set rebar with plastic cap stamped "LS 34979"
- □ Utility pedestal
- —P—P— Overhead utility lines
- —x—x— Fence

BOUNDARY LINE ADJUSTMENT – TAYLOR PROPERTY
TWO PARCELS THE WITHIN SE1/4NW1/4NW1/4 OF SECTION 11, TOWNSHIP 49 NORTH, RANGE 1 WEST, N.M.P.M. GUNNISON COUNTY, COLORADO
PROPERTY ADDRESS: 277 & 594 COUNTY ROAD 50

PEARSON SURVEYING
P.O. BOX 652
GUNNISON, CO 81230
970–641–2910
PROJECT # 24–1–4

DATE : 6/28/24
LATEST REVISION DATE : 1/28/26

EASEMENT AGREEMENT

This Easement Agreement (the "Agreement") is entered into this __ day of _____, 2026, by and between David A. Taylor and Susan M. Taylor on the one hand ("Taylors") and Hartman Castle Preservation Corporation, a Colorado nonprofit corporation, on the other hand ("Hartman") (individually referred to as a "Party" and collectively, the "Parties").

RECITALS

A. The Taylors are the owners of real property with a legal description of Resultant Parcel 1 according to the Boundary Line Adjustment – Taylor Property Plat recorded in the real property records of Gunnison County, Colorado on _____, 2026 at Reception No. _____ ("Taylor Property").

B. Hartman is the owner of real property with a legal description of Resultant Parcel 2 according to the Boundary Line Adjustment – Taylor Property Plat recorded in the real property records of Gunnison County, Colorado on _____, 2026 at Reception No. _____ ("Hartman Property").

C. The Taylor Property and the Hartman Property are adjacent to each other.

D. There is part of a driveway used to access the Hartman Property located off County Road No. 50 that travels through the Taylor Property as shown on Exhibit A hereto as the Access Easement and that is legally described in Exhibit B hereto.

E. The Taylors desire to grant an easement to Hartman so that Hartman may use that part of the driveway on the Taylor Property for purposes of ingress and egress to the Hartman Property.

NOW THEREFORE, in consideration of the above recitals and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the Parties agree as follows:

AGREEMENT

1. Grant of Easement to Hartman. The Taylors grant to Hartman a perpetual, appurtenant, non-exclusive easement (the "Easement") on, over, across, and through that portion of the Taylor Property shown on Exhibit A to this Agreement as the "Access Easement" and legally described in Exhibit B to this Agreement for purposes of ingress and egress to and from the Hartman Property. For clarity, there is a portion of the driveway located on the Taylor Property which is not part of the easement being granted herein to Hartman. Only that part of the driveway located within that area shown on Exhibit A as the "Access Easement" and legally described in Exhibit B is the easement being granted to Hartman herein.

2. Use of the Easement. The Easement may be used by Hartman and its successors, assigns, members, officers, agents, contractors, employees, guests, customers, and invitees for residential or commercial purposes ("Hartman Permitted Users") for ingress and egress to and from the Hartman Property. The Easement is non-exclusive and each Party shall use the Easement with due regard to the rights of the other Party. The Taylors may use the Easement in any manner that does not unreasonably interfere with or obstruct Hartman's permitted use of the Easement.

3. Covenants Run with the Land. The grant of the Easement and the conditions and provisions contained in this Agreement shall run with the land and be binding upon the current and future owners of the Taylor Property and the Hartman Property.

4. Maintenance of the Access Easement. The Parties shall equally share the costs to maintain the Access Easement which maintenance includes but is not limited to snow plowing, resurfacing, grading, and any other activity necessary to keep the Access Easement in good condition and reasonably passable by passenger vehicles on a year-round basis. All maintenance shall be performed in a good and workmanlike manner. The Parties shall agree on a contractor to perform necessary maintenance on the Access Easement. Notwithstanding the foregoing, if the Taylors' actions or the actions of the Taylors' successors, assigns, members, offices, agents, contractors, employees, guests, or invitees ("Taylor Users") are the primary cause of a needed item of repair or maintenance to the Access Easement, then the Taylors shall make said repairs or maintenance at the Taylors' cost, and if Hartman's actions or the Hartman Permitted Users' actions are the primary cause of a needed item of repair or maintenance to the Access Easement, then Hartman shall make said repairs at Hartman's cost.

5. Indemnification by the Taylors. The Taylors agree to indemnify and defend Hartman from any and all claims, causes of action, debts, damages, demands, and liabilities arising out of or relating to the use of the Access Easement by the Taylors or the Taylor Users except to the extent any such claims, causes of action, debts, damages, demands, or liabilities arise out of any negligence, recklessness, or intentional misconduct by Hartman or the Hartman Permitted Users or any breach of this Agreement by Hartman.

6. Indemnification by Hartman. Hartman agrees to indemnify and defend the Taylors from any and all claims, causes of action, debts, damages, demands, and liabilities arising out of or relating to the use of the Access Easement by Hartman or the Hartman Permitted Users except to the extent any such claims, causes of action, debts, damages, demands, or liabilities arise out of any negligence, recklessness, or intentional misconduct by the Taylors or the Taylor Users or any breach of this Agreement by the Taylors.

7. Severability. If any term or provision of this Agreement or the application thereof to any person or circumstance shall, to any extent, be invalid or unenforceable, the remainder of this Agreement shall not be affected thereby, and each term and provision of this Agreement shall be valid and enforceable to the fullest extent permitted by law.

8. Modifications and Waiver. This Agreement may not be modified in any respect except by a further agreement in writing duly executed by the Parties or their successors in interest. No waiver shall be deemed or construed to be a continuing waiver with respect to any breach or default, whether of similar or different nature, unless expressly stated in a writing signed by the waiving party.

9. Attorneys' Fees and Costs. The prevailing party in any legal proceeding to interpret or enforce this Agreement shall be awarded such prevailing party's reasonable attorneys' fees and costs incurred in connection with such proceeding.

10. Governing Law and Venue. This Agreement shall be governed by and construed in accordance with the laws of the State of Colorado. Venue for any legal action related to this Agreement shall be exclusively in Gunnison County, Colorado.

11. Counterparts. This Agreement may be executed in counterparts, each of which shall constitute an original, and all of which together shall constitute one and the same document.

12. Recording. This Agreement shall be recorded in the records of the Gunnison County Clerk and Recorder.

IN WITNESS WHEREOF, the Parties have executed this Agreement.

_____
David A. Taylor

_____
Susan M. Taylor

Hartman Castle Preservation Corporation

_____
By: Pamela Williams, Board President

STATE OF COLORADO)
) ss.
COUNTY OF_____)

The foregoing instrument was acknowledged before me this ____ day of_____, 2026, by Pamela Williams as Board President of Hartman Castle Preservation Corporation, a Colorado nonprofit corporation. Witness my hand and official seal.
My commission expires: _____.

_____
Notary Public

STATE OF COLORADO)
) ss.
COUNTY OF_____)

The foregoing instrument was acknowledged before me this ____ day of _____, 2026, by David A. Taylor and Susan M. Taylor. Witness my hand and official seal.
My commission expires: _____.

_____
Notary Public

EXHIBIT A
Plat

EXHIBIT B
Legal Description

A tract of land within the SE1/4NW1/4NW1/4 of Section 11, Township 49 North, Range 1 West, New Mexico Principal Meridian, Gunnison County, Colorado, and also within the Taylor Property as described by deed recorded at Reception No. 612691 in the records of Gunnison County, said tract being more particularly described as follows:

Commencing at the northwest corner of said Section 11, thence South 56°16'00" East 1607.00 feet to the northeast corner of that tract described as Parcel No. 2 of Parcel A in said deed, the POINT OF BEGINNING, thence the following courses:

1. South 46°16'00" West 92.00 feet along the north boundary of said Parcel No. 2;
2. South 20°32'02" West 84.45 feet;
3. North 48°33'45" East 137.76 feet to the east boundary of said Parcel No. 2;
4. North 00°29'00" West 57.43 feet along said boundary to the POINT OF BEGINNING.

AGENDA ITEM or FINAL CONTRACT REVIEW SUBMITTAL FORM

Agenda Item: Potential Upcoming Legislation Discussion

Action Requested: Discussion

Parties to the Agreement:

Term Begins: **Term Ends:** **Grant Contract #:**

Summary:

Legislative discussion

Fiscal Impact:

Submitted by: Holly Perry **Submitter's Email Address:** hperry@gunnisoncounty.org

Finance Review: ○ Required ◉ Not Required

Comments:

Reviewed by: Discharge Date:

County Attorney Review: ◉ Required ○ Not Required

Comments:
Legally sufficient. SO 2/24/26

Reveiwed by: GUNCOUNTY1\sobaid Discharge Date: 2/24/2026 Certificate of Insurance Required

Yes ○ No ◉

County Manager Review:

Comments:

Reveiwed by: GUNCOUNTY1\mbirnie Discharge Date: 2/25/2026

○ Consent Agenda ◉ Regular Agenda ○ Worksession Time Allotted: 60

Agenda Date: 3/3/2026

Revised April 2015

Second Regular Session
Seventy-fifth General Assembly
STATE OF COLORADO

INTRODUCED

LLS NO. 26-0319.01 Clare Haffner x6137 **HOUSE BILL 26-1007**

HOUSE SPONSORSHIP

Smith and Stewart R.,

SENATE SPONSORSHIP

Kipp,

House Committees
Energy & Environment

Senate Committees

A BILL FOR AN ACT

CONCERNING MEASURES TO IMPROVE A CUSTOMER'S ABILITY TO USE DISTRIBUTED ENERGY RESOURCES.

Bill Summary

(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at http://leg.colorado.gov.)

The bill defines, and creates requirements for, portable-scale solar generation devices. In addition, the bill prohibits a provider of retail electric service or wholesale energy from, among other things, requiring a customer to obtain the provider's approval before installing or using a portable-scale solar generation device. The bill also prohibits a person from restricting, prohibiting, or imposing unreasonable conditions on the

installation, use, or operation of a portable-scale solar generation device.

Under current law, a utility that is subject to regulation by the public utilities commission (commission) must allow for customer ownership and use of a meter collar adapter through the utility's interconnection standards. The bill requires the commission, on or before December 31, 2026, to revise existing commission interconnection rules to explicitly require commission-regulated utilities to allow for customer ownership and use of meter collar adapters and to prohibit commission-regulated utilities from requiring a production meter as a condition of interconnection for a customer-sited distributed energy resource.

The bill requires municipally owned utilities and cooperative electric associations to also allow for customer ownership and use of meter collar adapters and prohibits municipally owned utilities and cooperative electric associations from requiring a production meter as a condition of interconnection for a customer-sited distributed energy resource.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Legislative declaration. (1) The general assembly finds and declares that:

(a) With weather-related power outages on the rise, distributed generation systems, such as residential solar energy systems, create a clean, reliable energy source that, especially when paired with an energy storage system, is less vulnerable to natural disasters and grid failures;

(b) Customers across the state are increasingly wanting to have more freedom and choice over their energy decisions and to increase the self-reliance and self-sufficiency of their families and communities;

(c) Portable-scale solar generation devices plug in directly to a wall outlet and immediately provide energy to a home. These devices can play a meaningful role in addressing energy affordability statewide, and they are ideal for any small space, such as an apartment balcony or a small patio.

(d) While clean energy technologies, including portable-scale

solar generation devices, are becoming increasingly available for customers, interconnection fees and other utility processes can make the adoption of such technologies unnecessarily costly and burdensome;

(e) It is the policy of the state and the intent of the general assembly to encourage the use of portable-scale solar generation devices and to limit obstacles to customers' use of these devices; and

(f) Increasing renewable energy generation and allowing customers across the state to have more freedom, choice, and self-sufficiency over their energy decisions through the use of portable-scale solar generation devices is a matter of statewide concern.

(2) The general assembly further finds that:

(a) Customer-sited distributed energy resources, including rooftop solar and energy storage, are important tools to help customers manage bills, improve resilience, and support achievement of the state's clean energy and climate goals;

(b) Ensuring efficient, low-cost, and timely interconnection of distributed energy resources is a matter of statewide concern;

(c) Use of meter collar adapters can reduce or avoid costly and time-consuming service panel upgrades when interconnecting distributed energy resources, thereby lowering the costs of and barriers to customer-sited distributed energy resources for households and small businesses;

(d) Cooperative electric associations are required to comply with the interconnection rules adopted by the public utilities commission, and municipally owned utilities are required to adopt interconnection standards that are functionally similar to those established by the public utilities commission;

(e) However, existing law does not explicitly require that cooperative electric associations and municipally owned utilities must allow for customer use of meter collar adapters; and

(f) Therefore, additional statutory direction is needed to ensure that all utilities in the state fully and efficiently accommodate the use of meter collar adapters.

(3) The general assembly further finds that requiring separate production meters for customer-sited distributed energy resources in circumstances where net energy consumption can be accurately measured at the customer's billing meter adds unnecessary cost and complexity that discourage beneficial distributed energy resources.

SECTION 2. In Colorado Revised Statutes, **add** 40-2-140 as follows:

40-2-140. Portable-scale solar generation devices - requirements - exemptions - definition.

(1) AS USED IN THIS SECTION, "PORTABLE-SCALE SOLAR GENERATION DEVICE" OR "DEVICE" MEANS A PHOTOVOLTAIC SYSTEM AND ASSOCIATED EQUIPMENT THAT:

(a) IS DESIGNED OR COMMISSIONED TO SUPPLY A MAXIMUM POWER OUTPUT OF NOT MORE THAN ONE THOUSAND NINE HUNDRED TWENTY WATTS TO THE ELECTRIC GRID; AND

(b) IS CERTIFIED BY A NATIONALLY RECOGNIZED TESTING LABORATORY.

(2) A PORTABLE-SCALE SOLAR GENERATION DEVICE MUST INCLUDE A FEATURE THAT PREVENTS THE DEVICE FROM ENERGIZING THE ELECTRIC GRID DURING A POWER OUTAGE.

(3) A CUSTOMER THAT USES A PORTABLE-SCALE SOLAR

GENERATION DEVICE MAY PARTICIPATE IN A NET METERING PROGRAM MADE AVAILABLE BY THE CUSTOMER'S UTILITY PURSUANT TO SECTION 40-2-124 OR 40-9.5-118 (2).

(4) A PROVIDER OF RETAIL ELECTRIC SERVICE OR WHOLESALE ENERGY SHALL NOT REQUIRE A CUSTOMER TO:

(a) OBTAIN THE PROVIDER'S APPROVAL BEFORE INSTALLING OR USING A PORTABLE-SCALE SOLAR GENERATION DEVICE;

(b) PAY THE PROVIDER A FEE RELATED TO A PORTABLE-SCALE SOLAR GENERATION DEVICE; OR

(c) INSTALL ANY ADDITIONAL CONTROLS OR EQUIPMENT BEYOND WHAT IS INTEGRATED INTO A PORTABLE-SCALE SOLAR GENERATION DEVICE.

(5) A PORTABLE-SCALE SOLAR GENERATION DEVICE THAT HAS A POWER OUTPUT OF NOT MORE THAN THREE HUNDRED NINETY-ONE WATTS IS EXEMPT FROM:

(a) THE SOLAR PHOTOVOLTAIC INSTALLATION REQUIREMENTS DESCRIBED IN SECTION 40-2-128; AND

(b) ANY BUILDING SAFETY CODE PROVISIONS OR PRODUCT LISTING PROVISIONS THAT WOULD REQUIRE ALTERATIONS TO THE BUILDING'S ELECTRICAL WIRING.

(6) A PERSON SHALL NOT ADOPT OR ENFORCE A RESTRICTION, COVENANT, BYLAW, REGULATION, LEASE STIPULATION, OR OTHER RULE THAT DIRECTLY OR INDIRECTLY RESTRICTS, PROHIBITS, OR IMPOSES UNREASONABLE CONDITIONS ON THE INSTALLATION, USE, OR OPERATION OF A PORTABLE-SCALE SOLAR GENERATION DEVICE THAT MEETS THE REQUIREMENTS DESCRIBED IN THIS SECTION. ANY SUCH RESTRICTION, COVENANT, BYLAW, REGULATION, LEASE STIPULATION, OR OTHER RULE IS

VOID AS A MATTER OF PUBLIC POLICY.

SECTION 3. In Colorado Revised Statutes, 40-2-124, **amend** (7)(b)(IV); and **add** (1.3) as follows:

40-2-124. Renewable energy standards - qualifying retail and wholesale utilities - definitions - net metering - legislative declaration - rules.

(1.3) ON OR BEFORE DECEMBER 31, 2026, THE COMMISSION SHALL REVISE EXISTING RULES TO:

(a) REQUIRE A QUALIFYING RETAIL UTILITY TO ALLOW FOR CUSTOMER OWNERSHIP AND USE OF A METER COLLAR ADAPTER TO PERMIT THE INTERCONNECTION OF DISTRIBUTED ENERGY RESOURCES AND FOR ELECTRICAL ISOLATION OF THE CUSTOMER'S SITE FOR ENERGY BACKUP PURPOSES;

(b) REQUIRE A QUALIFYING RETAIL UTILITY TO HAVE A TRANSPARENT PROCESS FOR APPROVING CUSTOMER-OWNED METER COLLAR ADAPTERS THAT MEET MINIMUM SAFETY REQUIREMENTS. THE APPROVAL PROCESS MUST TAKE NO MORE THAN SIXTY DAYS AFTER THE DATE OF SUBMISSION FOR APPROVAL OF A SPECIFIC METER COLLAR ADAPTER BY THE PROPOSING PARTY. A QUALIFYING RETAIL UTILITY SHALL POST ON ITS WEBSITE A PUBLIC LIST OF APPROVED METER COLLAR ADAPTERS AND UPDATE THE LIST AT LEAST ANNUALLY. A QUALIFYING RETAIL UTILITY SHALL APPROVE A PROPOSED CUSTOMER-OWNED METER COLLAR ADAPTER THAT:

(I) IS CERTIFIED FOR COMPLIANCE WITH THE STANDARDS REFERENCED IN UL 414 AND RATED ADEQUATELY FOR THE CONNECTED EQUIPMENT; AND

(II) DOES NOT IMPEDE ACCESS TO THE SEALED METER SOCKET

COMPARTMENT OR PULL SECTION OF THE SERVICE ENTRANCE STATION;

(c) REQUIRE A QUALIFYING RETAIL UTILITY TO ESTABLISH AND PUBLISH IN THE QUALIFYING RETAIL UTILITY'S TARIFFS A PROCESS FOR A CUSTOMER TO REQUEST AND INSTALL A METER COLLAR ADAPTER, WHICH PROCESS MUST TAKE NO LONGER THAN THIRTY DAYS AND NOT BE UNDULY BURDENSOME TO THE CUSTOMER;

(d) REQUIRE A QUALIFYING RETAIL UTILITY TO ALLOW FOR THE INSTALLATION OF A METER COLLAR ADAPTER BY A PROFESSIONAL CONTRACTOR WITH AN ACTIVE ELECTRICAL CONTRACTOR LICENSE; AND

(e) PROHIBIT A QUALIFYING RETAIL UTILITY FROM REQUIRING A PRODUCTION METER AS A CONDITION OF INTERCONNECTION FOR A CUSTOMER-SITED DISTRIBUTED ENERGY RESOURCE.

(7) (b) Each municipally owned utility shall allow a customer-generator's retail electricity consumption to be offset by the electricity generated from eligible energy resources on the customer-generator's side of the meter that are interconnected with the facilities of the municipally owned utility, subject to the following:

(IV) **Interconnection standards.** Each municipally owned utility shall adopt and post small generation interconnection standards and insurance requirements that are functionally similar to those established in the rules ~~promulgated~~ ADOPTED by the ~~public utilities~~ commission pursuant to this section; except that the municipally owned utility may reduce or waive any of the insurance requirements. If any customer-generator subject to the size specifications specified in ~~subparagraph (V) of this paragraph (b)~~ SUBSECTION (7)(b)(V) OF THIS SECTION is denied interconnection by the municipally owned utility, the utility shall provide a written technical or economic explanation of such

denial to the customer. A MUNICIPALLY OWNED UTILITY SHALL NOT REQUIRE A PRODUCTION METER AS A CONDITION FOR INTERCONNECTION FOR A CUSTOMER-SITED DISTRIBUTED ENERGY RESOURCE. A MUNICIPALLY OWNED UTILITY'S INTERCONNECTION STANDARDS MUST:

(A) ALLOW FOR CUSTOMER OWNERSHIP AND USE OF A METER COLLAR ADAPTER TO PERMIT THE INTERCONNECTION OF DISTRIBUTED ENERGY RESOURCES AND FOR ELECTRICAL ISOLATION OF THE CUSTOMER'S SITE FOR ENERGY BACKUP PURPOSES;

(B) INCLUDE A TRANSPARENT PROCESS FOR APPROVING CUSTOMER-OWNED METER COLLAR ADAPTERS THAT MEET MINIMUM SAFETY REQUIREMENTS. THE APPROVAL PROCESS MUST TAKE NO MORE THAN SIXTY DAYS AFTER THE DATE OF SUBMISSION FOR APPROVAL OF A SPECIFIC METER COLLAR ADAPTER BY THE PROPOSING PARTY. A MUNICIPALLY OWNED UTILITY SHALL POST ON ITS WEBSITE A PUBLIC LIST OF APPROVED METER COLLAR ADAPTERS AND UPDATE THE LIST AT LEAST ANNUALLY. A MUNICIPALLY OWNED UTILITY SHALL APPROVE A PROPOSED CUSTOMER-OWNED METER COLLAR ADAPTER THAT IS CERTIFIED FOR COMPLIANCE WITH THE STANDARDS REFERENCED IN UL 414, IS RATED ADEQUATELY FOR THE CONNECTED EQUIPMENT, AND DOES NOT IMPEDE ACCESS TO THE SEALED METER SOCKET COMPARTMENT OR PULL SECTION OF THE SERVICE ENTRANCE STATION.

(C) INCLUDE A PROCESS FOR A CUSTOMER TO REQUEST AND INSTALL A METER COLLAR ADAPTER, WHICH PROCESS MUST TAKE NO LONGER THAN THIRTY DAYS AND NOT BE UNDULY BURDENSOME TO THE CUSTOMER; AND

(D) ALLOW FOR THE INSTALLATION OF A METER COLLAR ADAPTER BY A PROFESSIONAL CONTRACTOR WITH A VALID ELECTRICIAN LICENSE

ISSUED PURSUANT TO ARTICLE 115 OF TITLE 12.

SECTION 4. In Colorado Revised Statutes, 40-9.5-118, **amend** (2)(d) as follows:

40-9.5-118. Net metering - rules.

(2) Each cooperative electric association shall allow a customer-generator's retail electricity consumption to be offset by the electricity generated from eligible energy resources on the customer-generator's side of the meter that are interconnected with the facilities of the cooperative electric association, subject to the following:

(d) **Interconnection standards.** A cooperative electric association and a customer-generator shall comply with the interconnection standards and insurance requirements established in the rules ~~promulgated~~ ADOPTED by the public utilities commission pursuant to section 40-2-124; except that the cooperative electric association may reduce or waive any of the insurance requirements; and except that the public utilities commission shall initiate a rule-making proceeding no later than October 1, 2008, for the purpose of addressing cooperative electric association system issues in its small generator interconnection procedures. A cooperative electric association shall not prevent or unreasonably burden the installation of a net metering system if such system includes protective equipment that prevents any export of customer-generated electricity from the customer's side of the meter. A COOPERATIVE ELECTRIC ASSOCIATION AND A CUSTOMER-GENERATOR SHALL COMPLY WITH THE RULES ADOPTED BY THE PUBLIC UTILITIES COMMISSION PURSUANT TO SECTION 40-2-124 (1.3) REGARDING METER COLLAR ADAPTERS AND PRODUCTION METERS.

SECTION 5. Act subject to petition - effective date. This act takes effect at 12:01 a.m. on the day following the expiration of the

ninety-day period after final adjournment of the general assembly (August 12, 2026, if adjournment sine die is on May 13, 2026); except that, if a referendum petition is filed pursuant to section 1 (3) of article V of the state constitution against this act or an item, section, or part of this act within such period, then the act, item, section, or part will not take effect unless approved by the people at the general election to be held in November 2026 and, in such case, will take effect on the date of the official declaration of the vote thereon by the governor.

Second Regular Session
Seventy-fifth General Assembly
STATE OF COLORADO

INTRODUCED

LLS NO. 26-0502.01 Clare Haffner x6137 **HOUSE BILL 26-1008**

HOUSE SPONSORSHIP

Lukens and Taggart,

SENATE SPONSORSHIP

Marchman and Rich,

House Committees
Agriculture, Water & Natural Resources

Senate Committees

A BILL FOR AN ACT

CONCERNING MEASURES TO ENHANCE OUTDOOR RECREATION OPPORTUNITIES IN THE STATE, AND, IN CONNECTION THEREWITH, EXPANDING THE DIVISION OF PARKS AND WILDLIFE'S CAPACITY FOR OUTDOOR RECREATION COORDINATION, PLANNING, AND MANAGEMENT.

Bill Summary

(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at http://leg.colorado.gov.)

The bill requires the division of parks and wildlife (division) in the department of natural resources to expand the division's capacity for

outdoor recreation coordination, planning, and management and take a leading role in state-level coordination, strategic planning, and implementation of Colorado's outdoors strategy. The division is directed to, among other things, engage with relevant partners, stakeholders, and agencies to coordinate and incorporate wildlife, conservation, recreation, and climate-resilience considerations across agency planning and decision-making processes.

In addition, the division is required to support, in consultation with relevant entities, the planning, development, and maintenance of outdoor recreation infrastructure to enhance outdoor recreation opportunities while protecting private property rights, wildlife, and natural resources.

The bill also requires the division to create, and update at least annually, integrated regional outdoor recreation and conservation planning reports to inform division awareness and operational decision-making.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Short title. The short title of this act is the "Colorado Outdoor Opportunities Act".

SECTION 2. Legislative declaration. (1) The general assembly finds and declares that:

(a) It is the policy of the state of Colorado that the state's unparalleled landscapes, wildlife, public lands, and outdoor experiences be protected, conserved, and enhanced for the benefit and enjoyment of current and future generations, while protecting the state's agricultural heritage and private property rights;

(b) Outdoor recreation, access to quality outdoor experiences, and the conservation of lands and wildlife habitats, all within the context of a changing climate and growing population, are vital components in ensuring a thriving future for Colorado's outdoors;

(c) Outdoor recreation is fundamental to Colorado's economy, culture, and identity, contributing to public health, community well-being, and the development of lifelong connections to the outdoors. Outdoor

recreation annually contributes $65.8 billion to Colorado's economy and supports 404,000 jobs, over 12% of the entire labor force in Colorado. Ensuring safe, high-quality outdoor experiences is essential to sustaining the state's outdoor heritage.

(d) Connecting youth to outdoor experiences is vital for ensuring the long-term well-being of the state's residents, since research demonstrates that outdoor engagement supports improved cognitive abilities, fosters creativity and resilience, and is essential for promoting public health and reducing stress;

(e) Colorado's outdoors face significant and urgent pressures from growing populations, human disturbance, and development, alongside severe climate-driven impacts such as wildfires, drought, and rising temperatures;

(f) Thoughtful planning and management of outdoor recreation can support conservation goals by reducing resource impacts, improving stewardship, and sustaining the long-term health of the state's public lands;

(g) As more visitors and Coloradans participate in all forms of outdoor recreation, it is important to advance exceptional recreation experiences that are accessible, inclusive, and sustainable so that future generations may continue to enjoy the state's world-class outdoor opportunities;

(h) To effectively manage these challenges, the state must strengthen collaboration across conservation, wildlife, agriculture, and recreation partners, local governments, tribal nations, and federal land managers; develop shared tools and data; and align funding to support voluntary, strategic actions that sustain high-quality recreation

opportunities while maintaining resilient landscapes, wildlife habitat, working lands, and community values for all Coloradans;

(i) Colorado's outdoors strategy, developed by the department of natural resources, the division of parks and wildlife, great outdoors Colorado, the office of climate preparedness in the governor's office, and the outdoor recreation industry office in the office of economic development, in collaboration with partners and stakeholders, provides the necessary statewide vision and coordination to advance conservation, climate resilience, and outdoor recreation opportunities;

(j) The general assembly recognizes the role that the Colorado outdoor regional partnerships initiative, created by the governor's executive order B 2020 008, plays in convening vital perspectives, partners, and expertise in land conservation, land use, and recreation planning. The initiative is a locally driven and powerful platform for early and proactive coordination among stakeholders, helping to identify shared priorities, reduce conflict, and advance tangible outcomes for outdoor recreation and conservation statewide.

(k) Meaningful engagement with tribal nations is important, and the collaborative framework developed in Colorado's outdoors strategy is crucial to support ongoing tribal participation in statewide outdoor recreation and conservation efforts;

(l) The outdoor recreation industry office plays a vital role in advancing outdoor recreation. The mission of the office is to champion industry, communities, and people through Colorado's great outdoors. The office is a vital partner for the division of parks and wildlife in coordinating outdoor recreation industry partnerships and supporting the division in planning and outcomes for the advancement of exceptional

and sustainable outdoor recreation opportunities.

(m) With approximately 60% of Colorado land in private ownership, working with private landowners is also essential to the success of Colorado's outdoors strategy, and it is important to ensure that agricultural interests, private landowners, and local governments are integrally involved in state efforts; wildlife habitats are protected; and private property rights are upheld as conservation and recreation management decisions are made;

(n) The division of parks and wildlife possesses a long history of outdoor recreation planning, management, and recreational asset delivery through its state parks system, which serves as a significant source of exceptional and accessible outdoor recreation opportunities. The division's responsibilities extend beyond state park boundaries and encompass outdoor recreation coordination, wildlife conservation, and support for partners managing lands across all jurisdictions. As a leader in outdoor recreation management, the division is well-positioned to play a critical coordinating role in advancing outdoor recreation planning and management statewide, beyond the boundaries of its current 43 state parks.

(o) The division of parks and wildlife assumes lead responsibility as the state's coordinating entity for advancing implementation of Colorado's outdoors strategy, in partnership with the department of natural resources, great outdoors Colorado, the outdoor recreation industry office, the office of climate preparedness, and other state and local partners. In this role, the division facilitates early and proactive coordination and planning among agencies and stakeholders to reduce conflict, improve efficiency, and ensure accountability in advancing its

goals and vision to find mutually beneficial outcomes that support and maintain Colorado's world-class outdoor recreation and natural resources.

(2) The general assembly further finds the need to expand and strengthen the division of parks and wildlife's capacity for the coordination, planning, development, and management of Colorado's outdoor recreation to ensure the state's recreation opportunities provide high-quality visitor experiences that are responsibly managed to align natural resources, wildlife, agricultural heritage, private property, and public safety. The general assembly further recognizes the growing need for the division to support recreation management and stewardship on federal public lands, which necessitates increased staff capacity and enhanced coordination with federal land management agencies.

SECTION 3. In Colorado Revised Statutes, 33-10-102, **add** (2.5), (2.7), (7.5), (10.5), and (13.5) as follows:

33-10-102. Definitions.

As used in articles 10 to 15 of this title 33, unless the context otherwise requires:

(2.5) "COLORADO'S OUTDOORS STRATEGY" MEANS THE STRATEGY DEVELOPED COLLABORATIVELY BY THE DIVISION AND COORDINATING PARTNERS AND STAKEHOLDERS TO ADVANCE COORDINATION, TOOLS, AND FUNDING TO ALIGN, PRIORITIZE, AND IMPLEMENT STRATEGIC ACTIONS TO SUPPORT CONSERVATION, OUTDOOR RECREATION, AND CLIMATE RESILIENCE IN THE STATE.

(2.7) "COORDINATING PARTNERS" MEANS THE DEPARTMENT, GREAT OUTDOORS COLORADO, THE OUTDOOR RECREATION INDUSTRY OFFICE, AND THE OFFICE OF CLIMATE PREPAREDNESS.

(7.5) "GREAT OUTDOORS COLORADO" MEANS THE GREAT

OUTDOORS COLORADO PROGRAM ESTABLISHED BY ARTICLE XXVII OF THE STATE CONSTITUTION AND IMPLEMENTED PURSUANT TO ARTICLE 60 OF THIS TITLE 33.

(10.5) "OFFICE OF CLIMATE PREPAREDNESS" MEANS THE OFFICE OF CLIMATE PREPAREDNESS CREATED IN SECTION 24-38.8-102 (1).

(13.5) "OUTDOOR RECREATION INDUSTRY OFFICE" MEANS THE OUTDOOR RECREATION INDUSTRY OFFICE CREATED IN SECTION 24-48.5-129.

SECTION 4. In Colorado Revised Statutes, **add** 33-10-119 as follows:

33-10-119. Parks and outdoor recreation capacity - outdoor recreation coordination, planning, and management - duties of the division - planning reports - legislative declaration.

(1) THE GENERAL ASSEMBLY FINDS AND DECLARES THAT:

(a) IT IS IMPORTANT THAT THE DIVISION PERPETUATE THE WILDLIFE RESOURCES OF THE STATE, PROVIDE A HIGH-QUALITY STATE PARKS SYSTEM, AND PROVIDE ENJOYABLE AND SUSTAINABLE OUTDOOR RECREATION OPPORTUNITIES THAT EDUCATE AND INSPIRE CURRENT AND FUTURE GENERATIONS TO SERVE AS ACTIVE STEWARDS OF THE STATE'S NATURAL RESOURCES;

(b) THE DIVISION, PURSUANT TO SECTION 33-9-101, PROVIDES A COMPREHENSIVE PROGRAM DESIGNED TO OFFER THE GREATEST POSSIBLE VARIETY OF RECREATION OPPORTUNITIES TO STATE RESIDENTS AND VISITORS; AND

(c) THE DIVISION IS BEST POSITIONED TO SERVE AS THE STATE'S COORDINATING ENTITY FOR ADVANCING IMPLEMENTATION OF COLORADO'S OUTDOORS STRATEGY, IN COLLABORATION WITH

COORDINATING PARTNERS AND OTHER STATE, FEDERAL, AND LOCAL PARTNERS; TRIBAL GOVERNMENT PARTNERS; AND INTERESTED STAKEHOLDERS, INCLUDING LOCAL COMMUNITIES, PRIVATE LANDOWNERS, RECREATION STAKEHOLDERS, CONSERVATION STAKEHOLDERS, AGRICULTURAL STAKEHOLDERS, AND WILDLIFE AND SPORTSPERSON STAKEHOLDERS. IN THIS ROLE, THE DIVISION SHOULD FACILITATE PLANNING AND DATA COORDINATION AMONG PARTNERS AND STAKEHOLDERS TO SUPPORT COORDINATION AND ACCOUNTABILITY IN ADVANCING THE STRATEGY'S GOALS AND VISION.

(2) THE DIVISION SHALL DEVELOP AND MAINTAIN THE ORGANIZATIONAL CAPACITY SUFFICIENT TO EFFECTIVELY EXECUTE THE DUTIES AND RESPONSIBILITIES DESCRIBED IN THIS SECTION.

(3) THE DIVISION SHALL:

(a) ENSURE THAT OUTDOOR RECREATION NEEDS ARE PRIORITIZED AND REPRESENTED WITHIN THE LEADERSHIP OF THE DIVISION; AND

(b) DEVELOP THE CAPACITY OF THE DIVISION TO INCREASE COORDINATION BETWEEN OUTDOOR RECREATION, WILDLIFE, AND CLIMATE-RESILIENCE EFFORTS AND INTERAGENCY PLANNING AND ACTIVITIES.

(4) IN IMPLEMENTING SUBSECTIONS (2) AND (3) OF THIS SECTION, THE DIVISION SHALL FOCUS ON THE FOLLOWING GOALS:

(a) STRENGTHENING THE DIVISION'S CAPACITY FOR COORDINATED RECREATION MANAGEMENT, PARTICULARLY AT THE REGIONAL LEVEL, TO ANTICIPATE AND WORK THROUGH POTENTIAL CONFLICTS, BY COORDINATING AND INCORPORATING WILDLIFE, CONSERVATION, RECREATION, AND CLIMATE-RESILIENCE CONSIDERATIONS ACROSS DIVISION PLANNING AND DECISION-MAKING AND IN ALIGNMENT WITH

LOCAL PERSPECTIVES;

(b) PROACTIVELY ENGAGING WITH STATE, FEDERAL, AND LOCAL PARTNERS; TRIBAL GOVERNMENT PARTNERS; AND INTERESTED STAKEHOLDERS, INCLUDING LOCAL COMMUNITIES, PRIVATE LANDOWNERS, RECREATION STAKEHOLDERS, CONSERVATION STAKEHOLDERS, AGRICULTURAL STAKEHOLDERS, AND WILDLIFE AND SPORTSPERSON STAKEHOLDERS, TO ENSURE THAT ALL PERSPECTIVES AND AREAS OF EXPERTISE ARE CONSIDERED IN THE DIVISION'S PLANNING AND MANAGEMENT PROCESSES;

(c) ADVANCING AND FORMALIZING INTERNAL PROCESSES TO BETTER INTEGRATE RECREATION OPPORTUNITIES AND RESOURCE MANAGEMENT INTO THE DIVISION'S CORE OPERATIONS, ENSURING COORDINATION BETWEEN RECREATION ACCESS AND WILDLIFE AND HABITAT STEWARDSHIP;

(d) COORDINATING AND BALANCING THE DIVISION'S PARTICIPATION IN EXTERNAL PROCESSES, INCLUDING PUBLIC PLANNING, FEDERAL LAND MANAGEMENT, AND LEGISLATIVE ENGAGEMENT, TO ENSURE THAT RECREATION, WILDLIFE, CONSERVATION, AND COMMUNITY PRIORITIES ARE CONSISTENTLY REPRESENTED;

(e) COLLABORATING CLOSELY WITH COORDINATING PARTNERS TO LEAD ENGAGEMENT WITH OTHER STATE AGENCIES TO ADVANCE A COORDINATED AND UNIFIED APPROACH TO ENHANCING OUTDOOR RECREATION OPPORTUNITIES, MANAGEMENT, AND PLANNING AT THE STATE LEVEL;

(f) PROACTIVELY ENGAGING WITH TRIBAL NATIONS THROUGH THE FRAMEWORK COLLABORATIVELY DEVELOPED IN COLORADO'S OUTDOORS STRATEGY, ENSURING THAT TRIBAL PERSPECTIVES AND PRIORITIES ARE

MEANINGFULLY INCORPORATED INTO STATEWIDE PLANNING AND COORDINATION PROCESSES; AND

(g) SERVING AS A CLEARINGHOUSE FOR INFORMATION ON BEST PRACTICES, TOOLS, AND STRATEGIES, INCLUDING THROUGH ADVANCEMENT OF THE COLORADO OUTDOORS STRATEGY TOOLKIT, TO SUPPORT INTERDISCIPLINARY AND INCLUSIVE PLANNING PROCESSES AT ALL LEVELS.

(5) CONSISTENT WITH THE MISSION AND DIRECTIVES OF THE DIVISION OUTLINED IN THIS ARTICLE 10, AND AS THE STATE AGENCY WITH PRIMARY COORDINATING RESPONSIBILITY FOR OUTDOOR RECREATION PLANNING, SUSTAINABLE VISITOR USE MANAGEMENT, AND REGIONAL PARTNERSHIP COORDINATION, THE DIVISION SHALL:

(a) PROVIDE PROACTIVE APPROACHES TO VISITOR USE MANAGEMENT TO FOSTER OUTCOMES THAT SUPPORT IMPROVED OUTDOOR RECREATION OPPORTUNITIES AND EXPERIENCES, NATURAL RESOURCE CONSERVATION, AND PROTECTION OF WILDLIFE HABITATS AND WORKING LANDS; AND

(b) IN ALIGNMENT WITH COLORADO'S OUTDOORS STRATEGY, SUPPORT THE PLANNING, DEVELOPMENT, AND MAINTENANCE OF OUTDOOR RECREATION FACILITIES, INFRASTRUCTURE, AND ACCESS IMPROVEMENTS STATEWIDE, WITH THE GOAL OF ENHANCING SUSTAINABLE AND EXCEPTIONAL OUTDOOR OPPORTUNITIES WHILE PROTECTING PRIVATE PROPERTY RIGHTS, WILDLIFE, AND NATURAL RESOURCES.

(6) CONSISTENT WITH THE DIVISION'S MISSION AND THE OBJECTIVES OF COLORADO'S OUTDOORS STRATEGY, THE DIVISION SHALL WORK TO ADVANCE SUSTAINABLE OUTDOOR RECREATION, WILDLIFE CONSERVATION, AND CLIMATE RESILIENCE OUTCOMES THROUGH

COLLABORATION, DATA INTEGRATION, PROACTIVE PLANNING, AND REPORTING. TO FULFILL ITS DUTIES RELATED TO STATEWIDE OUTDOOR COORDINATION, THE DIVISION SHALL:

(a) LEAD AND COORDINATE ACROSS STATE, LOCAL, AND FEDERAL PARTNERS AND TRIBAL NATIONS PARTICIPATING IN REGIONAL OUTDOOR PARTNERSHIPS AND RELATED VOLUNTARY EFFORTS ASSOCIATED WITH COLORADO'S OUTDOORS STRATEGY; AND

(b) (I) DEVELOP AND MAINTAIN A RECURRING INTERNAL COORDINATION AND REPORTING PROCESS, INCLUDING BY CREATING PLANNING REPORTS, TO INTEGRATE DATA, PRIORITIES, AND OUTCOMES FROM WILDLIFE, RECREATION, CLIMATE RESILIENCE, AND REGIONAL OUTDOOR PARTNERSHIP EFFORTS, ENSURING ALIGNMENT WITH THE GOALS OF COLORADO'S OUTDOORS STRATEGY AND OTHER DIVISION EFFORTS BOTH REGIONALLY AND ACROSS THE DIVISION. IN CREATING PLANNING REPORTS, THE DIVISION SHALL:

(A) INTEGRATE AND SUMMARIZE KEY METRICS, OUTCOMES, OPPORTUNITIES, NEEDS, AND PERFORMANCE INDICATORS FROM STATEWIDE AND REGIONAL INITIATIVES;

(B) COLLABORATE WITH STATE, FEDERAL, AND LOCAL PARTNERS; TRIBAL GOVERNMENT PARTNERS; AND INTERESTED STAKEHOLDERS, INCLUDING LOCAL COMMUNITIES, PRIVATE LANDOWNERS, RECREATION STAKEHOLDERS, CONSERVATION STAKEHOLDERS, AGRICULTURAL STAKEHOLDERS, AND WILDLIFE AND SPORTSPERSON STAKEHOLDERS;

(C) ESTABLISH PROCESSES WITH STATE GOVERNMENT ENTITIES AND ASSOCIATED PARTNERS, SUCH AS THE OUTDOOR RECREATION INDUSTRY OFFICE AND THE GREAT OUTDOORS COLORADO PROGRAM, TO IMPROVE COORDINATION AND EFFICIENCY ACROSS AGENCY PARTNERS;

(D) APPLY PROACTIVE AND ADAPTIVE APPROACHES TO THE DEVELOPMENT OF EXCEPTIONAL AND SUSTAINABLE OUTDOOR RECREATION OPPORTUNITIES TO SUPPORT LONG-TERM RESOURCE VIABILITY;

(E) IDENTIFY AREAS OF ALIGNMENT AND POTENTIAL CONFLICT AMONG RECREATION, WILDLIFE, CONSERVATION, AGRICULTURAL, AND COMMUNITY PRIORITIES AND FACILITATE COLLABORATIVE PROBLEM-SOLVING PROCESSES WITH RELEVANT PARTNERS TO SUPPORT MUTUALLY BENEFICIAL OUTCOMES;

(F) EMPLOY DATA-INFORMED MANAGEMENT STRATEGIES FOR PLANNING AND INVESTMENT IN PUBLIC LANDS AND REGIONAL OUTDOOR RECREATION RESOURCES TO SUPPORT SHARED UNDERSTANDING AND INFORMED DECISION-MAKING AMONG PARTNERS;

(G) INCORPORATE CLIMATE-RESILIENCE STRATEGIES FOR REGIONAL OUTDOOR RECREATION AND CONSERVATION PLANNING TO ADVANCE THE RESILIENCE AND ADAPTABILITY OF THE STATE'S NATURAL AND COMMUNITY ASSETS; AND

(H) COORDINATE ACROSS THE DIVISION TO ENSURE THE BEST AVAILABLE INFORMATION, INPUT, AND COLLABORATION. IN PARTICULAR, THE DIVISION SHALL ENSURE COORDINATION BETWEEN WILDLIFE, RECREATION, AND CLIMATE-RESILIENCE EFFORTS WITHIN THE DIVISION.

(II) THE DIVISION SHALL:

(A) REFER TO THE PLANNING REPORTS DESCRIBED IN SUBSECTION (6)(b)(I) OF THIS SECTION TO INFORM DIVISION PLANNING, OUTREACH, INVESTMENT, AND MANAGEMENT ACTIVITIES; AND

(B) UPDATE THE PLANNING REPORTS AT LEAST ANNUALLY TO REFLECT THE LATEST KNOWLEDGE AND ANY ASSOCIATED PLANNING UPDATES AND FACILITATE IMPROVED AWARENESS AND COORDINATION

WITHIN THE DIVISION AND AMONG THE DIVISION AND OTHER AGENCIES.

(7) NOTHING IN THIS SECTION:

(a) REQUIRES ACTION OR PARTICIPATION FROM A PRIVATE OR NON-STATE-GOVERNMENT ENTITY; OR

(b) GRANTS THE DIVISION DECISION-MAKING AUTHORITY OVER MATTERS THAT ARE WITHIN ANOTHER ENTITY'S JURISDICTION.

SECTION 5. Act subject to petition - effective date. This act takes effect at 12:01 a.m. on the day following the expiration of the ninety-day period after final adjournment of the general assembly (August 12, 2026, if adjournment sine die is on May 13, 2026); except that, if a referendum petition is filed pursuant to section 1 (3) of article V of the state constitution against this act or an item, section, or part of this act within such period, then the act, item, section, or part will not take effect unless approved by the people at the general election to be held in November 2026 and, in such case, will take effect on the date of the official declaration of the vote thereon by the governor.

Second Regular Session
Seventy-fifth General Assembly
STATE OF COLORADO

INTRODUCED

LLS NO. 26-0402.01 Alison Killen x4350 **HOUSE BILL 26-1119**

HOUSE SPONSORSHIP

Woodrow,

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Hinrichsen,

House Committees
Finance

Senate Committees

A BILL FOR AN ACT

CONCERNING THE AUTHORITY OF LOCAL TAXING ENTITIES TO IMPOSE PROPERTY TAXES ON THE ASSESSED VALUE OF LAND AND THE ASSESSED VALUE OF IMPROVEMENTS THEREON AT DIFFERENT MILL LEVY RATES.

Bill Summary

(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at http://leg.colorado.gov.)

Section 2 of the bill allows local governments and certain special districts authorized to impose property taxes (local taxing entities) to tax certain land and improvements thereon at different mill levy rates,

provided that the mill levy rate for the improvements is less than or equal to the mill levy rate for the land. A local taxing entity may not impose different mill levy rates for agricultural land, land used for renewable energy production, land subject to a perpetual conservation easement, leaseholds and lands producing oil or gas, producing mines or nonproducing mining claims, or state-assessed land. Nothing in **section 2** allows a local taxing entity to impose property taxes on the assessed value of land and the assessed value of improvements thereon at different mill levy rates in a manner that is not consistent with section 20 of article X of the state constitution or any statutory limitation on the local taxing entity's mill levy rates or total property tax revenue.

Section 3 requires boards of county commissioners and other local taxing entities to include with their certifications of all property tax levies the individual certification of any local taxing entity required by **section 5** regarding the different mill levy rates used for land and improvements thereon by the local taxing entity.

Section 4 updates the tax and levy rate information required to be made publicly available to include the specific, different mill levy rates used for land and improvements thereon, if applicable.

Section 5 modifies the duty of local taxing entities to certify their property tax levy to the board of county commissioners to require any local taxing entity that imposes property taxes on the assessed value of land and the assessed value of improvements thereon at different rates, as allowed by **section 2**, to specify those mill levy rates in the local taxing entity's certification of its levy.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Legislative declaration. (1) The general assembly finds and declares that:

(a) Colorado faces a severe housing shortage, with the state estimated to have a housing deficit of more than one hundred six thousand units according to the state demographer's office at the department of local affairs;

(b) More than one in three Colorado households are cost-burdened, spending more than thirty percent of their income on housing, and more than half of Colorado's renter households are cost-burdened, while nearly ninety percent of Colorado's extremely

low-income rental households are cost-burdened;

(c) The median monthly home mortgage payment in Colorado increased by seventy-one percent between 2017 and 2023 according to the Colorado housing and finance authority;

(d) Rising land costs are a significant driver of housing unaffordability in Colorado, with land values rising from thirty-one percent of Colorado home values in 2012 to fifty-eight percent in 2024, according to the American Enterprise Institute;

(e) High land costs create significant barriers to housing development, as developers struggle to make projects financially viable when the improvements they make to the property incur a larger property tax liability;

(f) Creating a partial building exemption will reduce this barrier to housing, making it easier to build and finance new housing development;

(g) The value of land is determined primarily by its location and the amenities and services surrounding it-factors created by the community-rather than by any ingenuity, investment, or initiative of the landowner, whereas the value of buildings reflects productive investments made by property owners;

(h) When governments invest in public services and amenities like transit, parks, and schools, the resulting increase to nearby land values is captured by private landowners rather than reinvested for the public benefit, creating windfall wealth increases for landowners, whose contributions to such improvements are substantially outweighed by the increased cost of housing for workers and families;

(i) While a shift towards a property tax system where all buildings

and improvements are exempt and only land is taxed is administratively and politically unrealistic in the short-term, one simple step in that direction is allowing local taxing entities to choose to "split" their mill levies so that a lower mill levy rate is imposed on buildings compared to unimproved land;

(j) Split-rate property taxation, which taxes land at a higher rate while providing partial "exemptions", provides economic incentives for productive investment and real estate development while disincentivizing land speculation and combating blight, because owners of vacant and underutilized land face higher tax burdens relative to owners who put their property to productive use;

(k) Split-rate property taxation incentivizes more efficient land use and development patterns by encouraging construction on vacant lots, infill development, and higher-density construction in areas with existing infrastructure, thereby reducing urban sprawl, lowering per-unit land costs, and minimizing environmental impacts associated with development on the urban fringe;

(l) Research and experience from jurisdictions that have implemented split-rate property taxation demonstrate that this policy can meaningfully boost housing construction while simultaneously reducing tax burdens for the majority of property owners who have invested in improving their land;

(m) The United States has more than a century of experience with split-rate property taxation, with split-rate taxation previously the law in Hawaii, as well as twenty-three jurisdictions in Pennsylvania having implemented such systems since 1913, and sixteen Pennsylvania cities currently using split-rate taxation, providing substantial empirical

evidence of its effects;

(n) The city of Harrisburg, Pennsylvania, which adopted split-rate taxation in 1975 and gradually increased the tax differential between land and buildings, experienced a transformation from one of the most distressed cities in the United States to a thriving community, with an eighty-five percent reduction in vacant structures over twenty years, a seven-fold increase in taxable real estate value, and between eighty and ninety percent of property owners paying less under the split-rate taxation system than they would have paid under a single, uniform property tax rate;

(o) The city of Pittsburgh, Pennsylvania, which adopted split-rate property taxation in 1913, experienced a seventy percent increase in building permits following an increase in their land-to-building tax differential in the 1980s, during a period in which comparable peer cities experienced a fourteen percent decline in building activity;

(p) Split-rate municipalities in Pennsylvania have experienced significantly higher construction activity than comparable single, uniform property tax rate cities, according to a 2000 study published in the Journal of Urban Economics;

(q) A 2010 study published in the Journal of Urban Economics found that split-rate property tax jurisdictions experienced five additional percentage points of housing growth compared to single, uniform property tax rate jurisdictions, with the increase occurring through infill developments rather than sprawl, leading the researchers to characterize split-rate property tax as "a potentially powerful anti-sprawl tool";

(r) Split-rate property taxation can have a significantly positive impact on aggregate market property values, with a 2022 study published

in the Public Finance Review finding that it can increase aggregate residential property value by twelve percent and commercial property value by twenty percent;

(s) Economist Joseph Stiglitz has demonstrated that higher land taxes are correlated with higher economic growth rates because such taxes discourage land speculation that diverts investment from productive economic activities;

(t) Split-rate property taxation is supported by a broad range of economists across the political spectrum because of its efficiency, neutrality, and lack of economic distortions, beginning with Adam Smith and including Nobel laureates Milton Friedman, Paul Krugman, and Joseph Stiglitz;

(u) Colorado county assessors already assess land values and improvement values separately on property tax records;

(v) Colorado already operates a form of split-rate property taxation, as the assessment rates for school district property taxes differ from the assessment rates for other local government taxes; and

(w) Allowing local governments and certain special districts to choose to adopt split-rate property taxation or building exemptions supports and reinforces recent state and local actions to address the housing supply and affordability crisis, including efforts to encourage transit-oriented development, accessory dwelling units, infill development, and smart growth strategies, all of which seek to promote more efficient use of land within existing communities and urban centers.

(2) Therefore, by enacting this House Bill _____, the general assembly intends to provide municipalities, counties, and certain special districts with the freedom to choose to split their mill levies and create

"building exemptions" so that a lower rate is levied on buildings and improvements compared to the land without improvements, consistent with section 20 of article X of the state constitution, to encourage housing production, discourage land speculation, promote efficient land use, and reduce tax burdens on property owners who productively improve and develop their land.

SECTION 2. In Colorado Revised Statutes, **add** 29-1-306 as follows:

29-1-306. Split mill levy - different mill levy rates for land and improvements to land - limitations - requirements - definitions.

(1) AS USED IN THIS SECTION, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(a) "AGRICULTURAL PROPERTY" MEANS THE SUBCLASS OF NONRESIDENTIAL PROPERTY DESCRIBED IN SECTION 39-1-104 (1.6)(c).

(b) "CONSERVATION EASEMENT PROPERTY" MEANS PROPERTY SUBJECT TO A PERPETUAL CONSERVATION EASEMENT.

(c) "IMPROVEMENTS" HAS THE MEANING SET FORTH IN SECTION 39-1-102 (6.3).

(d) "LOCAL TAXING ENTITY" MEANS ANY COUNTY, CITY AND COUNTY, CITY, TOWN, METROPOLITAN DISTRICT, BUSINESS IMPROVEMENT DISTRICT, LOCAL IMPROVEMENT DISTRICT, PUBLIC IMPROVEMENT DISTRICT, SPECIAL IMPROVEMENT DISTRICT, DOWNTOWN DEVELOPMENT AUTHORITY, URBAN RENEWAL AUTHORITY, OR COUNTY REVITALIZATION AREA AUTHORIZED TO LEVY PROPERTY TAXES.

(e) "MINING PROPERTY" MEANS PRODUCING MINES AND NONPRODUCING MINING CLAIMS VALUED FOR ASSESSMENT IN ACCORDANCE WITH ARTICLE 6 OF TITLE 39.

(f) "OIL AND GAS PROPERTY" MEANS LEASEHOLDS AND LANDS PRODUCING OIL OR GAS VALUED FOR ASSESSMENT IN ACCORDANCE WITH ARTICLE 7 OF TITLE 39.

(g) "PERPETUAL CONSERVATION EASEMENT" HAS THE MEANING SET FORTH IN SECTION 39-1-102 (8.7).

(h) "RENEWABLE ENERGY PRODUCTION PROPERTY" MEANS THE SUBCLASS OF NONRESIDENTIAL PROPERTY DESCRIBED IN SECTION 39-1-104 (1.6)(b).

(i) "STATE-ASSESSED PROPERTY" MEANS THE PROPERTY REQUIRED TO BE VALUED BY THE PROPERTY TAX ADMINISTRATOR PURSUANT TO SECTION 39-2-109 (1)(a).

(2) (a) NOTWITHSTANDING ANY LAW TO THE CONTRARY, EXCEPT AS PROVIDED IN SUBSECTION (2)(b) OF THIS SECTION, FOR PROPERTY TAX YEARS COMMENCING ON OR AFTER JANUARY 1, 2027, THE GOVERNING BODY OF A LOCAL TAXING ENTITY MAY, BY ORDINANCE OR RESOLUTION, IMPOSE PROPERTY TAXES ON THE ASSESSED VALUE OF LAND AND THE ASSESSED VALUE OF IMPROVEMENTS THEREON AT DIFFERENT MILL LEVY RATES, PROVIDED THAT THE MILL LEVY RATE IMPOSED BY THE LOCAL TAXING ENTITY FOR THE IMPROVEMENTS IS LESS THAN OR EQUAL TO THE MILL LEVY RATE IMPOSED BY THE LOCAL TAXING ENTITY FOR THE LAND.

(b) A LOCAL TAXING ENTITY SHALL NOT IMPOSE PROPERTY TAXES ON THE ASSESSED VALUE OF LAND AND THE ASSESSED VALUE OF IMPROVEMENTS THEREON AT DIFFERENT MILL LEVY RATES PURSUANT TO SUBSECTION (2)(a) OF THIS SECTION FOR AGRICULTURAL PROPERTY, CONSERVATION EASEMENT PROPERTY, MINING PROPERTY, OIL AND GAS PROPERTY, RENEWABLE ENERGY PRODUCTION PROPERTY, OR STATE-ASSESSED PROPERTY.

(3) NOTHING IN THIS SECTION ALLOWS A LOCAL TAXING ENTITY TO IMPOSE PROPERTY TAXES ON THE ASSESSED VALUE OF LAND AND THE ASSESSED VALUE OF IMPROVEMENTS THEREON AT DIFFERENT MILL LEVY RATES IN A MANNER THAT IS NOT CONSISTENT WITH SECTION 20 OF ARTICLE X OF THE STATE CONSTITUTION OR ANY STATUTORY LIMITATION ON THE LOCAL TAXING ENTITY'S MILL LEVY RATES OR TOTAL PROPERTY TAX REVENUE.

SECTION 3. In Colorado Revised Statutes, 39-1-111, **amend** (2) as follows:

39-1-111. Taxes levied by board of county commissioners.

(2) (a) As soon as such levies have been made, the board of county commissioners, or other body authorized by law to levy taxes, or either group's authorized party shall forthwith certify all such levies to the assessor, upon forms prescribed by the administrator, and shall transmit a copy of such certification to the administrator, to the division of local government, and to the department of education.

(b) A BOARD OF COUNTY COMMISSIONERS OR OTHER BODY REQUIRED TO CERTIFY ALL LEVIES TO THE ASSESSOR PURSUANT TO SUBSECTION (2)(a) OF THIS SECTION SHALL INCLUDE WITH ITS CERTICATION THE CERTIFIED LEVY OF ANY LOCAL TAXING ENTITY, AS DEFINED IN SECTION 29-1-306, THAT IMPOSES PROPERTY TAXES ON THE ASSESSED VALUE OF LAND AND THE ASSESSED VALUE OF IMPROVEMENTS THEREON AT DIFFERENT MILL LEVY RATES PURSUANT TO SECTION 29-1-306 (2)(a) AND IS REQUIRED BY SECTION 39-5-128 (4) TO INCLUDE IN ITS CERTIFICATION EACH MILL LEVY RATE FOR LAND AND IMPROVEMENTS THEREON IMPOSED BY SUCH LOCAL TAXING ENTITY.

SECTION 4. In Colorado Revised Statutes, 39-1-125, **amend**

(1)(a)(I) as follows:

39-1-125. Tax and levy rate information publicly available.

(1) (a) When each town, city, school district, special district, or other taxing authority certifies its levy pursuant to section 39-5-128, it shall also provide the following information for each levy that it imposes:

(I) The rate of the levy, INCLUDING THE DIFFERENT RATES FOR LAND AND IMPROVEMENTS THEREON, IF APPLICABLE;

SECTION 5. In Colorado Revised Statutes, 39-5-128, **add** (4) as follows:

39-5-128. Certification of valuation for assessment.

(4) A LOCAL TAXING ENTITY, AS DEFINED IN SECTION 29-1-306 (1), THAT IMPOSES PROPERTY TAXES ON THE ASSESSED VALUE OF LAND AND THE ASSESSED VALUE OF IMPROVEMENTS THEREON AT DIFFERENT MILL LEVY RATES PURSUANT TO SECTION 29-1-306 (2)(a) SHALL INCLUDE IN ITS CERTIFICATION EACH MILL LEVY RATE FOR LAND AND THE IMPROVEMENTS THEREON IMPOSED BY THE LOCAL TAXING ENTITY.

SECTION 6. Act subject to petition - effective date. This act takes effect at 12:01 a.m. on the day following the expiration of the ninety-day period after final adjournment of the general assembly (August 12, 2026, if adjournment sine die is on May 13, 2026); except that, if a referendum petition is filed pursuant to section 1 (3) of article V of the state constitution against this act or an item, section, or part of this act within such period, then the act, item, section, or part will not take effect unless approved by the people at the general election to be held in November 2026 and, in such case, will take effect on the date of the official declaration of the vote thereon by the governor.

Second Regular Session
Seventy-fifth General Assembly
STATE OF COLORADO

INTRODUCED

LLS NO. 26-0043.01 Jennifer Berman x3286 **HOUSE BILL 26-1238**

HOUSE SPONSORSHIP

Johnson and Lukens, Barron, Bradfield, Bradley, Clifford, Feret, Garcia Sander, Lieder, Martinez, Mauro, McCluskie, Nguyen, Richardson, Soper, Suckla, Taggart, Velasco, Winter T.

SENATE SPONSORSHIP

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Senate Committees

A BILL FOR AN ACT

CONCERNING EMERGENCY MEDICAL SERVICES PROVIDED IN THE STATE, AND, IN CONNECTION THEREWITH, DESIGNATING EMERGENCY MEDICAL SERVICES, INCLUDING AMBULANCE SERVICES AND AIR AMBULANCE SERVICES, TO BE ESSENTIAL SERVICES.

Bill Summary

(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at http://leg.colorado.gov.)

The bill declares emergency medical services as an essential service in the state and an integral part of the state's health-care

infrastructure. In relation to the declaration, the bill authorizes:

- Public and private ambulance services in the state to participate in, and receive reimbursement from, public safety-related systems coordinated by the department of personnel or the department of public safety;
- The disbursement of money from the emergency medical services account in the highway users tax fund to counties and cities and counties that authorize ambulance services within their boundaries; and
- The governor to direct the transfer of money from the disaster emergency fund to the emergency medical services account to finance emergency medical services needed in response to a declared disaster emergency.

The bill also updates certain definitions related to emergency medical services, including the addition of a definition of "out-of-hospital setting", which term is included in and may be used interchangeably with the existing defined term "prehospital setting".

The bill clarifies that an off-duty emergency medical service provider is not obligated to respond to the scene of a medical emergency or provide emergency medical services.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Legislative declaration. (1) The general assembly finds that:

(a) The state of Colorado recognizes the critical and essential role that emergency medical service providers play in safeguarding the health and safety of our communities;

(b) These dedicated professionals serve as first responders during medical crises, delivering immediate and often lifesaving care to people in dire need; and

(c) Emergency medical service providers encompass a diverse range of highly trained and skilled medical personnel, including paramedics, emergency medical technicians, and other specialized medical responders.

(2) The general assembly therefore declares that:

(a) The provision of emergency medical services constitutes a vital component of the health-care system in the state; and

(b) Our health-care system is multifaceted, and emergency medical services play a crucial role in the system and provide an essential service in the state.

SECTION 2. In Colorado Revised Statutes, 25-3.5-102, **add** (5) as follows:

25-3.5-102. Legislative declaration.

(5) (a) THE GENERAL ASSEMBLY FURTHER FINDS THAT:

(I) THE PROVISION OF EMERGENCY MEDICAL SERVICES, INCLUDING AMBULANCE SERVICES AND AIR AMBULANCE SERVICES, IS ESSENTIAL TO THE PROTECTION OF THE PUBLIC HEALTH, SAFETY, AND WELFARE OF THE PEOPLE OF THE STATE OF COLORADO;

(II) ACCESS TO TIMELY AND APPROPRIATE MEDICAL CARE IN AN OUT-OF-HOSPITAL SETTING IS A CRITICAL COMPONENT OF THE STATE'S HEALTH-CARE INFRASTRUCTURE, PARTICULARLY IN RURAL AND FRONTIER AREAS OF THE STATE IN WHICH HOSPITALS AND OTHER HEALTH-CARE RESOURCES MAY BE LIMITED; AND

(III) EMERGENCY MEDICAL SERVICES FUNCTION AS AN INTEGRAL PART OF THE CONTINUUM OF CARE BY BRIDGING PREHOSPITAL, INTERFACILITY, AND COMMUNITY-BASED HEALTH-CARE DELIVERY.

(b) THEREFORE, THE GENERAL ASSEMBLY DECLARES THAT:

(I) IT IS NECESSARY TO RECOGNIZE AND SUPPORT EMERGENCY MEDICAL SERVICES AS AN ESSENTIAL SERVICE IN THE STATE OF COLORADO AND TO ENSURE THAT EACH RESIDENT OF AND VISITOR TO THE STATE HAS ACCESS TO EMERGENCY MEDICAL SERVICES;

(II) AS ESSENTIAL HEALTH-CARE PROVIDERS AND FIRST

RESPONDERS, EMERGENCY MEDICAL SERVICE PROVIDERS ARE EXPECTED TO RESPOND DURING A DECLARED DISASTER, PRESCRIBED CLOSURE, CRISIS, OR EMERGENCY; AND

(III) IT IS THE POLICY OF THE STATE OF COLORADO THAT:

(A) WHEN IN ACTIVE SERVICE, EMERGENCY MEDICAL SERVICE PROVIDERS ARE AUTHORIZED TO TRAVEL UNENCUMBERED UPON THE ROADS AND HIGHWAYS WITHIN THE STATE; AND

(B) AT ANY TIME OR PLACE IN WHICH EMERGENCY MEDICAL SERVICE PROVIDERS ARE CALLED TO RESPOND, THEIR PERFORMANCE OF EMERGENCY MEDICAL SERVICES FALLS WITHIN THE DUTIES AND CLASSIFIED DEMANDS OF THEIR JOBS AND THE REGULAR USAGE AND WEAR OF THEIR VEHICLES AND EQUIPMENT.

SECTION 3. In Colorado Revised Statutes, 25-3.5-103, **amend** (1.3), (3), (9), and (10.3); and **add** (7.2), (8.9), and (9.2) as follows:

25-3.5-103. Definitions.

As used in this article 3.5, unless the context otherwise requires:

(1.3) "Air ambulance service" means ~~any~~ A public or private entity that uses an air ambulance to transport patients to a medical facility AND INCLUDES THE PROVISION OF EMERGENCY AMBULANCE SERVICE AND NONEMERGENCY AMBULANCE SERVICE.

(3) (a) "Ambulance service" means the furnishing, operating, conducting, maintaining, advertising, or otherwise engaging in or professing to be engaged in the transportation of patients by ambulance AND INCLUDES THE PROVISION OF EMERGENCY AMBULANCE SERVICE AND NONEMERGENCY AMBULANCE SERVICE.

(b) Taken in context, ~~it~~ "AMBULANCE SERVICE" also means the person ~~so engaged~~ PROVIDING or professing to be ~~so engaged~~ PROVIDING

AMBULANCE SERVICE.

(c) The person ~~so engaged~~ PROVIDING and the vehicles used for the emergency transportation of ~~persons~~ INDIVIDUALS injured at a mine are excluded from this definition when the personnel utilized in the operation of ~~said~~ THE vehicles are subject to the mandatory safety standards of the federal mine safety and health administration, or its successor agency.

(7.2) "EMERGENCY AMBULANCE SERVICE" MEANS AN IMMEDIATE AMBULANCE OR AIR AMBULANCE RESPONSE AT THE TIME AMBULANCE SERVICE OR AIR AMBULANCE SERVICE IS REQUESTED THAT RESULTS IN THE ASSESSMENT, TREATMENT, OR TRANSPORT OF A PATIENT BY AN AMBULANCE OR AIR AMBULANCE.

(8.9) "NONEMERGENCY AMBULANCE SERVICE" MEANS THE TRANSPORT OF A PATIENT BY AN AMBULANCE OR AIR AMBULANCE AND THAT INCLUDES THE PROVISION OF MEDICALLY NECESSARY SUPPLIES AND SERVICES AND MEETS THE MEDICAL NECESSITY REQUIREMENTS UNDER 42 CFR 410.40 (e), AS THAT SECTION EXISTED ON JULY 1, 2025.

(9) ~~"Patient" means any individual who is sick, injured, or otherwise incapacitated or helpless~~ "OUT-OF-HOSPITAL SETTING" MEANS FURNISHING ANY NECESSARY GOODS AND SERVICES OUTSIDE OF A HOSPITAL SETTING FOR THE PURPOSE OF PREVENTING, ALLEVIATING, CURING, OR HEALING HUMAN ILLNESS, A PHYSICAL DISABILITY, A PHYSICAL INJURY, OR A SUBSTANCE USE DISORDER WHILE RESPONDING TO AN EMERGENCY OR OTHER HEALTH-CARE CONDITION.

(9.2) "PATIENT" MEANS AN INDIVIDUAL WHO IS SICK, INJURED, OR OTHERWISE INCAPACITATED OR HELPLESS.

(10.3) "Prehospital setting":

(a) Means one of the following settings in which an emergency medical service provider performs patient care, which care is subject to medical direction by a medical director:

~~(a)~~ (I) At the site of an emergency;

~~(b)~~ (II) During emergency transport; or

~~(c)~~ (III) During interfacility transport; AND

(b) INCLUDES AND MAY BE USED INTERCHANGEABLY WITH THE TERM "OUT-OF-HOSPITAL SETTING".

SECTION 4. In Colorado Revised Statutes, **add** 25-3.5-109 as follows:

25-3.5-109. Use of governor's disaster emergency fund authorized for emergency medical services, ambulance services, and air ambulance services.

THE DISASTER EMERGENCY FUND CREATED IN SECTION 24-33.5-706 (2)(a) MAY BE USED FOR THE PURPOSES OF PROVIDING EMERGENCY MEDICAL SERVICES, INCLUDING AMBULANCE SERVICES AND AIR AMBULANCE SERVICES, IN ACCORDANCE WITH THIS ARTICLE 3.5 AND IN RESPONSE TO A DISASTER EMERGENCY DECLARED PURSUANT TO SECTION 24-33.5-704 (4).

SECTION 5. In Colorado Revised Statutes, 25-3.5-203, **add** (6) as follows:

25-3.5-203. Emergency medical service providers - licensure - renewal of license - duties of department - rules - record checks - definitions.

(6) NOTWITHSTANDING ANY OTHER PROVISION OF LAW, NOTHING IN THIS ARTICLE 3.5 IMPOSES ON AN EMERGENCY MEDICAL SERVICE PROVIDER AN OBLIGATION TO RESPOND TO THE SCENE OF A MEDICAL

EMERGENCY OR TO PROVIDE EMERGENCY MEDICAL SERVICES WHEN THE EMERGENCY MEDICAL SERVICE PROVIDER IS OFF DUTY.

SECTION 6. In Colorado Revised Statutes, **add** 25-3.5-404 as follows:

25-3.5-404. Participation of all licensed ambulance services in emergency response systems - telecommunications subsystem - regional and statewide mutual aid system - interoperable communications system.

(1) AN AMBULANCE SERVICE LICENSED IN THE STATE PURSUANT TO SECTION 25-3.5-314, REGARDLESS OF WHETHER THE AMBULANCE SERVICE IS A PUBLIC OR PRIVATE ENTITY, SHALL NOT BE PROHIBITED FROM PARTICIPATING IN AND RECEIVING REIMBURSEMENT FROM:

(a) THE TELECOMMUNICATIONS SUBSYSTEM COORDINATED BY THE DEPARTMENT OF PERSONNEL PURSUANT TO SECTION 25-3.5-401;

(b) THE REGIONAL AND STATEWIDE MUTUAL AID SYSTEM IMPLEMENTED BY THE DIRECTOR OF THE DIVISION OF FIRE PREVENTION AND CONTROL IN THE DEPARTMENT OF PUBLIC SAFETY PURSUANT TO SECTION 24-33.5-1235; AND

(c) THE INTEROPERABLE COMMUNICATIONS SYSTEM OVERSEEN BY THE DEPARTMENT OF PUBLIC SAFETY PURSUANT TO SECTION 24-33.5-2509.

SECTION 7. In Colorado Revised Statutes, 25-3.5-603, **amend** (1)(a); and **add** (3)(d) as follows:

25-3.5-603. Emergency medical services account - creation - allocation of money - rules - repeal.

(1) (a) There is ~~hereby~~ created a special account within the highway users tax fund established under section 43-4-201, to be known as the emergency medical services account, which consists of all money

transferred into the account in accordance with section 42-3-304 (21) OR SECTION 24-33.5-706 (4.5)(c), fees collected under section 25-3.5-203 for provisional certifications or licenses of emergency medical service providers, and fees collected under section 25-3.5-1103 for provisional registration of emergency medical responders.

(3) The general assembly shall appropriate money in the emergency medical services account:

(d) TO THE DEPARTMENT FOR DISBURSEMENT TO COUNTIES AND CITIES AND COUNTIES THAT PARTICIPATE IN THE AUTHORIZATION TO OPERATE AMBULANCE SERVICES WITHIN THE COUNTY'S OR THE CITY AND COUNTY'S BOUNDARIES FOR USE IN IMPLEMENTING ESSENTIAL EMERGENCY MEDICAL SERVICES, INCLUDING AMBULANCE SERVICES.

SECTION 8. In Colorado Revised Statutes, 24-33.5-706, **amend** (2)(a); and **add** (4.5)(c) as follows:

24-33.5-706. Disaster emergency fund - established - financing - legislative intent.

(2) (a) A disaster emergency fund is ~~hereby~~ established. The fund consists of any money appropriated by the general assembly, money transferred pursuant to ~~subsections (2.5) and~~ SUBSECTION (4)(b) of this section, and money to reimburse expenditures from the fund that ~~are~~ IS transmitted to the state treasurer and credited to the fund. Money in the disaster emergency fund ~~shall remain~~ REMAINS in the fund until expended or until transferred pursuant to subsection ~~(2.5)(c),~~ (4.3), (4.5), or (4.7) of this section or section 24-33.5-1228 (3)(c)(III).

(4.5) (c) THE GOVERNOR MAY, FROM TIME TO TIME AS THE GOVERNOR DEEMS NECESSARY BASED ON THE GOVERNOR'S DETERMINATION THAT A DISASTER EMERGENCY IS IMMINENT, DIRECT THE

STATE TREASURER TO TRANSFER, AND THE STATE TREASURER SHALL TRANSFER, MONEY FROM THE DISASTER EMERGENCY FUND TO THE EMERGENCY MEDICAL SERVICES ACCOUNT CREATED IN SECTION 25-3.5-603 (1)(a).

SECTION 9. Act subject to petition - effective date. This act takes effect at 12:01 a.m. on the day following the expiration of the ninety-day period after final adjournment of the general assembly (August 12, 2026, if adjournment sine die is on May 13, 2026); except that, if a referendum petition is filed pursuant to section 1 (3) of article V of the state constitution against this act or an item, section, or part of this act within such period, then the act, item, section, or part will not take effect unless approved by the people at the general election to be held in November 2026 and, in such case, will take effect on the date of the official declaration of the vote thereon by the governor.

Second Regular Session
Seventy-fifth General Assembly
STATE OF COLORADO

INTRODUCED

LLS NO. 26-0687.01 Christopher McMichael x4775 **HOUSE BILL 26-1257**

HOUSE SPONSORSHIP

Gonzalez R. and Rutinel,

SENATE SPONSORSHIP

(None),

House Committees
Transportation, Housing & Local Government

Senate Committees

A BILL FOR AN ACT

101 **CONCERNING THE LOCAL REGULATION OF MASSAGE FACILITIES.**

Bill Summary

(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at http://leg.colorado.gov.)

Current law authorizes a local government to license and regulate the operation of massage facilities within the local government's jurisdiction and to prevent the operation of illicit massage businesses, which are businesses that engage in massage but also engage in human-trafficking-related offenses. For the purpose of local enforcement, the bill expands the definition of "illicit massage business" to include a massage business that engages in crimes other than human-trafficking-related offenses.

Current law states that if a local government adopts a resolution or ordinance to establish business licensure requirements or to prohibit unlawful activities relating to illicit massage businesses, the resolution or ordinance must not be more restrictive than the requirements set forth in state law. The bill removes this limitation. The bill also allows a local government to impose local licensing requirements in addition to those requirements prescribed in state law.

Current law allows a local government to impose an administrative fee not to exceed $150 for issuing or renewing a license. The bill removes the $150 cap on such fees. Current law exempts businesses that held licenses before August 10, 2022, from the administrative fees. The bill removes this exemption.

Current law allows a local government to deny, revoke, or suspend a license under certain circumstances. The bill allows a local government to establish additional grounds to deny, revoke, or suspend a license.

Current law prohibits a person from owning a massage facility if the person:

- Has not submitted to a required background check at least 30 days before assuming an ownership interest in the massage facility; or
- Has been convicted of or entered a plea of nolo contendere that is accepted by the court for any of certain enumerated offenses.

The bill provides that, if a local government establishes business licensure requirements for massage facilities, the resolution or ordinance adopted by the local government must prohibit ownership of massage facilities by the types of persons that are prohibited from ownership in current law.

Current law states that preventing the operation of illicit massage businesses is a matter of statewide concern, and licensing and regulation of massage facilities is a matter of mixed statewide and local concern. The bill states that preventing the operation of illicit massage businesses is a matter of mixed statewide and local concern.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. In Colorado Revised Statutes, 30-15-401.4, **amend** (1)(a)(III), (1)(a)(IV) introductory portion, (1)(a)(IV)(A), (1)(b)(I), (2)(d), (3)(a), (4)(a) introductory portion, (4)(a)(II), (4)(a)(IV) introductory portion, (4)(a)(XI.5) introductory portion, (4)(a)(XI.5)(C), (4)(a)(XII) introductory portion, (4)(a)(XII)(D), (4.5)(a) introductory portion, (5)

introductory portion, (6), and (7) introductory portion; and **add** (4)(a)(XIII) as follows:

30-15-401.4. Statewide policy to prevent the operation of illicit massage businesses - local regulation authorized - background checks required - legislative declaration - definitions.

(1) (a) The general assembly finds and declares that:

(III) All local governments in the state already have authority to enact resolutions or ordinances to establish licensing authorities to regulate or otherwise regulate massage facilities and to deter and shut down illicit massage facilities WHERE THE FACILITIES EXIST OR ARE REASONABLY LIKELY TO OCCUR; and

(IV) Because preventing the operation of illicit massage facilities by requiring current and prospective operators, owners, and employees of massage facilities to submit to periodic background checks ~~is a matter of statewide concern and licensing~~ and other regulation of massage facilities is a matter of mixed statewide and local concern, ~~that~~ AND BECAUSE local governments have significant discretion to ~~address~~ ADOPT ORDINANCES AND RESOLUTIONS in accordance with local needs, it is necessary, appropriate, and in the best interest of all Coloradans to:

(A) Require ~~uniformly throughout the state as a matter of statewide policy,~~ that every current and prospective operator, owner, and employee of a massage facility submit to a background check, which generally means a fingerprint-based criminal history record check, as required by this section; and

(b) The general assembly further finds and declares that:

(I) A local government may adopt a resolution or ordinance to establish business licensure requirements to regulate massage facilities or

to regulate and prohibit unlawful activities for the ~~sole~~ purpose of deterring illicit massage businesses and preventing human trafficking;

(2) As used in this section, unless the context otherwise requires:

(d) "Illicit massage business" means a business that ~~may provide~~ PROVIDES massage ~~but~~ AND:

(I) Engages in human-trafficking-related offenses, as described in ~~sections~~ SECTION 18-3-503 ~~and~~ OR 18-3-504; OR

(II) COMMITS OTHER OFFENSES AS DEFINED BY STATE LAW OR LOCAL ORDINANCE.

(3) (a) In addition to any other powers, a local government may adopt a resolution or ordinance to establish business licensure requirements or to regulate and prohibit unlawful activities to prevent the operation of illicit massage businesses that engage in human trafficking-related offenses as described in sections 18-3-503 and 18-3-504 ~~If a local government adopts a resolution or ordinance to establish business licensure requirements pursuant to subsection (4) of this section or to prohibit unlawful activities pursuant to subsection (5) of this section, the resolution or ordinance must not be more restrictive than the requirements set forth in this section~~ OR COMMIT OTHER OFFENSES AS DEFINED BY STATE LAW OR LOCAL ORDINANCE.

(4) (a) If a local government adopts a resolution or ordinance to establish business licensure requirements for massage facilities as set forth in subsection (3)(a) of this section, the business licensure requirements may ~~only~~ include:

(II) Requiring a reasonable administrative fee ~~not to exceed one hundred fifty dollars~~ for issuing or renewing licensure applications. The fee must not be based on the number of employees. ~~This subsection~~

~~(4)(a)(II) applies only to new businesses applying for a license or renewal on or after August 10, 2022. Businesses that hold a license before August 10, 2022, are exempt from the administrative fees described in this subsection (4)(a)(II).~~

(IV) Allowing a licensing authority, or ~~a~~ THE licensing authority's designee, to deny an application FOR REASONS DESCRIBED IN THE ORDINANCE OR RESOLUTION ADOPTED BY THE LOCAL GOVERNMENT, INCLUDING if:

(XI.5) Granting ~~the~~ A licensing authority, or the licensing authority's designees, authority to revoke or suspend a license FOR REASONS DESCRIBED IN THE ORDINANCE OR RESOLUTION ADOPTED BY THE LOCAL GOVERNMENT, INCLUDING if:

(C) An owner of the licensed massage facility has been convicted of or entered a plea of nolo contendere that is accepted by the court for an offense listed in subsection (4)(a)(IV)(C) of this section or is registered as a sex offender or is required by law to register as a sex offender, as described in section 16-22-103; ~~and~~

(XII) Granting a licensing authority, or THE licensing authority's designees, the authority to revoke or suspend a license for violating prohibited acts pursuant to subsection (5) of this section. A licensing authority, or the licensing authority's designees, may temporarily suspend a license ~~with~~ AND SCHEDULE a hearing ~~to be scheduled~~ within fifteen days ~~when~~ AFTER the licensing authority MAKES FINDINGS AS DESCRIBED IN THE ORDINANCE OR RESOLUTION ADOPTED BY THE LOCAL GOVERNMENT OR finds:

(D) The licensee failed to permit an inspection at a time the massage facility was open for business; AND

(XIII) ANY OTHER PROVISIONS RELATED TO THE BUSINESS LICENSURE OR OPERATION OF MASSAGE FACILITIES THAT ARE DEEMED NECESSARY BY THE LOCAL GOVERNMENT.

(4.5) (a) ~~A person is prohibited from being an owner if the person either~~ IF A LOCAL GOVERNMENT ADOPTS A RESOLUTION OR ORDINANCE TO ESTABLISH BUSINESS LICENSURE REQUIREMENTS FOR MASSAGE FACILITIES IN ACCORDANCE WITH THIS SECTION, THE BUSINESS LICENSURE REQUIREMENTS MUST PROHIBIT A PERSON FROM OWNING A MASSAGE FACILITY IF THE PERSON:

(5) A local government may adopt a resolution or ordinance to prohibit activities to prevent the operation of illicit massage businesses that engage in human trafficking-related offenses as described in sections 18-3-503 and 18-3-504. Prohibited activities MAY include:

(6) (a) If authorized by the ~~local government~~ COUNTY resolution or ordinance, a law enforcement officer may follow the penalty assessment procedure described in section 16-2-201 for any violation of the prohibitions set forth in subsection (5) of this section. As part of the ~~local government~~ COUNTY ordinance or resolution authorizing the penalty assessment procedure, the ~~local government~~ COUNTY may adopt a graduated fine schedule for violations of the prohibitions set forth in subsection (5) of this section. A graduated fine schedule may provide for increased penalty assessments for repeat offenses by the same person.

(b) A ~~local government~~ COUNTY may specify in the resolution or ordinance that a massage facility that engages in two or more violations of the resolution or ordinance is a public nuisance, as described in section 16-13-303, unless the violation is already a public nuisance, as described in section 16-13-303. The county attorney of a county, the city attorney

of a city and county, ~~the city or town attorney of a municipality,~~ or the district attorney acting pursuant to section 16-13-302 may bring an action in the district court of the county for an injunction against the massage facility that violates the resolution or ordinance.

(7) A RESOLUTION OR ORDINANCE ADOPTED BY A LOCAL GOVERNMENT PURSUANT TO THIS SECTION MUST NOT CONSIDER ANY OF THE FOLLOWING TO BE A massage facility: ~~does not include:~~

SECTION 2. In Colorado Revised Statutes, 31-15-401, **add** (1)(s) as follows:

31-15-401. General police powers.

(1) In relation to the general police power, the governing bodies of municipalities have the following powers:

(s) TO LICENSE AND REGULATE THE ESTABLISHMENT AND OPERATION OF MASSAGE FACILITIES TO PREVENT HUMAN TRAFFICKING AND THE OPERATION OF ILLICIT MASSAGE FACILITIES IN ACCORDANCE WITH SECTION 30-15-401.4.

SECTION 3. In Colorado Revised Statutes, 31-15-407, **amend** (1) as follows:

31-15-407. Statewide policy to prevent the operation of illicit massage businesses - background checks required - legislative declaration.

(1) The general assembly finds and declares that because preventing the operation of illicit massage businesses, as defined in section 30-15-401.4, ~~is a matter of statewide concern, and licensing and regulation of massage facilities~~ is a matter of mixed statewide and local concern, it is necessary, appropriate, and in the best interest of all Coloradans to require, uniformly throughout the state as a matter of

statewide policy, that every current and prospective operator, owner, and employee of a massage facility submit to a background check, as defined in section 30-15-401.4 (2)(a.5), which generally means a fingerprint-based criminal history record check as required by section 30-15-401.4.

SECTION 4. Act subject to petition - effective date. This act takes effect at 12:01 a.m. on the day following the expiration of the ninety-day period after final adjournment of the general assembly (August 12, 2026, if adjournment sine die is on May 13, 2026); except that, if a referendum petition is filed pursuant to section 1 (3) of article V of the state constitution against this act or an item, section, or part of this act within such period, then the act, item, section, or part will not take effect unless approved by the people at the general election to be held in November 2026 and, in such case, will take effect on the date of the official declaration of the vote thereon by the governor.

Second Regular Session
Seventy-fifth General Assembly
STATE OF COLORADO

INTRODUCED

LLS NO. 26-0214.02 Jennifer Berman x3286 **HOUSE BILL 26-1268**

HOUSE SPONSORSHIP

McCormick and Smith,

SENATE SPONSORSHIP

(None),

House Committees
Energy & Environment

Senate Committees

A BILL FOR AN ACT

CONCERNING MEASURES TO ADVANCE RENEWABLE ENERGY PROJECTS ON PREVIOUSLY DISTURBED LANDS THROUGH THE DESIGNATION OF RENEWABLE ENERGY REINVESTMENT AREAS.

Bill Summary

(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at http://leg.colorado.gov.)

Section 1 of the bill authorizes a local government with permitting authority over land uses (local government) to designate one or more areas within the jurisdiction of the local government as renewable energy reinvestment areas for the siting of renewable energy and energy storage system projects (eligible projects). In designating an area as a renewable

energy reinvestment area, the local government must hold at least one public hearing, engage in outreach of disproportionately impacted communities, and ensure that an eligible project may be permitted and constructed pursuant to an administrative approval process based solely on the eligible project's compliance with objective standards.

If an eligible project is sited in a renewable energy reinvestment area, an urban renewal authority or county revitalization authority (tax increment financing authority) may distribute tax revenue to finance any public infrastructure needed for the eligible project in a manner consistent with the tax increment financing authority's governing statutes.

Section 1 requires a utility to respond to a request made by a local government or an eligible project developer for interconnection information regarding the proposed site of an eligible project within 30 days after the request is made.

Section 2 requires the Colorado energy office to consolidate, publish on its website, and periodically update information and resources concerning the process for siting, permitting, and developing eligible projects in renewable energy reinvestment areas.

Sections 3 and 4 make conforming amendments.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. In Colorado Revised Statutes, **add** part 5 to article 20 of title 29 as follows:

PART 5

SITING OF RENEWABLE ENERGY PROJECTS

29-20-501. Definitions.

AS USED IN THIS PART 5, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(1) "BROWNFIELD SITE" HAS THE MEANING SET FORTH IN SECTION 30-31-103 (3).

(2) "CLOSED LANDFILL" HAS THE MEANING SET FORTH IN SECTION 30-20-124 (1)(c).

(3) "COUNTY REVITALIZATION AUTHORITY" HAS THE MEANING SET FORTH IN SECTION 30-31-103 (6).

(4) "DEVELOPER" MEANS A PERSON RESPONSIBLE FOR DEVELOPING AN ELIGIBLE PROJECT.

(5) "ELIGIBLE PROJECT" MEANS UNDERTAKINGS AND ACTIVITIES RELATED TO THE DEVELOPMENT OF RENEWABLE ENERGY OR ENERGY STORAGE SYSTEM INFRASTRUCTURE, WHICH UNDERTAKINGS AND ACTIVITIES ARE RELATED TO AN ELIGIBLE SITE AND MAY INCLUDE ACQUISITION OF LAND AND OTHER PROPERTY; DEMOLITION AND REMOVAL OF BUILDINGS AND IMPROVEMENTS; SITE PREPARATION, CLEANUP, AND REMEDIATION; AND INSTALLATION OF RENEWABLE ENERGY OR ENERGY STORAGE SYSTEM INFRASTRUCTURE.

(6) "ELIGIBLE SITE" MEANS A BROWNFIELD SITE; LAND AFFECTED BY A MINING OPERATION, INCLUDING LAND AFFECTED BY A MINING OPERATION FOR WHICH THE LIFE OF THE MINE HAS BEEN TERMINATED; A CLOSED LANDFILL; OR LAND THAT IS REGULATED:

(a) BY THE UNITED STATES ENVIRONMENTAL PROTECTION AGENCY UNDER THE FEDERAL "COMPREHENSIVE ENVIRONMENTAL RESPONSE, COMPENSATION, AND LIABILITY ACT OF 1980", 42 U.S.C. SEC. 9601 ET SEQ.;

(b) BY THE UNITED STATES ENVIRONMENTAL PROTECTION AGENCY UNDER THE CORRECTIVE ACTION PROGRAM OF THE FEDERAL "RESOURCE CONSERVATION AND RECOVERY ACT OF 1976", 42 U.S.C. SEC. 6901 ET SEQ.; OR

(c) BY THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT UNDER THE "VOLUNTARY CLEAN-UP AND REDEVELOPMENT ACT", PART 3 OF ARTICLE 16 OF TITLE 25.

(7) "ENERGY STORAGE SYSTEM" HAS THE MEANING SET FORTH IN SECTION 40-2-130 (2)(a).

(8) "LAND AFFECTED BY A MINING OPERATION" HAS THE SAME MEANING AS "AFFECTED LAND", AS DEFINED IN SECTION 34-32-103 (1.5).

(9) "LIFE OF THE MINE" HAS THE MEANING SET FORTH IN SECTION 34-32-103 (6).

(10) "LOCAL GOVERNMENT" MEANS A STATUTORY OR HOME RULE CITY, TOWN, COUNTY, OR CITY AND COUNTY.

(11) "LOCAL PERMITTING ENTITY" MEANS THE GOVERNING BODY OF A LOCAL GOVERNMENT OR AN AGENCY OF A LOCAL GOVERNMENT WITH PERMITTING AUTHORITY OVER LAND USES.

(12) (a) "RENEWABLE ENERGY" MEANS USEFUL ELECTRIC, THERMAL, OR MECHANICAL ENERGY:

(I) THAT IS:

(A) CONVERTED DIRECTLY OR INDIRECTLY FROM RESOURCES OF CONTINUOUS ENERGY FLOW; OR

(B) PERPETUALLY REPLENISHED; AND

(II) THE UTILIZATION OF WHICH IS SUSTAINABLE INDEFINITELY.

(b) "RENEWABLE ENERGY" INCLUDES SOLAR, WIND, AND GEOTHERMAL ENERGY.

(13) "RENEWABLE ENERGY REINVESTMENT AREA" MEANS ONE OR MORE ELIGIBLE SITES THAT A LOCAL PERMITTING ENTITY DESIGNATES AS AN APPROPRIATE LOCATION FOR THE SITING OF ELIGIBLE PROJECTS FOR WHICH PUBLIC INVESTMENT MAY BE FINANCED THROUGH TAX INCREMENT FINANCING PURSUANT TO SECTION 29-20-502 (2).

(14) "TAX INCREMENT FINANCING AUTHORITY" MEANS AN URBAN RENEWAL AUTHORITY OR A COUNTY REVITALIZATION AUTHORITY THAT DISTRIBUTES TAX REVENUE PURSUANT TO SECTION 31-25-107 (9) OR 30-31-109 (13), RESPECTIVELY.

(15) "URBAN RENEWAL AUTHORITY" HAS THE MEANING SET FORTH IN SECTION 31-25-103 (8.5).

(16) (a) "UTILITY" MEANS AN ELECTRIC UTILITY IN THE STATE.

(b) "UTILITY" INCLUDES:

(I) AN INVESTOR-OWNED ELECTRIC UTILITY;

(II) A COOPERATIVE ELECTRIC ASSOCIATION FORMED PURSUANT TO ARTICLE 9.5 OF TITLE 40;

(III) A MUNICIPALLY OWNED UTILITY; AND

(IV) A WHOLESALE ELECTRIC COOPERATIVE AS DEFINED IN SECTION 40-2-136 (3)(c).

29-20-502. Renewable energy reinvestment areas - designation by a local permitting entity - public investment for eligible projects - tax increment financing.

(1) (a) A LOCAL PERMITTING ENTITY MAY DESIGNATE ONE OR MORE ELIGIBLE SITES WITHIN ITS JURISDICTION AS A RENEWABLE ENERGY REINVESTMENT AREA FOR THE SITING OF ELIGIBLE PROJECTS.

(b) TO DESIGNATE ONE OR MORE ELIGIBLE SITES AS A RENEWABLE ENERGY REINVESTMENT AREA, A LOCAL PERMITTING ENTITY MUST:

(I) COMPILE AND MAKE PUBLICLY AVAILABLE RELEVANT DOCUMENTATION DEMONSTRATING THAT THE SITE IS AN ELIGIBLE SITE;

(II) CONSULT WITH THE DIVISION OF PARKS AND WILDLIFE CREATED IN SECTION 33-9-104 (1) REGARDING THE WILDLIFE AND HABITAT IMPACTS OF CONSTRUCTING ELIGIBLE PROJECTS ON THE SITE, INCLUDING IMPACTS TO STATE AND FEDERALLY LISTED SPECIES AND SPECIES AND HABITATS OF CONSERVATION CONCERN;

(III) (A) HOLD ONE OR MORE PUBLIC HEARINGS REGARDING THE DESIGNATION OF THE SITE OR SITES AS A RENEWABLE ENERGY

REINVESTMENT AREA; OR

(B) DESIGNATE THE ELIGIBLE SITE OR SITES AS PART OF A SUBSTANTIAL MODIFICATION TO AN EXISTING URBAN RENEWAL PLAN PURSUANT TO SECTION 31-25-107 OR TO AN EXISTING COUNTY REVITALIZATION PLAN PURSUANT TO SECTION 30-31-109;

(IV) ENSURE THAT OUTREACH TO AND ENGAGEMENT OF DISPROPORTIONATELY IMPACTED COMMUNITIES REGARDING THE DESIGNATION OF A RENEWABLE ENERGY REINVESTMENT AREA WITHIN THE JURISDICTION OF THE LOCAL PERMITTING ENTITY IS SUBSTANTIALLY CONSISTENT WITH THE PROCESS SET FORTH IN SECTION 24-4-109 (3) REGARDING THE DESIGNATION; AND

(V) ENSURE THAT DESIGNATED ELIGIBLE PROJECTS CAN BE PERMITTED AND CONSTRUCTED PURSUANT TO AN ADMINISTRATIVE APPROVAL PROCESS THROUGH WHICH THE PROJECT IS APPROVED, APPROVED WITH CONDITIONS, OR DENIED BY LOCAL GOVERNMENT ADMINISTRATIVE STAFF BASED SOLELY ON ITS COMPLIANCE WITH OBJECTIVE STANDARDS.

(2) (a) NOTWITHSTANDING ANY PROCEDURAL REQUIREMENTS SET FORTH IN A TAX INCREMENT FINANCING AUTHORITY'S GOVERNING STATUTES, THE TAX INCREMENT FINANCING AUTHORITY MAY DISTRIBUTE TAX REVENUE PURSUANT TO EITHER SECTION 31-25-107 (9)(a)(II) OR 30-31-109 (13)(a)(II) IN A MANNER THAT IS OTHERWISE CONSISTENT WITH THE TAX INCREMENT FINANCING AUTHORITY'S GOVERNING STATUTES IN ORDER TO FINANCE COSTS INCURRED TO CARRY OUT ONE OR MORE ELIGIBLE PROJECTS SITED IN A RENEWABLE ENERGY REINVESTMENT AREA.

(b) AN URBAN RENEWAL AUTHORITY NEED NOT INCLUDE THE DISTRIBUTION OF REVENUE AUTHORIZED PURSUANT TO THIS SUBSECTION

(2) IN ITS URBAN RENEWAL PLAN ADOPTED PURSUANT TO SECTION 31-25-107.

(c) A COUNTY REVITALIZATION AUTHORITY NEED NOT INCLUDE THE DISTRIBUTION OF REVENUE AUTHORIZED PURSUANT TO THIS SUBSECTION (2) IN ITS COUNTY REVITALIZATION PLAN ADOPTED PURSUANT TO SECTION 30-31-109.

29-20-503. Interconnection information for siting eligible projects in renewable energy reinvestment areas - requests from local governments or developers.

UPON A REQUEST BY A LOCAL GOVERNMENT OR A DEVELOPER FOR INFORMATION REGARDING ELECTRIC GRID HOSTING CAPACITY AND ANY KNOWN SYSTEM CONSTRAINTS FOR THE SPECIFIC LOCATION OF THE DESIGNATED RENEWABLE ENERGY REINVESTMENT AREA, INCLUDING AVAILABLE CAPACITY AT SUBSTATIONS AND FEEDERS, A UTILITY SHALL RESPOND TO THE REQUEST WITHIN THIRTY DAYS AFTER THE REQUEST IS MADE.

29-20-504. Saving clause. NOTHING IN THIS PART 5 SHALL BE CONSTRUED TO AUTHORIZE THE CONSTRUCTION, OPERATION, OR EXPANSION OF AN ELIGIBLE PROJECT IN A RENEWABLE ENERGY REINVESTMENT AREA IF THE PROJECT WOULD OTHERWISE BE PROHIBITED OR DISALLOWED UNDER APPLICABLE FEDERAL OR STATE ENVIRONMENTAL STATUTES, RULES, OR REGULATIONS, INCLUDING STATUTES, RULES, OR REGULATIONS GOVERNING THE IDENTIFICATION, ASSESSMENT, REMEDIATION, OR REUSE OF A BROWNFIELD SITE.

SECTION 2. In Colorado Revised Statutes, **add** 24-38.5-126 as follows:

24-38.5-126. Development guidance for renewable energy

development in renewable energy reinvestment areas - definition.

(1) ON OR BEFORE SEPTEMBER 1, 2027, THE COLORADO ENERGY OFFICE SHALL:

(a) PUBLISH ON THE COLORADO ENERGY OFFICE'S WEBSITE AN OUTLINE OF THE GENERAL PROCESS FOR SITING, PERMITTING, AND DEVELOPING RENEWABLE ENERGY PROJECTS IN RENEWABLE ENERGY REINVESTMENT AREAS; AND

(b) CONSOLIDATE RELEVANT TECHNICAL AND INFORMATIONAL RESOURCES FOR RENEWABLE ENERGY DEVELOPMENT IN RENEWABLE ENERGY REINVESTMENT AREAS.

(2) THE COLORADO ENERGY OFFICE SHALL PERIODICALLY REVIEW AND UPDATE THE INFORMATION PROVIDED PURSUANT TO SUBSECTION (1) OF THIS SECTION ON THE OFFICE'S WEBSITE.

(3) AS USED IN THIS SECTION, UNLESS THE CONTEXT OTHERWISE REQUIRES, "RENEWABLE ENERGY REINVESTMENT AREA" HAS THE MEANING SET FORTH IN SECTION 29-20-501 (13).

SECTION 3. In Colorado Revised Statutes, 31-25-105, **amend** (1)(l); and **add** (1)(m) as follows:

31-25-105. Powers of an authority.

(1) Every authority has all the powers necessary or convenient to carry out and effectuate the purposes and provisions of this part 1, including, but not limited to, the following powers in addition to others granted in this part 1:

(l) To rent or to provide by any other means suitable quarters for the use of the authority or to accept the use of such quarters as may be furnished by the municipality or any other public body, and to equip such quarters with such furniture, furnishings, equipment, records, and

supplies as the authority may deem necessary to enable it to exercise its powers under this part 1; AND

(m) PURSUANT TO SECTION 31-25-107 (9)(a)(II), TO AUTHORIZE THE DISTRIBUTION OF TAX REVENUE TO FINANCE ANY PUBLIC INFRASTRUCTURE NEEDED FOR ONE OR MORE ELIGIBLE PROJECTS SITED IN A RENEWABLE ENERGY REINVESTMENT AREA, AS THOSE TERMS ARE DEFINED IN SECTION 29-20-501.

SECTION 4. In Colorado Revised Statutes, 30-31-105, **add** (5) as follows:

30-31-105. Powers of an authority.

(5) PURSUANT TO SECTION 30-31-109 (13)(a)(II), AN AUTHORITY MAY DISTRIBUTE TAX REVENUE TO FINANCE COSTS INCURRED TO CARRY OUT ONE OR MORE ELIGIBLE PROJECTS SITED IN A RENEWABLE ENERGY REINVESTMENT AREA, AS THOSE TERMS ARE DEFINED IN SECTION 29-20-501.

SECTION 5. Act subject to petition - effective date. This act takes effect at 12:01 a.m. on the day following the expiration of the ninety-day period after final adjournment of the general assembly (August 12, 2026, if adjournment sine die is on May 13, 2026); except that, if a referendum petition is filed pursuant to section 1 (3) of article V of the state constitution against this act or an item, section, or part of this act within such period, then the act, item, section, or part will not take effect unless approved by the people at the general election to be held in November 2026 and, in such case, will take effect on the date of the official declaration of the vote thereon by the governor.

Second Regular Session
Seventy-fifth General Assembly
STATE OF COLORADO

INTRODUCED

LLS NO. 26-0501.03 Jacob Baus x2173

HOUSE BILL 26-1276

HOUSE SPONSORSHIP

Velasco and Garcia, Brown, Carter, Clifford, Duran, Froelich, Gilchrist, Goldstein, Jackson, Lindsay, Lukens, Mabrey, Martinez, McCormick, Nguyen, Paschal, Rutinel, Rydin, Sirota, Smith, Stewart K., Stewart R., Story, Titone, Willford, Woodrow, Zokaie

SENATE SPONSORSHIP

(None),

House Committees
Judiciary

Senate Committees

A BILL FOR AN ACT

CONCERNING MEASURES TO PROTECT THE SAFETY OF INDIVIDUALS WHO ARE IMMIGRANTS IN COLORADO.

Bill Summary

(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at http://leg.colorado.gov.)

Under current law, the division of criminal justice (division) in the department of public safety (department) is required to create an annual report including information about law enforcement agency activity. The bill requires a law enforcement agency that participates in, or dedicates peace officers or resources to, a multijurisdictional or coordinated investigation or task force to submit that information to the division for

inclusion in the report. The division is required to submit the information to the general assembly's judiciary committees. A law enforcement agency is subject to a civil penalty for intentional failure to report the information as required.

Under current law, a state agency or political subdivision employee who intentionally violates provisions concerning the treatment of a person's personal identifying information is subject to a civil penalty. The bill extends the civil penalty liability to the state agency or political subdivision.

The bill requires a state agency or political subdivision that is served a subpoena by federal immigration authorities to send a copy of the subpoena to the department for the department to upload to its website. If the state agency or political subdivision fulfills the subpoena, the state agency or political subdivision is required to notify the person who is subject to the subpoena.

The bill prohibits a governmental entity or an airport from engaging with federal immigration authorities to transport individuals detained by federal immigration authorities. A governmental entity that violates these requirements is subject to a civil penalty.

The bill authorizes a public health agency to inspect or examine a facility that houses or detains individuals who are noncitizens for purposes of civil immigration proceedings.

Under current law, the department of public health and environment is authorized to inspect facilities that house or detain individuals who are noncitizens for purposes of civil immigration proceedings. The bill expands the inspection authority, including the frequency of inspections and items that are subject to inspection. A facility that refuses to allow the inspection is subject to a license revocation or a civil penalty.

The bill authorizes the department of public health and environment to require facilities that house or detain individuals who are noncitizens for purposes of civil immigration proceedings to require the facility to comply with requirements, including health and safety standards and paying for environmental impact studies. A facility that fails to comply is subject to a civil penalty. The bill requires the department of public health and environment to submit an annual report to the attorney general concerning facilities' compliance with these new requirements.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. In Colorado Revised Statutes, 24-31-903, **amend** (1), (3), and (5); and **add** (2.5) as follows:

24-31-903. Division of criminal justice report - penalties.

(1) ~~Beginning July 1, 2023,~~ The division of criminal justice in the department of public safety shall create an annual report including all of the information that is reported to the division pursuant to ~~subsection (2)~~ SUBSECTIONS (2) AND (2.5) of this section, ~~aggregated and broken down~~ IN TOTAL AND DISAGGREGATED by the law enforcement agency that employs peace officers, along with the underlying data.

(2.5) (a) ON OR BEFORE JULY 15, 2026, AND ON OR BEFORE JULY 15 EACH YEAR THEREAFTER, A LAW ENFORCEMENT AGENCY THAT PARTICIPATES IN A MULTIJURISDICTIONAL OR COORDINATED INVESTIGATION OR TASK FORCE, OR THAT DEDICATES PEACE OFFICERS OR RESOURCES TO A MULTIJURISDICTIONAL OR COORDINATED INVESTIGATION OR TASK FORCE, SHALL SUBMIT A REPORT TO THE DIVISION OF CRIMINAL JUSTICE IN THE DEPARTMENT OF PUBLIC SAFETY. THE REPORT MUST CONTAIN INFORMATION REGARDING EACH MULTIJURISDICTIONAL OR COORDINATED INVESTIGATION OR TASK FORCE THE AGENCY PARTICIPATED IN. THE REPORT MUST INCLUDE THE FOLLOWING INFORMATION REGARDING THE PERIOD FROM JULY 1 THROUGH JUNE 30 IMMEDIATELY PRECEDING THE REPORT SUBMISSION:

(I) THE PURPOSE OF THE MULTIJURISDICTIONAL OR COORDINATED INVESTIGATION OR TASK FORCE THE LAW ENFORCEMENT AGENCY PARTICIPATED IN OR DEDICATED PEACE OFFICERS OR RESOURCES TO;

(II) EACH FEDERAL, STATE, AND LOCAL LAW ENFORCEMENT AGENCY THAT PARTICIPATED IN, OR DEDICATED PEACE OFFICERS OR RESOURCES TO, THE MULTIJURISDICTIONAL OR COORDINATED INVESTIGATION OR TASK FORCE;

(III) THE TOTAL NUMBER OF ARRESTS MADE BY A PARTICIPATING

AGENCY DURING THE REPORTING PERIOD AS A RESULT OF THE MULTIJURISDICTIONAL OR COORDINATED INVESTIGATION OR TASK FORCE THE LAW ENFORCEMENT AGENCY PARTICIPATED IN OR DEDICATED PEACE OFFICERS OR RESOURCES TO; AND

(IV) THE TOTAL NUMBER OF PEOPLE DETAINED FOR IMMIGRATION PURPOSES OR CRIMINAL VIOLATIONS FOR OFFENSES RELATED TO AN INDIVIDUAL'S IMMIGRATION STATUS BY A PARTICIPATING AGENCY AS A RESULT OF THE MULTIJURISDICTIONAL OR COORDINATED INVESTIGATION OR TASK FORCE THE LAW ENFORCEMENT AGENCY PARTICIPATED IN OR DEDICATED PEACE OFFICERS OR RESOURCES TO.

(b) (I) ON OR BEFORE JANUARY 15, 2027, AND ON OR BEFORE JANUARY 15 EACH YEAR THEREAFTER, THE DIVISION OF CRIMINAL JUSTICE IN THE DEPARTMENT OF PUBLIC SAFETY SHALL SUBMIT A REPORT TO THE JUDICIARY COMMITTEES OF THE HOUSE OF REPRESENTATIVES AND THE SENATE, OR THEIR SUCCESSOR COMMITTEES, CONCERNING THE INFORMATION RECEIVED PURSUANT TO SUBSECTION (2.5)(a) OF THIS SECTION.

(II) NOTWITHSTANDING SECTION 24-1-136 (11)(a)(I), THE REQUIREMENT TO SUBMIT THE REPORT IN THIS SUBSECTION (2.5) CONTINUES INDEFINITELY.

(c) AS USED IN THIS SUBSECTION (2.5), UNLESS THE CONTEXT OTHERWISE REQUIRES:

(I) "LAW ENFORCEMENT AGENCY" HAS THE MEANING SET FORTH IN SECTION 16-2.5-402.

(II) "PARTICIPATING AGENCY" MEANS A FEDERAL, STATE, OR LOCAL LAW ENFORCEMENT AGENCY THAT PARTICIPATED IN, OR DEDICATED PEACE OFFICERS OR RESOURCES TO, A MULTIJURISDICTIONAL

OR COORDINATED INVESTIGATION OR TASK FORCE.

(3) The Colorado state patrol and local law enforcement agencies, PURSUANT TO SUBSECTION (2) OF THIS SECTION, AND LAW ENFORCEMENT AGENCIES, PURSUANT TO SUBSECTION (2.5) OF THIS SECTION, shall not report the name, address, social security number, or other unique personal identifying information of the subject of the use of force, victim of the official misconduct, eyewitness or subject in a showup, or persons contacted, searched, or subjected to a property seizure. Notwithstanding any provision of law to the contrary, the data reported pursuant to this section is available to the public pursuant to subsection (4) of this section.

(5) (a) The Colorado state patrol, ~~and any~~ A local law enforcement agency, OR A LAW ENFORCEMENT AGENCY that fails to meet its reporting requirements pursuant to this section is:

~~(a)~~ (I) Subject to the suspension of its funding by its appropriating authority; and

~~(b)~~ (II) Unless the Colorado state patrol, ~~or~~ local law enforcement agency, OR LAW ENFORCEMENT AGENCY is working with the division of criminal justice to meet its reporting requirements pursuant to this section, not eligible to be awarded grants under the multidisciplinary crime prevention grant program CREATED in section 24-33.5-527; the law enforcement workforce recruitment, retention, and tuition grant program CREATED in section 24-33.5-528; or the state's mission for assistance in recruiting and training (SMART) policing grant program CREATED in section 24-33.5-529.

(b) (I) IN ADDITION TO PENALTIES DESCRIBED IN SUBSECTION (5)(a) OF THIS SECTION, IF A LAW ENFORCEMENT AGENCY DESCRIBED IN SUBSECTION (2.5) OF THIS SECTION INTENTIONALLY FAILS TO DISCLOSE A

MULTIJURISDICTIONAL OR COORDINATED INVESTIGATION OR TASK FORCE THAT THE LAW ENFORCEMENT AGENCY PARTICIPATED IN, OR A MULTIJURISDICTIONAL OR COORDINATED INVESTIGATION OR TASK FORCE THAT THE LAW ENFORCEMENT AGENCY DEDICATED PEACE OFFICERS OR RESOURCES TO, THE LAW ENFORCEMENT AGENCY IS LIABLE FOR A CIVIL PENALTY OF NOT MORE THAN FIFTY THOUSAND DOLLARS FOR EACH VIOLATION.

(II) THE ATTORNEY GENERAL MAY BRING AN ACTION TO ENFORCE THIS SUBSECTION (5)(b), INCLUDING AN ACTION SEEKING A CIVIL PENALTY.

(III) ANY CIVIL PENALTY MONEY COLLECTED PURSUANT TO THIS SUBSECTION (5)(b) MUST BE TRANSFERRED TO THE STATE TREASURER, WHO SHALL CREDIT THE MONEY TO THE IMMIGRATION LEGAL DEFENSE FUND ESTABLISHED PURSUANT TO SECTION 8-3.8-101.

SECTION 2. In Colorado Revised Statutes, 24-74-107, **amend** (1) as follows:

24-74-107. Data privacy breaches - civil penalty - legislative declaration.

(1) (a) A state agency employee or political subdivision employee who, AND THE STATE AGENCY OR POLITICAL SUBDIVISION THAT EMPLOYS THE EMPLOYEE WHO, intentionally violates a provision of this article 74 or section 25-2-108.5 ~~is~~ ARE EACH subject to an injunction and ~~is~~ ARE EACH liable for a civil penalty of not more than fifty thousand dollars for each violation.

(b) THE ATTORNEY GENERAL MAY BRING AN ACTION TO ENFORCE THIS SUBSECTION (1), INCLUDING AN ACTION SEEKING A CIVIL PENALTY.

SECTION 3. In Colorado Revised Statutes, **add** 24-76.6-105 as follows:

24-76.6-105. Public disclosure of federal subpoena.

(1) WITHIN THIRTY DAYS AFTER THE EFFECTIVE DATE OF THIS SECTION, THE DEPARTMENT OF PUBLIC SAFETY SHALL MAKE AVAILABLE ON A PUBLIC-FACING PAGE ON THE DEPARTMENT'S WEBSITE A COPY OF ALL SUBPOENAS SERVED BY FEDERAL IMMIGRATION AUTHORITIES ON A STATE AGENCY OR POLITICAL SUBDIVISION, AS EACH IS DEFINED IN SECTION 24-74-102. A STATE AGENCY OR POLITICAL SUBDIVISION THAT IS SERVED WITH A SUBPOENA BY FEDERAL IMMIGRATION AUTHORITIES SHALL PROVIDE A COPY OF THE SUBPOENA WITHIN SEVENTY-TWO HOURS AFTER RECEIVING THE SUBPOENA TO THE DEPARTMENT OF PUBLIC SAFETY FOR DISPLAY ON THE DEPARTMENT'S WEBSITE. THE DEPARTMENT OF PUBLIC SAFETY SHALL UPDATE ITS WEBSITE TO INCLUDE THE COPY OF THE SUBPOENA WITHIN TWENTY-FOUR HOURS AFTER RECEIVING THE COPY OF THE SUBPOENA FROM A STATE AGENCY OR POLITICAL SUBDIVISION. THE DEPARTMENT OF PUBLIC SAFETY SHALL USE EXISTING OR FREELY AVAILABLE TECHNOLOGY TO ACCOMPLISH THE REQUIREMENTS OF THIS SUBSECTION (1).

(2) (a) A STATE AGENCY OR POLITICAL SUBDIVISION THAT IS SERVED WITH A SUBPOENA BY FEDERAL IMMIGRATION AUTHORITIES SHALL INFORM THE HOUSE OF REPRESENTATIVES JUDICIARY COMMITTEE AND THE SENATE JUDICIARY COMMITTEE, OR THEIR SUCCESSOR COMMITTEES, WITHIN SEVENTY-TWO HOURS AFTER RECEIVING THE SUBPOENA.

(b) IF A STATE AGENCY OR POLITICAL SUBDIVISION FULFILLS A SUBPOENA SERVED UPON THE STATE AGENCY OR POLITICAL SUBDIVISION BY FEDERAL IMMIGRATION AUTHORITIES AND THE SUBPOENA CONTAINS INFORMATION ABOUT, CONCERNING, OR OTHERWISE RELATING TO AN INDIVIDUAL WHO LIVES IN COLORADO, THE STATE AGENCY OR POLITICAL

SUBDIVISION SHALL INFORM THE INDIVIDUAL AT THEIR LAST-KNOWN ADDRESS THAT THEIR INFORMATION HAS BEEN SHARED WITH FEDERAL IMMIGRATION AUTHORITIES WITHIN SEVENTY-TWO HOURS AFTER FULFILLING THE SUBPOENA.

SECTION 4. In Colorado Revised Statutes, **add** 24-76.7-104 as follows:

24-76.7-104. Transportation for deportation purposes prohibited - civil penalty.

(1) A GOVERNMENTAL ENTITY SHALL NOT:

(a) TRANSPORT BY ANY MEANS, INCLUDING BY MUNICIPAL BUS OR TRAIN, INDIVIDUALS DETAINED BY FEDERAL IMMIGRATION AUTHORITIES FOR THE PURPOSE OF DEPORTATION;

(b) PROVIDE AN ITEM OF ITS FLEET, INCLUDING A MUNICIPAL BUS OR TRAIN, TO A GOVERNMENTAL ENTITY FOR THE TRANSPORT OF INDIVIDUALS DETAINED BY FEDERAL IMMIGRATION AUTHORITIES FOR THE PURPOSE OF DEPORTATION; OR

(c) ENTER INTO, RENEW, OR EXTEND ANY AGREEMENT WITH A GOVERNMENTAL ENTITY FOR THE TRANSPORT BY ANY MEANS, INCLUDING BY MUNICIPAL BUS OR TRAIN, OF INDIVIDUALS DETAINED BY FEDERAL IMMIGRATION AUTHORITIES FOR THE PURPOSE OF DEPORTATION.

(2) (a) A GOVERNMENTAL ENTITY THAT VIOLATES THIS SECTION IS LIABLE FOR A CIVIL PENALTY OF NOT MORE THAN FIFTY THOUSAND DOLLARS FOR EACH VIOLATION.

(b) THE ATTORNEY GENERAL MAY BRING AN ACTION TO ENFORCE THIS SECTION, INCLUDING AN ACTION SEEKING INJUNCTIVE RELIEF OR A CIVIL PENALTY.

(c) ANY CIVIL PENALTY MONEY COLLECTED PURSUANT TO THIS

SECTION MUST BE TRANSFERRED TO THE STATE TREASURER, WHO SHALL CREDIT THE MONEY TO THE IMMIGRATION LEGAL DEFENSE FUND ESTABLISHED PURSUANT TO SECTION 8-3.8-101.

SECTION 5. In Colorado Revised Statutes, **add** 24-76.7-105 as follows:

24-76.7-105. Airport for deportation purposes prohibited - civil penalty.

(1) AN AIRPORT OPERATED PURSUANT TO PART 1 OR PART 2 OF ARTICLE 4 OF TITLE 41 SHALL NOT ENTER INTO, RENEW, OR EXTEND A CONTRACT, GRANT, OR COOPERATIVE AGREEMENT WITH A COMMERCIAL AIRLINE OR GOVERNMENTAL ENTITY THAT TRANSPORTS INDIVIDUALS DETAINED BY FEDERAL IMMIGRATION AUTHORITIES FOR THE PURPOSE OF DEPORTATION.

(2) (a) AN AIRPORT THAT VIOLATES THIS SECTION IS LIABLE FOR A CIVIL PENALTY OF NOT MORE THAN FIFTY THOUSAND DOLLARS FOR EACH VIOLATION.

(b) THE ATTORNEY GENERAL MAY BRING AN ACTION TO ENFORCE THIS SECTION, INCLUDING AN ACTION SEEKING INJUNCTIVE RELIEF OR A CIVIL PENALTY.

(c) ANY CIVIL PENALTY MONEY COLLECTED PURSUANT TO THIS SECTION MUST BE TRANSFERRED TO THE STATE TREASURER, WHO SHALL CREDIT THE MONEY TO THE IMMIGRATION LEGAL DEFENSE FUND ESTABLISHED PURSUANT TO SECTION 8-3.8-101.

SECTION 6. In Colorado Revised Statutes, 25-1-506, **amend** (3)(b) introductory portion, (3)(b)(XIV), and (3)(b)(XV); and **add** (3)(b)(XVI) as follows:

25-1-506. County or district public health agency.

(3) (b) In addition to other powers and duties, an agency ~~shall have~~ HAS the following duties:

(XIV) To collaborate with the state department and the state board in all matters pertaining to public health, the water quality control commission in all matters pertaining to water quality, the air quality control commission and the division of administration of the state department in all matters pertaining to air pollution, and the solid and hazardous waste commission in all matters pertaining to solid and hazardous waste; ~~and~~

(XV) To establish or arrange for the establishment of, by January 1, 2015, and subject to available appropriations, a local or regional child fatality prevention review team pursuant to section 25-20.5-404; AND

(XVI) IN ITS DISCRETION, TO INSPECT OR EXAMINE A FACILITY THAT HOUSES OR DETAINS INDIVIDUALS WHO ARE NONCITIZENS FOR PURPOSES OF CIVIL IMMIGRATION PROCEEDINGS.

SECTION 7. In Colorado Revised Statutes, 25-1.5-101, **amend** (1)(i)(I)(D); and **add** (1)(dd) as follows:

25-1.5-101. Powers and duties of department - laboratory cash fund - office of suicide prevention - suicide prevention coordination cash fund - dispensation of payments under contracts with grantees - report - rules - definitions.

(1) The department has, in addition to all other powers and duties imposed upon it by law, the powers and duties provided in this section as follows:

(i) (I) (D) With respect to ~~any~~ A facility that houses or detains INDIVIDUALS WHO ARE noncitizens for purposes of civil immigration proceedings, ~~such~~ THE inspections and examinations must be made

annually, and additional unannounced inspections ~~may~~ AND EXAMINATIONS MUST be conducted after the annual inspection. UNANNOUNCED INSPECTIONS AND EXAMINATIONS MUST BE MADE AT LEAST ONE TIME EVERY THREE MONTHS, AND MAY BE MADE MORE FREQUENTLY, AND THE FACILITY SHALL PAY FOR THE INSPECTIONS AND EXAMINATIONS. THE INSPECTIONS AND EXAMINATIONS MADE PURSUANT TO THIS SUBSECTION (1)(i)(I)(D) MUST INCLUDE A REVIEW OF THE FOLLOWING: ADHERENCE TO FOOD SAFETY STANDARDS AND DRINKING WATER QUALITY STANDARDS, CONFINEMENT CONDITIONS, AND STANDARDS OF CARE PROVIDED TO INDIVIDUALS WHO ARE DETAINED IN THE FACILITY. THE FACILITY SHALL PROVIDE TO A DEPARTMENT REPRESENTATIVE WHO IS CONDUCTING AN INSPECTION OR EXAMINATION PURSUANT TO THIS SUBSECTION (1)(i)(I)(D) ALL ACCESS NECESSARY TO PERFORM THE INSPECTION, INCLUDING ACCESS TO PEOPLE WHO ARE DETAINED, RECORDS, FACILITY OFFICIALS, AND FACILITY PERSONNEL. IF A FACILITY REFUSES TO ALLOW AN INSPECTION OR EXAMINATION, THE DEPARTMENT MAY REVOKE THE FACILITY'S LICENSE, AND THE FACILITY IS LIABLE FOR A CIVIL PENALTY OF NOT MORE THAN FIFTY THOUSAND DOLLARS FOR EACH REFUSAL. THE ATTORNEY GENERAL MAY BRING AN ACTION TO ENFORCE THIS SUBSECTION (1)(i)(I)(D), INCLUDING AN ACTION SEEKING A CIVIL PENALTY. ANY CIVIL PENALTY MONEY COLLECTED PURSUANT TO THIS SUBSECTION (1)(i)(I)(D) MUST BE TRANSFERRED TO THE STATE TREASURER, WHO SHALL CREDIT THE MONEY TO THE IMMIGRATION LEGAL DEFENSE FUND ESTABLISHED PURSUANT TO SECTION 8-3.8-101. THE DEPARTMENT MAY ADOPT RULES IT DETERMINES ARE NECESSARY FOR PURPOSES OF THIS SUBSECTION (1)(i)(I)(D).

(dd) (I) WITH RESPECT TO A FACILITY THAT HOUSES OR DETAINS

INDIVIDUALS WHO ARE NONCITIZENS FOR PURPOSES OF CIVIL IMMIGRATION PROCEEDINGS, THE POWER TO REQUIRE THE FACILITY TO:

(A) PROVIDE TO THE DEPARTMENT A YEARLY REPORT DETAILING THE FOLLOWING: THE OUTCOMES OF PREGNANT INDIVIDUALS IN THE FACILITY, OUTCOMES OF INDIVIDUALS WITH CHRONIC HEALTH CONDITIONS, OUTCOMES OF INDIVIDUALS WITH DISABILITIES, ACCESS TO FOOD FOR INDIVIDUALS WITH DIETARY RESTRICTIONS, AVERAGE TEMPERATURE WITHIN THE FACILITY, HIGHEST AND LOWEST TEMPERATURES RECORDED WITHIN THE FACILITY, INDIVIDUALS' ACCESS TO AN ATTORNEY, AND INDIVIDUALS' ACCESS TO SPACES OF WORSHIP OR SILENT REFLECTION;

(B) PAY FOR AND PASS AN ENVIRONMENTAL IMPACT STUDY. IF THE ENVIRONMENTAL IMPACT STUDY IDENTIFIES A NEGATIVE IMPACT THAT IS OR WILL BE CAUSED BY THE FACILITY, THE FACILITY IS PROHIBITED FROM OPERATING UNTIL THE NEGATIVE IMPACT IS CORRECTED. THE FACILITY SHALL PAY FOR ANY COST INCURRED RELATED TO PERMITTING OR AGENCY REVIEW AS REQUIRED BY LAW.

(C) PROHIBIT THE HOUSING OR DETENTION OF A MINOR IN THE SAME ROOM AS A NONFAMILIAL ADULT; AND

(D) ON THE FACILITY'S SITE AND AT ALL TIMES, STAFF THE FACILITY WITH MEDICAL PROFESSIONALS AND MENTAL HEALTH PROFESSIONALS WHO ARE ACCESSIBLE TO INDIVIDUALS WHO ARE NONCITIZENS AND DETAINED FOR PURPOSES OF CIVIL IMMIGRATION PROCEEDINGS.

(II) (A) IF A FACILITY FAILS TO COMPLY WITH A REQUIREMENT IMPOSED BY THE DEPARTMENT PURSUANT TO THIS SUBSECTION (1)(dd), THE DEPARTMENT MAY REVOKE THE FACILITY'S LICENSE. IF THE DEPARTMENT DOES NOT REVOKE THE FACILITY'S LICENSE, THE FACILITY IS

LIABLE FOR A CIVIL PENALTY OF NOT MORE THAN FIFTY THOUSAND DOLLARS FOR EACH VIOLATION.

(B) THE ATTORNEY GENERAL MAY BRING AN ACTION TO ENFORCE THIS SUBSECTION (1)(dd), INCLUDING AN ACTION SEEKING A CIVIL PENALTY.

(C) ANY CIVIL PENALTY MONEY COLLECTED PURSUANT TO THIS SUBSECTION (1)(dd) MUST BE TRANSFERRED TO THE STATE TREASURER, WHO SHALL CREDIT THE MONEY TO THE IMMIGRATION LEGAL DEFENSE FUND ESTABLISHED PURSUANT TO SECTION 8-3.8-101.

(III) ON OR BEFORE JANUARY 15, 2027, AND ON OR BEFORE JANUARY 15 EACH YEAR THEREAFTER, THE DEPARTMENT SHALL SUBMIT A REPORT TO THE ATTORNEY GENERAL REGARDING FACILITIES' COMPLIANCE WITH THIS SUBSECTION (1)(dd) AND INFORMATION COLLECTED PURSUANT TO SUBSECTION (1)(dd)(I)(A) OF THIS SECTION. THE DEPARTMENT SHALL MAKE THE REPORT AVAILABLE ON A PUBLIC-FACING PAGE ON THE DEPARTMENT'S WEBSITE.

(IV) THIS SUBSECTION (1)(dd) APPLIES TO LOCAL, COUNTY, OR PRIVATE DETENTION FACILITIES THAT HOUSE OR DETAIN INDIVIDUALS WHO ARE NONCITIZENS FOR PURPOSES OF CIVIL IMMIGRATION PROCEEDINGS, INCLUDING ANY FACILITY THAT IS OPERATED ON BEHALF OF OR PURSUANT TO A CONTRACT WITH FEDERAL IMMIGRATION AUTHORITIES. THIS SUBSECTION (1)(dd) DOES NOT APPLY TO DETENTION FACILITIES OPERATED DIRECTLY BY THE FEDERAL GOVERNMENT.

(V) THE DEPARTMENT MAY ADOPT RULES IT DETERMINES ARE NECESSARY FOR PURPOSES OF THIS SUBSECTION (1)(dd).

(VI) AS USED IN THIS SUBSECTION (1)(dd), UNLESS THE CONTEXT OTHERWISE REQUIRES:

(A) "MEDICAL PROFESSIONAL" MEANS AN ADVANCED PRACTICE REGISTERED NURSE REGISTERED PURSUANT TO SECTION 12-255-111, A PHYSICIAN ASSISTANT LICENSED PURSUANT TO SECTION 12-240-113, OR A MEDICAL DOCTOR OR DOCTOR OF OSTEOPATHY LICENSED PURSUANT TO ARTICLE 240 OF TITLE 12.

(B) "MENTAL HEALTH PROFESSIONAL" MEANS A MENTAL HEALTH PROFESSIONAL LICENSED OR CERTIFIED PURSUANT TO ARTICLE 245 OF TITLE 12, AN ADVANCED PRACTICE REGISTERED NURSE REGISTERED PURSUANT TO SECTION 12-255-111 WITH TRAINING IN SUBSTANCE USE DISORDERS OR MENTAL HEALTH, OR A PHYSICIAN ASSISTANT LICENSED PURSUANT TO SECTION 12-240-113 WITH TRAINING IN SUBSTANCE USE DISORDERS OR MENTAL HEALTH. "MENTAL HEALTH PROFESSIONAL" DOES NOT MEAN AN UNLICENSED PSYCHOTHERAPIST AS DEFINED IN SECTION 12-245-202.

SECTION 8. In Colorado Revised Statutes, 8-3.8-101, **amend** (2)(b) as follows:

8-3.8-101. Immigration legal assistance - fund - report - definitions.

(2) (b) The state treasurer shall credit any civil penalty money transferred to the state treasurer pursuant to section ***24-31-903 (5)(b),*** 24-74-107, ~~or~~ 24-74.1-103, ***24-76.7-104 (2), 24-76.7-105 (2),*** OR ***25-1.5-101 (1)(i)(I)(D)*** OR ***(1)(dd)*** and interest and income derived from the deposit and investment of the civil penalty money in the fund to the fund.

SECTION 9. Severability. If any provision of this act or the application of this act to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the act that

can be given effect without the invalid provision or application, and to this end the provisions of this act are declared to be severable.

SECTION 10. Safety clause. The general assembly finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, or safety or for appropriations for the support and maintenance of the departments of the state and state institutions.

Second Regular Session
Seventy-fifth General Assembly
STATE OF COLORADO

INTRODUCED

LLS NO. 26-0106.01 Christopher McMichael x4775 **HOUSE BILL 26-1278**

HOUSE SPONSORSHIP

Richardson, Brooks, Caldwell, Garcia, Goldstein, Hartsook, Johnson, Mauro, Paschal, Soper, Titone, Winter T., Woog

SENATE SPONSORSHIP

Pelton R. and Snyder, Cutter, Frizell, Hinrichsen, Marchman

House Committees
Energy & Environment

Senate Committees

A BILL FOR AN ACT

CONCERNING THE PRESERVATION OF LOCAL LAND USE AUTHORITY BY REQUIRING LOCAL GOVERNMENT APPROVAL BEFORE AN INVESTOR-OWNED ELECTRIC UTILITY MAY COMMENCE A CONDEMNATION PROCEEDING FOR HIGH-VOLTAGE TRANSMISSION INFRASTRUCTURE.

Bill Summary

(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at http://leg.colorado.gov.)

The bill requires that an investor-owned electric utility receive a certificate of public convenience and necessity (certificate) from the

public utilities commission and obtain all necessary local government land use approvals and permits prior to initiating any condemnation proceedings related to a high-voltage transmission infrastructure project requiring the certificate.

The bill does not change existing application and review processes related to the development of transmission projects that have been established by the public utilities commission or a relevant local government.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Legislative declaration. (1) The general assembly finds and declares that:

(a) Projects built by public utilities fulfill an essential public need, supporting the health, safety, economic prosperity, and welfare of Coloradans by ensuring access to electricity, gas, water, and telecommunications services;

(b) Individual property rights are fundamental to our constitutional order, protected by the fifth amendment of the United States constitution and section 15 of article II of the state constitution, which states that "[p]rivate property shall not be taken or damaged, for public or private use, without just compensation";

(c) These constitutional provisions prohibit the taking of private property for speculative or undefined public uses, ensuring that condemnations are necessary, justified, and executed with due process;

(d) Under Colorado law, investor-owned electric utilities that hold a certificate of public convenience and necessity issued by the public utilities commission may initiate condemnation proceedings prior to obtaining all required local government land use permits and approvals, which creates circumstances in which private property is condemned without certainty that the property is necessary for a final, approved

project;

(e) Speculative acquisitions of property via condemnation undermine constitutional protections, burden landowners, and erode public trust in both government and utility providers;

(f) Local governments exercise their land use powers to regulate development in harmony with local needs, environmental stewardship, and community priorities. Preserving these powers ensures that investor-owned electric utility projects are implemented with full consideration of local impacts while serving statewide and regional public needs.

(g) Therefore, it is the intent of the general assembly to protect private property rights, uphold constitutional takings standards, and reinforce local government land use authority by clarifying that no condemnation action taken by an investor-owned electric utility may occur until final approval of the project, including local government authorization, has been granted.

SECTION 2. In Colorado Revised Statutes, **add** 40-5-101.3 as follows:

40-5-101.3. Construction of electric transmission infrastructure - certificate of public convenience and necessity - eminent domain - approval by local government - definitions.

(1) AS USED IN THIS SECTION, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(a) "INVESTOR-OWNED ELECTRIC UTILITY" OR "UTILITY" MEANS AN INVESTOR-OWNED UTILITY THAT PROVIDES RETAIL ELECTRIC SERVICE AND IS REGULATED BY THE COMMISSION.

(b) "LOCAL GOVERNMENT" MEANS A COUNTY, HOME RULE OR

STATUTORY CITY, TOWN, TERRITORIAL CHARTER CITY, OR CITY AND COUNTY.

(c) "TRANSMISSION INFRASTRUCTURE" MEANS HIGH-VOLTAGE TRANSMISSION INFRASTRUCTURE THAT EXCEEDS ONE HUNDRED KILOVOLTS AND IS OWNED AND OPERATED BY AN INVESTOR-OWNED ELECTRIC UTILITY.

(2) A CERTIFICATE OF PUBLIC CONVENIENCE AND NECESSITY ISSUED BY THE COMMISSION PURSUANT TO THIS ARTICLE 5 DOES NOT CONFER THE POWER OF EMINENT DOMAIN UPON AN INVESTOR-OWNED ELECTRIC UTILITY UNLESS AND UNTIL:

(a) ALL LOCAL GOVERNMENT LAND USE PERMITS AND APPROVALS REQUIRED FOR THE TRANSMISSION INFRASTRUCTURE HAVE BEEN ISSUED BY THE RELEVANT ENTITIES OF THE LOCAL GOVERNMENT WHERE THE TRANSMISSION INFRASTRUCTURE WILL BE LOCATED; AND

(b) ANY TAKING OR DAMAGING OF PRIVATE PROPERTY FOR THE TRANSMISSION INFRASTRUCTURE IS CONDUCTED CONSISTENT WITH SECTION 15 OF ARTICLE II OF THE STATE CONSTITUTION TO ENSURE JUST COMPENSATION AND PROHIBIT SPECULATIVE TAKING OF PRIVATE PROPERTY.

(3) (a) AN INVESTOR-OWNED ELECTRIC UTILITY THAT HAS RECEIVED A CERTIFICATE OF PUBLIC CONVENIENCE AND NECESSITY FROM THE COMMISSION FOR TRANSMISSION INFRASTRUCTURE SHALL NOT INITIATE CONDEMNATION PROCEEDINGS FOR ANY PROPERTY RELATED TO THE INFRASTRUCTURE UNLESS AND UNTIL THE INVESTOR-OWNED ELECTRIC UTILITY OBTAINS:

(I) ALL LOCAL GOVERNMENT LAND USE PERMITS AND APPROVALS ISSUED BY THE LOCAL GOVERNMENT WHERE THE TRANSMISSION

INFRASTRUCTURE WILL BE LOCATED; AND

(II) CONFIRMATION OF THE FINAL APPROVED PROJECT DESIGN FROM THE LOCAL GOVERNMENT SUCH THAT THE SPECIFIC PROPERTY REQUIRED FOR THE TRANSMISSION INFRASTRUCTURE IS IDENTIFIED AND ANY TAKING OR DAMAGING OF PRIVATE PROPERTY REQUIRED FOR THE TRANSMISSION INFRASTRUCTURE IS CONDUCTED CONSISTENT WITH SECTION 15 OF ARTICLE II OF THE STATE CONSTITUTION.

(b) IF THE TRANSMISSION INFRASTRUCTURE WILL BE LOCATED WITHIN THE JURISDICTION OF MULTIPLE LOCAL GOVERNMENTS, THE INVESTOR-OWNED ELECTRIC UTILITY SHALL MEET THE REQUIREMENTS OF SUBSECTION (2) OF THIS SECTION AND THIS SUBSECTION (3) FOR EACH SPECIFIC LOCAL GOVERNMENT JURISDICTION WHERE THE TRANSMISSION INFRASTRUCTURE WILL BE LOCATED BEFORE INITIATING A CONDEMNATION PROCEEDING RELATED TO THE TRANSMISSION INFRASTRUCTURE WITHIN A SPECIFIC LOCAL GOVERNMENT JURISDICTION THAT HAS NOT YET APPROVED THE TRANSMISSION INFRASTRUCTURE.

(4) THE ISSUANCE OF A CERTIFICATE OF PUBLIC CONVENIENCE AND NECESSITY BY THE COMMISSION PURSUANT TO THIS ARTICLE 5 DOES NOT RELIEVE AN INVESTOR-OWNED ELECTRIC UTILITY FROM THE UTILITY'S OBLIGATION TO OBTAIN ALL NECESSARY LOCAL GOVERNMENT LAND USE PERMITS AND APPROVALS PRIOR TO EXERCISING THE UTILITY'S EMINENT DOMAIN AUTHORITY.

(5) THIS SECTION SHALL NOT IMPACT OR DELAY EXISTING APPLICATION REVIEW PROCESSES OR TIMELINES ESTABLISHED BY THE COMMISSION OR A RELEVANT LOCAL GOVERNMENT.

SECTION 3. In Colorado Revised Statutes, 29-20-108, **add** (8) as follows:

29-20-108. Local government regulation - location, construction, or improvement of major electrical or natural gas facilities - powerline trail notification - expedited review for certain transmission line projects - transmission infrastructure exception - legislative declaration - definitions.

(8) (a) THIS SECTION DOES NOT APPLY TO LOCAL GOVERNMENT LAND USE PERMITS AND APPROVALS REQUIRED FOR INVESTOR-OWNED ELECTRIC UTILITIES' TRANSMISSION INFRASTRUCTURE, AS GOVERNED BY SECTION 40-5-101.3.

(b) AS USED IN THIS SUBSECTION (8):

(I) "INVESTOR-OWNED ELECTRIC UTILITY" HAS THE MEANING SET FORTH IN SECTION 40-5-101.3 (1)(a).

(II) "TRANSMISSION INFRASTRUCTURE" HAS THE MEANING SET FORTH IN SECTION 40-5-101.3 (1)(c).

SECTION 4. Act subject to petition - effective date - applicability. (1) This act takes effect January 1, 2027; except that, if a referendum petition is filed pursuant to section 1 (3) of article V of the state constitution against this act or an item, section, or part of this act within the ninety-day period after final adjournment of the general assembly, then the act, item, section, or part will not take effect unless approved by the people at the general election to be held in November 2026 and, in such case, will take effect January 1, 2027, or on the date of the official declaration of the vote thereon by the governor, whichever is later.

(2) This act applies to condemnation proceedings initiated on or after the applicable effective date of this act.

Second Regular Session
Seventy-fifth General Assembly
STATE OF COLORADO

INTRODUCED

LLS NO. 26-0525.01 Jacob Bennington x2371 **SENATE BILL 26-082**

SENATE SPONSORSHIP

Pelton B.,

HOUSE SPONSORSHIP

(None),

Senate Committees
Transportation & Energy

House Committees

A BILL FOR AN ACT

CONCERNING THE PROCESS BY WHICH A LOCAL GOVERNMENT CONTROLS THE DEVELOPMENT OF RENEWABLE ENERGY PROJECTS, AND, IN CONNECTION THEREWITH, AUTHORIZING A LOCAL GOVERNMENT TO IMPLEMENT AN OPTIONAL TWO-TIER APPLICATION FEE PROGRAM AND A SUCCESS FEE.

Bill Summary

(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at http://leg.colorado.gov.)

A renewable energy project developer (facility owner) that intends to undertake a project to build a renewable energy facility (renewable

energy project) may currently submit an application for land use approval from the renewable energy project to a local government. However, current law does not specify what process a local government may use to charge fees or set a timeline for the local government to make a final decision regarding land use approval for the renewable energy project. The bill specifies that control over the specifics of the application process rests with the local government. The local government may establish fees for an application for a renewable energy project and may offer two independent tracks for the application based on the fee the facility owner pays. The standard track allows a facility owner to pay a lower fee, but does not guarantee a specific timeline for the local government to issue a final decision on the application. The expedited track allows a facility owner to pay an additional fee, with an agreement that if the local government takes longer than 120 days, minus any permitted tolling periods, a percentage of the higher fee will be refunded.

The bill gives local governments authority to contract with third-party technical reviewers to review the application for a final decision. The bill also requires a facility owner to pay a success fee to the local government upon final approval of the project, based on the amount of time between receipt of the application and when the project is approved, to be used by the local government for expenses related to regulating renewable energy facilities and maintaining local roads impacted by facility construction.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. In Colorado Revised Statutes, **add** 29-20-406 as follows:

29-20-406. Renewable energy project fees - local authority - fast-track program - refund - reporting - legislative declaration - definitions.

(1) (a) THE GENERAL ASSEMBLY HEREBY FINDS AND DECLARES THAT:

(I) COLORADO HAS LONG RECOGNIZED THAT LAND USE IS A LOCAL FUNCTION, AND COUNTIES ARE BEST POSITIONED TO BALANCE ENERGY DEVELOPMENT WITH COMMUNITY IMPACTS; AND

(II) FACILITIES CAN CREATE SIGNIFICANT LOCAL IMPACTS ON

ROADS, EMERGENCY SERVICES, AND THE ENVIRONMENT THAT ARE MOST DIRECTLY BORNE BY LOCAL GOVERNMENTS AND RESIDENTS.

(b) THEREFORE, IT IS THE INTENT OF THE GENERAL ASSEMBLY TO:

(I) REAFFIRM THAT LOCAL GOVERNMENTS RETAIN AUTHORITY TO APPROVE, CONDITION, OR DENY PROJECTS THROUGH LOCAL LAND USE PROCESSES;

(II) CREATE A VOLUNTARY STRUCTURE THAT INCENTIVIZES FASTER, PREDICTABLE LOCAL PERMITTING BY ALLOWING LOCAL GOVERNMENTS TO RETAIN HIGHER FACILITY OWNER-PAID FEES WHEN STATUTORY TIMELINES ARE MET; AND

(III) ENSURE PROJECTS CONTRIBUTE FAIRLY AND PREDICTABLY TO LOCAL FISCAL IMPACTS THROUGH A SUCCESS FEE CHARGED ON FINAL APPROVAL OF THE PROJECT.

(2) (a) THE POWER AND AUTHORITY GRANTED BY THIS SECTION DOES NOT LIMIT ANY POWER OR AUTHORITY PRESENTLY EXERCISED BY A LOCAL GOVERNMENT OR PREVIOUSLY GRANTED TO A LOCAL GOVERNMENT. EACH LOCAL GOVERNMENT WITHIN ITS RESPECTIVE JURISDICTION HAS THE AUTHORITY TO:

(I) DEVELOP A UNIFORM ELECTRONIC APPLICATION AND PERMITTING SYSTEM FOR FACILITY OWNERS APPLYING FOR LAND USE APPROVAL TO DEVELOP A RENEWABLE ENERGY PROJECT;

(II) CREATE A STANDARD PERMIT APPLICATION PROCESS, AS WELL AS ESTABLISH AND COLLECT A STANDARD FEE FROM FACILITY OWNERS;

(III) CREATE AN EXPEDITED PERMIT APPLICATION PROCESS, AS WELL AS ESTABLISH AND COLLECT AN EXPEDITED FEE FROM FACILITY OWNERS; AND

(IV) ESTABLISH AND COLLECT A SUCCESS FEE FROM FACILITY

OWNERS AFTER A LOCAL GOVERNMENT APPROVES A RENEWABLE ENERGY PROJECT.

(b) A PERMITTING AND APPLICATION SYSTEM DEVELOPED BY A LOCAL GOVERNMENT PURSUANT TO THIS SUBSECTION (2) MUST COMPLY WITH SUBSECTIONS (3) THROUGH (7) OF THIS SECTION.

(3) A FACILITY OWNER THAT INTENDS TO DEVELOP A RENEWABLE ENERGY PROJECT MAY SUBMIT EITHER A STANDARD PERMIT APPLICATION OR, IF ESTABLISHED BY THE LOCAL GOVERNMENT, AN EXPEDITED PERMIT APPLICATION TO THE LOCAL GOVERNMENT IN ACCORDANCE WITH THE PROCEDURES DEVELOPED BY THE LOCAL GOVERNMENT PURSUANT TO SUBSECTION (2) OF THIS SECTION.

(4) (a) FOR EXPEDITED PERMIT APPLICATIONS RECEIVED BY THE LOCAL GOVERNMENT ON OR AFTER JANUARY 1, 2027, EXCEPT AS OTHERWISE PROVIDED IN THIS SUBSECTION (4), THE LOCAL GOVERNMENT SHALL ISSUE A DETERMINATION OF WHETHER THE APPLICATION IS COMPLETE WITHIN TWENTY DAYS AFTER RECEIVING THE APPLICATION. THE LOCAL GOVERNMENT SHALL NOTIFY THE FACILITY OWNER IN WRITING WHETHER THE APPLICATION IS COMPLETE.

(b) A DETERMINATION THAT AN APPLICATION IS NOT COMPLETE MUST INCLUDE A CONSOLIDATED DEFICIENCY NOTICE WITH A LIST OF ALL MISSING OR INCOMPLETE ITEMS THAT THE FACILITY OWNER MUST CORRECT FOR THE APPLICATION TO BE DEEMED COMPLETE.

(c) (I) AN APPLICATION SUBMITTED TO A LOCAL GOVERNMENT PURSUANT TO SUBSECTION (3) OF THIS SECTION IS DEEMED APPROVED BY THE LOCAL GOVERNMENT IF THE LOCAL GOVERNMENT HAS NOT, WITHIN TWENTY DAYS AFTER RECEIPT OF THE APPLICATION, NOTIFIED THE FACILITY OWNER PURSUANT TO SUBSECTION (4)(a) OF THIS SECTION

WHETHER THE APPLICATION IS COMPLETE.

(II) IF THE LOCAL GOVERNMENT DETERMINES AN APPLICATION IS NOT COMPLETE, THE LOCAL GOVERNMENT MAY HAVE AN ADDITIONAL THIRTY DAYS AFTER PROVIDING INITIAL NOTICE THAT THE APPLICATION IS INCOMPLETE TO PROVIDE THE CONSOLIDATED DEFICIENCY NOTICE.

(5) IF AN APPLICATION IS DEEMED INCOMPLETE, THE FACILITY OWNER HAS THIRTY DAYS FROM THE DATE THAT THE LOCAL GOVERNMENT PROVIDED THE CONSOLIDATED DEFICIENCY NOTICE TO CURE ANY DEFICIENCIES IDENTIFIED IN THE CONSOLIDATED DEFICIENCY NOTICE OR TO APPEAL THE DETERMINATION.

(6) (a) THE EXPEDITED PERMIT FEE CONSISTS OF THE STANDARD FEE, AS WELL AS AN ADDITIONAL CHARGE THAT THE LOCAL GOVERNMENT SHALL REFUND TO THE FACILITY OWNER AS FOLLOWS:

(I) IF THE LOCAL GOVERNMENT ISSUES A FINAL DECISION WITHIN ONE HUNDRED TWENTY DAYS OR FEWER AFTER RECEIPT OF THE APPLICATION, ZERO PERCENT OF THE ADDITIONAL CHARGE IS REFUNDED TO THE FACILITY OWNER;

(II) IF THE LOCAL GOVERNMENT ISSUES A FINAL DECISION BETWEEN ONE HUNDRED TWENTY-ONE DAYS AND ONE HUNDRED EIGHTY DAYS AFTER RECEIPT OF THE APPLICATION, FIFTY PERCENT OF THE ADDITIONAL CHARGE IS REFUNDED TO THE FACILITY OWNER;

(III) IF THE LOCAL GOVERNMENT ISSUES A FINAL DECISION BETWEEN ONE HUNDRED EIGHTY-ONE DAYS AND TWO HUNDRED FORTY DAYS AFTER RECEIPT OF THE APPLICATION, SEVENTY-FIVE PERCENT OF THE ADDITIONAL CHARGE IS REFUNDED TO THE FACILITY OWNER; OR

(IV) IF THE LOCAL GOVERNMENT ISSUES A FINAL DECISION MORE THAN TWO HUNDRED FORTY DAYS AFTER RECEIPT OF THE APPLICATION,

ONE HUNDRED PERCENT OF THE ADDITIONAL CHARGE IS REFUNDED TO THE FACILITY OWNER.

(b) IN DETERMINING THE AMOUNT OF THE ADDITIONAL CHARGE FOR AN EXPEDITED APPLICATION THAT A LOCAL GOVERNMENT MUST REFUND PURSUANT TO SUBSECTION (6)(a) OF THIS SECTION, THE LOCAL GOVERNMENT SHALL NOT INCLUDE ANY PORTION OF THE THIRTY-DAY CURE PERIOD IN THE CALCULATION OF THE TIME IT TAKES FOR THE LOCAL GOVERNMENT TO ISSUE A FINAL DECISION.

(7) (a) IF A FACILITY OWNER HAS SUBMITTED AN EXPEDITED PERMIT APPLICATION, THE LOCAL GOVERNMENT SHALL SELECT AND HIRE A QUALIFIED AND INDEPENDENT NONGOVERNMENTAL CONTRACTOR UNDER THE DIRECTION OF THE LOCAL GOVERNMENT TO PROVIDE THE LOCAL GOVERNMENT WITH TECHNICAL ASSISTANCE IN REVIEWING THE APPLICATION.

(b) AN INDEPENDENT NONGOVERNMENTAL CONTRACTOR THAT PROVIDES TECHNICAL ASSISTANCE PURSUANT TO THIS SUBSECTION (7) MAY ASSIST THE LOCAL GOVERNMENT WITH SOME OR ALL OF THE FOLLOWING, AT THE LOCAL GOVERNMENT'S DISCRETION:

(I) REVIEWING THE FACILITY OWNER'S APPLICATION AND PROPOSAL;

(II) PREPARING THE LOCAL GOVERNMENT'S COMPLETENESS DETERMINATION;

(III) PREPARING THE LOCAL GOVERNMENT'S CONSOLIDATED DEFICIENCY NOTICE;

(IV) PROVIDING RESPONSES TO A FACILITY OWNER'S APPEAL OF ANY ITEM IN A CONSOLIDATED DEFICIENCY NOTICE; AND

(V) PREPARING A FINAL DECISION ON THE FACILITY OWNER'S

APPLICATION.

(c) THE FACILITY OWNER SHALL BEAR THE INDEPENDENT NONGOVERNMENTAL CONTRACTOR'S COSTS FOR ANY TECHNICAL ASSISTANCE PROVIDED PURSUANT TO THIS SECTION AND SHALL REMIT PAYMENT FOR THE COSTS TO THE LOCAL GOVERNMENT, WHICH SHALL PAY THE CONTRACTOR. THE LOCAL GOVERNMENT MAY CHARGE THE FACILITY OWNER AN ADDITIONAL FEE IN AN AMOUNT NOT TO EXCEED TEN PERCENT OF THE COST OF THE CONTRACT WITH THE CONTRACTOR FOR CONTRACT ADMINISTRATION, TECHNICAL REVIEW, AND ADDITIONAL PERMIT PROCESSING.

(d) (I) THE LOCAL GOVERNMENT, IN ITS SOLE DISCRETION, SHALL PROVIDE OVERSIGHT TO ENSURE THAT INDEPENDENT NONGOVERNMENTAL CONTRACTORS PROVIDE TECHNICAL ASSISTANCE IN ACCORDANCE WITH THE TERMS OF THEIR CONTRACTS. THE LOCAL GOVERNMENT MAY REQUIRE A CONTRACTOR'S TECHNICAL ASSISTANCE TO CONFORM TO ALL LAWS AND ORDINANCES APPLICABLE TO THE APPLICATION IN QUESTION.

(II) THE LOCAL GOVERNMENT MAY DEEM SOME OR ALL OF THE CONTRACTOR'S TECHNICAL ASSISTANCE AS UNACCEPTABLE AND MAY REJECT, REQUIRE CORRECTION OF, OR DENY APPROVAL FOR SUCH ASSISTANCE.

(8) (a) ANY FACILITY OWNER WHOSE RENEWABLE ENERGY PROJECT IS APPROVED PURSUANT TO THIS SECTION SHALL PAY A SUCCESS FEE IN AN AMOUNT SET BY THE LOCAL GOVERNMENT UPON FINAL APPROVAL OF THE PROJECT.

(b) A FACILITY OWNER WHOSE RENEWABLE ENERGY PROJECT IS APPROVED PURSUANT TO A LOCAL GOVERNMENT'S EXPEDITED PERMIT APPLICATION SHALL PAY AN ADDITIONAL SUCCESS FEE, IN AN AMOUNT SET

BY THE LOCAL GOVERNMENT, BASED ON THE AMOUNT OF TIME BETWEEN THE LOCAL GOVERNMENT'S RECEIPT OF THE APPLICATION AND ITS ISSUANCE OF FINAL APPROVAL OF THE PROJECT. THE PERCENTAGE OF THE ADDITIONAL SUCCESS FEE TO BE PAID BY THE FACILITY OWNER IS DETERMINED AS FOLLOWS:

(I) IF THE LOCAL GOVERNMENT ISSUES FINAL APPROVAL WITHIN ONE HUNDRED TWENTY DAYS OR FEWER AFTER RECEIPT OF THE APPLICATION, ONE HUNDRED PERCENT OF THE ADDITIONAL SUCCESS FEE;

(II) IF THE LOCAL GOVERNMENT ISSUES FINAL APPROVAL BETWEEN ONE HUNDRED TWENTY-ONE DAYS AND ONE HUNDRED EIGHTY DAYS AFTER RECEIPT OF THE APPLICATION, FIFTY PERCENT OF THE ADDITIONAL SUCCESS FEE;

(III) IF THE LOCAL GOVERNMENT ISSUES FINAL APPROVAL BETWEEN ONE HUNDRED EIGHTY-ONE DAYS AND TWO HUNDRED FORTY DAYS AFTER RECEIPT OF THE APPLICATION, TWENTY-FIVE PERCENT OF THE ADDITIONAL SUCCESS FEE; OR

(IV) IF THE LOCAL GOVERNMENT ISSUES A FINAL DECISION MORE THAN TWO HUNDRED FORTY DAYS AFTER RECEIPT OF THE APPLICATION, THE LOCAL GOVERNMENT SHALL ONLY CHARGE THE SUCCESS FEE FOR A STANDARD PERMIT APPLICATION APPROVAL PURSUANT TO SUBSECTION (8)(a) OF THIS SECTION.

(c) A LOCAL GOVERNMENT SHALL USE THE MONEY COLLECTED FROM THE SUCCESS FEE ONLY FOR FUNDING:

(I) LOCAL GOVERNMENT STAFF RESPONSIBLE FOR PERMITTING AND ENFORCEMENT OF LOCAL RENEWABLE ENERGY LAWS AND ORDINANCES;

(II) INSPECTION AND COMPLIANCE MONITORING IN CONNECTION WITH RENEWABLE ENERGY PROJECTS;

(III) MITIGATION AND REPAIR TO LOCAL ROADS IMPACTED BY HAULING OF HEAVY MACHINERY FOR RENEWABLE ENERGY PROJECTS;

(IV) EMERGENCY MANAGEMENT AND FIRE READINESS RELATED TO THE RENEWABLE ENERGY FACILITY; AND

(V) OVERSIGHT OF ANY DECOMMISSIONING OF A RENEWABLE ENERGY FACILITY.

SECTION 2. Act subject to petition - effective date. This act takes effect at 12:01 a.m. on the day following the expiration of the ninety-day period after final adjournment of the general assembly (August 12, 2026, if adjournment sine die is on May 13, 2026); except that, if a referendum petition is filed pursuant to section 1 (3) of article V of the state constitution against this act or an item, section, or part of this act within such period, then the act, item, section, or part will not take effect unless approved by the people at the general election to be held in November 2026 and, in such case, will take effect on the date of the official declaration of the vote thereon by the governor.

Second Regular Session
Seventy-fifth General Assembly
STATE OF COLORADO

INTRODUCED

LLS NO. 26-0693.01 Clare Haffner x6137 **SENATE BILL 26-098**

SENATE SPONSORSHIP

Liston and Ball,

HOUSE SPONSORSHIP

Rydin,

Senate Committees
Local Government & Housing

House Committees

A BILL FOR AN ACT

CONCERNING THE APPLICABILITY OF CERTAIN NOISE ABATEMENT PROVISIONS, AND, IN CONNECTION THEREWITH, REESTABLISHING LOCAL AUTHORITY WITH RESPECT TO NOISE ABATEMENT.

Bill Summary

(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at http://leg.colorado.gov.)

Under current law, there are statewide standards for noise level limits for various time periods and areas, and noise in excess of those limits is a public nuisance. The statewide noise level limits do not apply

to the use of property for certain purposes.

The bill states that the statewide noise level limits also do not apply to the following:

- The use of property owned or controlled by the state or a political subdivision of the state;
- The use of property pursuant to a permit or license that addresses sound emitted and that is issued by a local government; and
- The use of property owned or controlled by a nonprofit entity for a cultural, entertainment, athletic, or patriotic event.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. In Colorado Revised Statutes, 25-12-103, **amend** (11) as follows:

25-12-103. Maximum permissible noise levels.

(11) (a) ~~This article is not applicable to the use of property by this state, any political subdivision of this state, or any other entity not organized for profit, including, but not limited to, nonprofit corporations, or any of their lessees, licensees, or permittees, for the purpose of promoting, producing, or holding cultural, entertainment, athletic, or patriotic events, including, but not limited to, concerts, music festivals, and fireworks displays. This subsection (11) shall not be construed to preempt or limit the authority of any political subdivision having jurisdiction to regulate noise abatement.~~ THIS ARTICLE 12 DOES NOT APPLY TO:

(I) THE USE OF PROPERTY THAT IS OWNED OR CONTROLLED BY THE STATE OR A POLITICAL SUBDIVISION OF THE STATE;

(II) THE USE OF PROPERTY PURSUANT TO A PERMIT OR LICENSE ISSUED BY A LOCAL GOVERNMENT THAT ADDRESSES SOUND EMITTED, INCLUDING SOUND LEVELS AND HOURS, FROM THE PROPERTY, WHICH

PERMIT OR LICENSE MAY BE MORE OR LESS RESTRICTIVE THAN THIS ARTICLE 12; OR

(III) THE USE OF PROPERTY THAT IS OWNED OR CONTROLLED BY A NONPROFIT ENTITY FOR A CULTURAL, ENTERTAINMENT, ATHLETIC, OR PATRIOTIC EVENT, SUCH AS A CONCERT, MUSIC FESTIVAL, OR FIREWORKS DISPLAY, INCLUDING THE USE OF THE PROPERTY BY A LESSEE OF THE NONPROFIT ENTITY OR BY A PERSON WITH WRITTEN PERMISSION FROM THE NONPROFIT ENTITY.

(b) THIS SUBSECTION (11) DOES NOT PREEMPT OR LIMIT THE AUTHORITY OF A POLITICAL SUBDIVISION HAVING JURISDICTION TO REGULATE NOISE ABATEMENT.

SECTION 2. In Colorado Revised Statutes, **amend** 25-12-108 as follows:

25-12-108. Preemption.

Except as provided in sections 25-12-103 ~~(12)~~ (11) AND (12) and 25-12-110, this ~~article shall not be construed to~~ ARTICLE 12 DOES NOT preempt or limit the authority of ~~any~~ A municipality or county to adopt standards that are no less restrictive than ~~the provisions of this article~~ THIS ARTICLE 12.

SECTION 3. Safety clause. The general assembly finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, or safety or for appropriations for the support and maintenance of the departments of the state and state institutions.

Second Regular Session
Seventy-fifth General Assembly
STATE OF COLORADO

INTRODUCED

LLS NO. 26-0017.03 Sarah Lozano x3858 **SENATE BILL 26-102**

SENATE SPONSORSHIP

Kipp,

HOUSE SPONSORSHIP

Brown,

Senate Committees
Transportation & Energy

House Committees

A BILL FOR AN ACT

CONCERNING MEASURES TO ENSURE ACCOUNTABILITY FOR LARGE-LOAD DATA CENTERS.

Bill Summary

(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at http://leg.colorado.gov.)

The bill creates certain requirements for large-load data centers, which are defined in the bill as:

- A new data center that has a peak load of more than 30 megawatts or multiple new data centers with a collective peak load of more than 60 megawatts; or
- An existing data center that adds a peak load of more than

30 megawatts or multiple existing data centers that add a collective peak load of more than 60 megawatts.

No later than June 30, 2030, the public utilities commission (commission) is required to make a determination on whether 100% hourly matching by large-load data centers is technically and economically feasible. If the commission determines that 100% hourly matching is not technically and economically feasible, the commission must make a determination of the highest percentage of hourly matching by large-load data centers that is technically and economically feasible (hourly matching requirement), which percentage the commission must update on a regular basis.

Beginning January 1, 2031, an operator of a large-load data center (operator) must generate, purchase, or otherwise acquire a quantity of electricity generated from renewable resources necessary to meet 100% of the operator's large-load data center's total annual electricity consumption. An operator must also achieve the hourly matching requirement. An operator must comply with these requirements through a tariff, contract, or program entered into with a utility, one or more power purchase agreements entered into with an independent power producer, or a self-supply of electricity.

An operator must enter into contracts of at least 15 years with a utility to pay for certain infrastructure and resource costs. An operator must also contribute to utility demand-side management programs and comply with certain operational water management and on-site backup generation requirements.

No later than June 30, 2028, and no later than each June 30 thereafter, an operator must report to the department of public health and environment certain information about the large-load data center, including information about the large-load data center's annual electricity and water consumption. The department of public health and environment must compile the information reported and provide a report to the general assembly and commission and make the report publicly available on the department's website.

A utility is prohibited from interconnecting or supplying electricity to a large-load data center unless:

- The operator has either provided an up-front payment or entered into a contract of at least 15 years with the utility, which up-front payment or contract must require the operator to pay for certain infrastructure and resource costs;
- On or after January 1, 2031, the utility has verified that the operator is in compliance with the hourly matching requirement; and
- The utility determines and ensures that the addition of the large-load data center to the utility's system does not negatively affect the utility's ability to provide reliable

service to customers or meet applicable clean energy targets or increase the utility's greenhouse gas emissions.

A utility is prohibited from offering economic development rates to large-load data centers and is required to develop and offer demand response programs or flexible connection tariffs to the utility's customers that are operators. A utility is required to solicit and accept voluntary financial contributions from operators to certain utility programs, which contributions must supplement, rather than substitute, the utility's funding of those programs. A utility that is rate-regulated by the commission with customers that are operators is required to describe efforts to comply with the bill in the utility's annual report filed with the commission.

On or before June 30, 2027, the department of local affairs must publish model codes for the development of large-load data centers, which model codes must consider certain best practices. In developing the model codes, the department of local affairs must conduct a robust stakeholder and engagement process and evaluate, update, and review the model codes every 5 years.

With its development permit application for a large-load data center, the person responsible for the initial development of a large-load data center (developer) must submit a site assessment to the local government reviewing the application. A site assessment must include certain components.

If the siting of a large-load data center is proposed in a disproportionately impacted community or if an operator of an existing data center in a disproportionately impacted community plans to expand the data center's peak load such that the data center will become a large-load data center, the developer or operator must undergo a cumulative impacts analysis before the development or expansion begins. The developer or operator is required to contract with a third-party contractor selected by the department of public health and environment to perform the cumulative impacts analysis.

In reviewing a development permit application for a large-load data center that is in a disproportionately impacted community or is proposed to be in a disproportionately impacted community, the applicable local government is required to consider the applicant's cumulative impacts analysis and whether the mitigation strategies described by the applicant are sufficient to avoid any negative impacts identified in the cumulative impacts analysis. Prior to applying for a development permit that is in a disproportionately impacted community or is proposed to be in a disproportionately impacted community, a developer or operator must comply with certain public hearing, notice, and community outreach requirements.

If the siting of a large-load data center is proposed in a disproportionately impacted community or if an operator of an existing data center in a disproportionately impacted community plans to expand

the data center's peak load such that the data center will become a large-load data center, the developer or operator must enter into a community benefit agreement with the disproportionately impacted community before the development or expansion begins. The developer is required to consult with the applicable local government and certain coalition groups and consider certain topics during community benefit agreement negotiations.

An operator is required to comply with certain labor standards.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Legislative declaration. (1) The general assembly finds that:

(a) Colorado and the United States are experiencing rapid and unprecedented growth in data centers, which presents significant challenges for electric utilities, the electric grid, regulators, and electricity consumers statewide;

(b) Absent clear statutory direction and appropriate safeguards, the costs of serving new large-load data centers may be shifted to residential, commercial, and other existing ratepayers, increasing electricity bills and creating financial risk from overbuilt or stranded generation, transmission, and distribution infrastructure;

(c) At a time when electricity demand is increasing and affordability is a growing concern for Colorado households, costs to serve large-load data centers should not shift onto other ratepayers;

(d) Unchecked growth in large-load data centers may increase reliance on fossil fuel generation, hinder electric utilities' ability to meet state and utility clean energy and greenhouse gas emission reduction requirements, and adversely affect public health and disproportionately impacted communities;

(e) The general assembly has established statewide climate, clean

energy, and emission reduction goals, including a goal of reaching net-zero emissions by 2050, which require that new electricity demand be met through prudent planning, investment in zero-emission resources, and avoidance of unnecessary fossil fuel expansion;

(f) Maintaining affordable electricity for all Coloradans requires consumer protection guardrails to ensure that large-load data centers bear the incremental costs of the generation, transmission, and distribution infrastructure necessary to serve them;

(g) Operators of large-load data centers should help Colorado meet its clean energy and climate goals and be responsible for paying their fair share of the costs of new energy infrastructure and grid investments needed to meet the demand of large-load data centers;

(h) Flexible load and behind-the-meter resources, when designed and deployed to provide dispatchable capacity, can reduce peak demand, defer or avoid distribution and transmission system upgrades, and mitigate ratepayer impacts associated with large-load data center interconnections;

(i) Managing large-load data center growth should advance affordability, reliability, and electrification, ensuring that large-load data center development strengthens, rather than undermines, Colorado's clean energy transition;

(j) Colorado rivers have experienced severe water stress in recent years due to overuse and climate change. New large water users like large-load data centers may threaten Colorado's water supply security and the state's ability to provide reliable water resources for other critical water users, including communities, tribal nations, agricultural users, recreational users, and the environment.

(k) Promoting the efficient and maximum utilization of Colorado's water resources by large-load data centers through requiring transparency of use and sourcing and maximizing sustainable and water-smart cooling technologies can increase communities' resilience to drought and climate change, reduce the sale of agricultural water rights in response to increased demand for municipal water use, and protect river flows and aquifer levels;

(l) Certain information regarding sources and usage of both water and energy by large-load data centers is critical to decision-making processes and should be made available to relevant local and state authorities;

(m) Colorado has experienced decades of population growth that has resulted in greatly increased pressure on natural resources, including land, water, and wildlife. The siting and development of new large-load data centers and associated infrastructure, including on-site generation resources and other electrical infrastructure, can result in habitat loss and fragmentation without appropriate measures to avoid, minimize, and mitigate direct, indirect, and cumulative impacts to wildlife resources. The siting and development of new large-load data centers must be balanced with the obligation of the state to protect wildlife resources and the hunting, fishing, and recreation traditions that they support, which traditions are an important part of the economy and culture of Colorado.

(n) The cumulative impacts of pollution are even more devastating for communities of color and low-income communities who bear outsized environmental burdens due to past and present discriminatory environmental and land use policies, endure higher health risks from pollution exposure, experience systemic injustice, and have faced

exclusion from government and industry decision-making and enforcement efforts; and

(o) Data center development should support Colorado's workforce and communities by adhering to high labor standards.

(2) It is therefore in the best interests of the state of Colorado to establish a comprehensive framework for large-load data centers that:

(a) Ensures electricity service that is clean, affordable, and reliable;

(b) Protects consumers and communities, including disproportionately impacted communities;

(c) Advances the state's climate and clean energy goals; and

(d) Affirms the authority of the public utilities commission and local governments to oversee new large-load data center development in an equitable and responsible manner.

(3) It is the intent of the general assembly that nothing in this act:

(a) Alters the greenhouse gas emission reduction goals and deadlines established in section 25-7-102 (2)(g), Colorado Revised Statutes;

(b) Diminishes the air quality control commission's existing authority to require more than the minimum greenhouse gas emission reduction goals and deadlines established in section 25-7-102 (2)(g), Colorado Revised Statutes; or

(c) Prevents state or local authorities from enacting additional requirements for large-load data centers.

SECTION 2. In Colorado Revised Statutes, **add** article 2.5 to title 40 as follows:

ARTICLE 2.5

Large-load Data Centers

40-2.5-101. Definitions.

AS USED IN THIS ARTICLE 2.5, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(1) "CLOSED-LOOP COOLING SYSTEM" MEANS A COOLING CONFIGURATION THAT OPERATES BY RECIRCULATING AIR, WATER, REFRIGERANTS, OR OTHER HEAT-TRANSFER MEDIUMS WITHIN SEALED OR SELF-CONTAINED EQUIPMENT TO ABSORB AND REJECT HEAT WITHOUT EXPOSURE TO THE ATMOSPHERE OR ROUTINE EVAPORATIVE WATER LOSS.

(2) "CUMULATIVE IMPACTS" MEANS THE INCREMENTAL EFFECTS THAT A LARGE-LOAD DATA CENTER HAS ON THE ENVIRONMENT, INCLUDING EFFECTS ON AIR QUALITY, WATER QUALITY, WATER RESOURCE AVAILABILITY, CLIMATE, NOISE, ODOR, WILDLIFE, AND PUBLIC HEALTH, WHEN ADDED TO THE IMPACTS FROM OTHER PAST, PRESENT, AND REASONABLY FORESEEABLE FUTURE DEVELOPMENT OF ANY TYPE ON A DISPROPORTIONATELY IMPACTED COMMUNITY.

(3) "DATA CENTER" MEANS A FACILITY THAT:

(a) HOUSES INFORMATION TECHNOLOGY EQUIPMENT USED FOR DATA PROCESSING, DATA STORAGE, OR TELECOMMUNICATIONS; AND

(b) HAS THE PRIMARY FUNCTION OF DELIVERING ONE OR MORE INFORMATION TECHNOLOGY SERVICES, INCLUDING:

(I) PROVIDING DATA STORAGE, PROCESSING, AND TRANSPORT SERVICES;

(II) SUPPORTING THE DELIVERY OF CLOUD COMPUTING SERVICES;

(III) PROVIDING NETWORK CONNECTIVITY SERVICES; AND

(IV) SUPPORTING ARTIFICIAL INTELLIGENCE, MACHINE LEARNING, OR SIMILAR COMPUTATIONAL SERVICES.

(4) "EMERGENCY" MEANS AN UNPLANNED AND INVOLUNTARY INTERRUPTION OF UTILITY ELECTRIC SERVICE OR A CONDITION POSING AN IMMINENT RISK TO PUBLIC HEALTH OR SAFETY THAT IS DOCUMENTED AND VERIFIED BY THE SERVING ELECTRIC UTILITY.

(5) "HOURLY MATCHING" MEANS THE DEMONSTRATED PROPORTION OF A LARGE-LOAD DATA CENTER'S HOURLY ENERGY USAGE MET BY PURCHASED OR GENERATED RENEWABLE RESOURCES, REPRESENTED AS A PERCENTAGE AND DEMONSTRATED WITH CERTIFIED THIRD-PARTY ACCOUNTING, AS APPROVED BY THE COMMISSION.

(6) "LARGE-LOAD DATA CENTER" MEANS:

(a) A DATA CENTER THAT BEGINS OPERATION ON OR AFTER THE EFFECTIVE DATE OF THIS SECTION:

(I) WITH A PEAK LOAD OF MORE THAN THIRTY MEGAWATTS; OR

(II) THAT IS COVERED BY AN INTERCONNECTION AGREEMENT THAT ALLOWS FOR A PEAK LOAD OF MORE THAN THIRTY MEGAWATTS;

(b) MULTIPLE DATA CENTERS THAT BEGIN OPERATION ON OR AFTER THE EFFECTIVE DATE OF THIS SECTION AND THAT:

(I) HAVE A COLLECTIVE PEAK LOAD OF MORE THAN SIXTY MEGAWATTS; OR

(II) ARE COVERED BY AN INTERCONNECTION AGREEMENT OR MULTIPLE INTERCONNECTION AGREEMENTS THAT ALLOW FOR A COLLECTIVE PEAK LOAD OF MORE THAN SIXTY MEGAWATTS;

(c) A DATA CENTER EXISTING BEFORE THE EFFECTIVE DATE OF THIS SECTION THAT, ON OR AFTER THE EFFECTIVE DATE OF THIS SECTION:

(I) ADDS A PEAK LOAD OF MORE THAN THIRTY MEGAWATTS; OR

(II) SIGNS A NEW INTERCONNECTION AGREEMENT THAT ALLOWS FOR ADDING A PEAK LOAD OF MORE THAN THIRTY MEGAWATTS; OR

(d) MULTIPLE DATA CENTERS EXISTING BEFORE THE EFFECTIVE DATE OF THIS SECTION THAT, ON OR AFTER THE EFFECTIVE DATE OF THIS SECTION:

(I) ADD A COLLECTIVE PEAK LOAD OF MORE THAN SIXTY MEGAWATTS AT MULTIPLE DATA CENTERS; OR

(II) SIGN A NEW INTERCONNECTION AGREEMENT THAT ALLOWS FOR ADDING A COLLECTIVE PEAK LOAD OF MORE THAN SIXTY MEGAWATTS AT MULTIPLE DATA CENTERS.

(7) "LARGE-LOAD DATA CENTER DEVELOPER" OR "DEVELOPER" MEANS A PERSON THAT IS RESPONSIBLE FOR THE INITIAL DEVELOPMENT OF A LARGE-LOAD DATA CENTER, INCLUDING THE PURCHASE OF LAND AND THE CONSTRUCTION OF INFRASTRUCTURE INTENDED FOR A LARGE-LOAD DATA CENTER.

(8) "LARGE-LOAD DATA CENTER OPERATOR" OR "OPERATOR" MEANS AN OWNER OR OPERATOR OF A LARGE-LOAD DATA CENTER.

(9) "LOCAL GOVERNMENT" MEANS A STATUTORY OR HOME RULE CITY, TOWN, COUNTY, OR CITY AND COUNTY.

(10) "MULTIPLE DATA CENTERS" MEANS ALL DATA CENTERS THAT ARE:

(a) LOCATED ON A SINGLE SITE OR ON CONTIGUOUS SITES; AND

(b) OWNED OR OPERATED BY THE SAME PERSON OR BY A PERSON THAT CONTROLS, IS CONTROLLED BY, OR IS UNDER COMMON CONTROL WITH THE OTHER PERSON.

(11) "OFFICE" MEANS THE COLORADO ENERGY OFFICE CREATED IN SECTION 24-38.5-101.

(12) "PEAK LOAD" MEANS THE PEAK POWER CONSUMPTION TO BE USED BY A LARGE-LOAD DATA CENTER, MEASURED IN MEGAWATTS.

(13) "POWER-USAGE EFFECTIVENESS" MEANS THE TOTAL ELECTRICITY CONSUMPTION OF A LARGE-LOAD DATA CENTER DIVIDED BY THE ELECTRICITY CONSUMPTION OF INFORMATION TECHNOLOGY EQUIPMENT, INCLUDING COMPUTING, STORAGE, AND NETWORKING EQUIPMENT, IN THE LARGE-LOAD DATA CENTER ON AN ANNUAL BASIS, EXPRESSED AS A NUMBER.

(14) "RENEWABLE ENERGY STORAGE" HAS THE MEANING SET FORTH IN SECTION 40-2-124 (1)(a)(VII.5).

(15) "RENEWABLE RESOURCE" HAS THE SAME MEANING AS "RENEWABLE ENERGY RESOURCES" AS DEFINED IN SECTION 40-2-124 (1)(a)(VII).

(16) "USE BY RIGHT" MEANS A LAND USE THAT PROCEEDS UNDER OBJECTIVE STANDARDS SET FORTH IN ZONING OR OTHER LOCAL GOVERNMENT LAWS AND THAT DOES NOT HAVE A DISCRETIONARY APPROVAL PROCESS.

(17) "WATER-USAGE EFFECTIVENESS" MEANS THE TOTAL WATER CONSUMPTION OF A LARGE-LOAD DATA CENTER, INCLUDING DIRECT AND INDIRECT WATER USAGE, DIVIDED BY THE ELECTRICITY CONSUMPTION OF INFORMATION TECHNOLOGY EQUIPMENT, INCLUDING COMPUTING, STORAGE, AND NETWORKING EQUIPMENT, IN THE LARGE-LOAD DATA CENTER ON AN ANNUAL BASIS, EXPRESSED AS LITERS PER KILOWATT-HOUR.

40-2.5-102. Hourly matching requirements - determination by commission.

(1) NO LATER THAN JUNE 30, 2030, THE COMMISSION SHALL, IN CONSULTATION WITH THE OFFICE AND THE AIR POLLUTION CONTROL DIVISION IN THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT AND

FOLLOWING A NONADJUDICATORY PROCEEDING WITH THE OPPORTUNITY FOR PUBLIC INPUT, MAKE A DETERMINATION ON WHETHER ONE-HUNDRED-PERCENT HOURLY MATCHING BY LARGE-LOAD DATA CENTERS IS TECHNICALLY AND ECONOMICALLY FEASIBLE.

(2) IF THE COMMISSION DETERMINES THAT ACHIEVING ONE-HUNDRED-PERCENT HOURLY MATCHING BY LARGE-LOAD DATA CENTERS IS NOT TECHNICALLY AND ECONOMICALLY FEASIBLE, THE COMMISSION, IN CONSULTATION WITH THE OFFICE AND THE AIR POLLUTION CONTROL DIVISION AND FOLLOWING A NONADJUDICATORY PROCEEDING WITH THE OPPORTUNITY FOR PUBLIC INPUT, SHALL MAKE A DETERMINATION OF THE HIGHEST PERCENTAGE OF HOURLY MATCHING BY LARGE-LOAD DATA CENTERS THAT IS TECHNICALLY AND ECONOMICALLY FEASIBLE.

(3) AFTER THE COMMISSION DETERMINES THE HIGHEST PERCENTAGE OF HOURLY MATCHING BY LARGE-LOAD DATA CENTERS THAT IS TECHNICALLY AND ECONOMICALLY FEASIBLE, THE COMMISSION, IN CONSULTATION WITH THE OFFICE AND THE AIR POLLUTION CONTROL DIVISION AND FOLLOWING A NONADJUDICATORY PROCEEDING WITH THE OPPORTUNITY FOR PUBLIC INPUT, SHALL UPDATE THIS PERCENTAGE ON A REGULAR BASIS BUT NO LESS FREQUENTLY THAN EVERY THREE YEARS AFTER THE DATE OF THE MOST RECENT DETERMINATION.

(4) IN MAKING A DETERMINATION UNDER THIS SECTION, THE COMMISSION MAY CONSIDER THE ROLE OF FLEXIBLE LOAD, ENERGY EFFICIENCY, DISTRIBUTED ENERGY RESOURCES, AND VIRTUAL POWER PLANTS IN REDUCING PEAK DEMAND AND IMPROVING UTILIZATION OF RENEWABLE RESOURCES.

40-2.5-103. Large-load data center requirements - utilization

of renewable resources - utility infrastructure and program contribution obligations - backup generation requirements.

(1) A LARGE-LOAD DATA CENTER OPERATOR SHALL, BEGINNING JANUARY 1, 2031:

(a) GENERATE, PURCHASE, OR OTHERWISE ACQUIRE A QUANTITY OF ELECTRICITY GENERATED FROM RENEWABLE RESOURCES NECESSARY TO MEET ONE HUNDRED PERCENT OF THE OPERATOR'S LARGE-LOAD DATA CENTER'S TOTAL ANNUAL ELECTRICITY CONSUMPTION FOR EACH YEAR THAT THE LARGE-LOAD DATA CENTER IS OPERATIONAL;

(b) GENERATE, PURCHASE, OR OTHERWISE ACQUIRE A QUANTITY OF ELECTRICITY AND ASSOCIATED RENEWABLE ENERGY CREDITS GENERATED FROM RENEWABLE RESOURCES FOR THE OPERATOR'S LARGE-LOAD DATA CENTER NECESSARY TO ACHIEVE AT LEAST THE HIGHEST PERCENTAGE OF HOURLY MATCHING THAT THE COMMISSION DETERMINES IS TECHNICALLY AND ECONOMICALLY FEASIBLE FOR LARGE-LOAD DATA CENTERS PURSUANT TO SECTION 40-2.5-102; AND

(c) ENSURE THAT THE OPERATOR'S LARGE-LOAD DATA CENTER COMPLIES WITH THE HOURLY MATCHING REQUIREMENT DETERMINED BY THE COMMISSION PURSUANT TO SECTION 40-2.5-102 IN EFFECT AT THE TIME THAT THE LARGE-LOAD DATA CENTER ENTERS INTO, RENEWS, OR MATERIALLY AMENDS A POWER PURCHASE AGREEMENT, RENEWABLE ENERGY CONTRACT, OR COMMISSION-APPROVED CLEAN ENERGY TARIFF USED FOR COMPLIANCE WITH THIS SECTION.

(2) (a) THE RENEWABLE RESOURCES DESCRIBED IN SUBSECTION (1) OF THIS SECTION MUST BE NEW AND INCREMENTAL RESOURCES DELIVERABLE TO THE ELECTRIC GRID SERVING THE LARGE-LOAD DATA CENTER OR DELIVERABLE DIRECTLY TO THE LARGE-LOAD DATA CENTER.

(b) ANY RENEWABLE ENERGY CREDITS ASSOCIATED WITH THE ELECTRICITY GENERATED FROM RENEWABLE RESOURCES USED TO MEET THE REQUIREMENTS DESCRIBED IN SUBSECTION (1) OF THIS SECTION MUST BE RETIRED BY THE LARGE-LOAD DATA CENTER OPERATOR OR ON BEHALF OF THE LARGE-LOAD DATA CENTER OPERATOR IN THE YEAR THAT THE ELECTRICITY IS GENERATED.

(3) A LARGE-LOAD DATA CENTER OPERATOR SHALL IMPLEMENT ITS COMPLIANCE WITH THE REQUIREMENTS DESCRIBED IN SUBSECTION (1) OF THIS SECTION THROUGH ONE OF THE FOLLOWING OR A COMBINATION OF THE FOLLOWING METHODS, WHICH MUST COVER ALL OF THE OPERATOR'S LARGE-LOAD DATA CENTER'S ELECTRICITY DEMANDS:

(a) A TARIFF, CONTRACT, OR PROGRAM ENTERED INTO WITH THE UTILITY SUPPLYING THE LARGE-LOAD DATA CENTER WITH ELECTRICITY;

(b) ONE OR MORE POWER PURCHASE AGREEMENTS ENTERED INTO WITH AN INDEPENDENT POWER PRODUCER SUPPLYING THE LARGE-LOAD DATA CENTER WITH ELECTRICITY; OR

(c) SELF-SUPPLY OF ELECTRICITY, INCLUDING BEHIND-THE-METER GENERATION OF RENEWABLE RESOURCES, OR RENEWABLE ENERGY STORAGE USED TO SERVE THE LARGE-LOAD DATA CENTER'S ELECTRICITY DEMANDS.

(4) THROUGH CONTRACTS WITH UTILITIES OF AT LEAST FIFTEEN YEARS, IF USING UTILITY POWER SUPPLY, A LARGE-LOAD DATA CENTER OPERATOR SHALL PAY FOR THE FOLLOWING:

(a) ALL OF THE COSTS ASSOCIATED WITH A UTILITY CONSTRUCTING OR PROCURING GENERATION, TRANSMISSION, AND DISTRIBUTION INFRASTRUCTURE NECESSARY TO SUPPLY THE OPERATOR'S LARGE-LOAD DATA CENTER WITH ELECTRICITY;

(b) THE OPERATOR'S SHARE OF EXISTING GENERATION, TRANSMISSION, DISTRIBUTION, AND OTHER RESOURCES NEEDED TO SERVE THE OPERATOR'S LARGE-LOAD DATA CENTER AND OTHER ENERGY SUPPLY AND OPERATIONS INFRASTRUCTURE AND EQUIPMENT REQUIRED TO MAINTAIN GRID RELIABILITY AND OPERATIONAL PERFORMANCE FOR OTHER CUSTOMERS; AND

(c) ALL OF THE COSTS OF RENEWABLE RESOURCE ELECTRICITY CURTAILMENTS AND RESERVE REQUIREMENTS ASSOCIATED WITH THE OPERATOR'S RENEWABLE RESOURCE ELECTRICITY PURCHASES AND OF INFRASTRUCTURE AND INVESTMENTS REQUIRED TO MAINTAIN GRID SERVICE, STABILITY, AND RELIABILITY DUE TO STRESS ON THE ELECTRICAL SYSTEM CAUSED BY THE OPERATOR'S LARGE-LOAD DATA CENTER.

(5) (a) A LARGE-LOAD DATA CENTER OPERATOR SHALL CONTRIBUTE TO UTILITY DEMAND-SIDE MANAGEMENT PROGRAMS. THE AMOUNT OF MONEY THAT THE OPERATOR IS REQUIRED TO CONTRIBUTE MUST BE BASED ON THE LARGE-LOAD DATA CENTER'S TOTAL ANNUAL ELECTRICITY CONSUMPTION AND THE COST-RECOVERY MECHANISMS THAT FUND THE DEMAND-SIDE MANAGEMENT PROGRAMS.

(b) SUBSECTION (5)(a) OF THIS SECTION APPLIES TO A LARGE-LOAD DATA CENTER OPERATOR REGARDLESS OF WHETHER THE ELECTRICITY IS SUPPLIED BY A UTILITY OR ANOTHER SOURCE AS LONG AS THE LARGE-LOAD DATA CENTER IS CONNECTED TO THE UTILITY'S SYSTEM.

(6) A LARGE-LOAD DATA CENTER OPERATOR SHALL OPTIMIZE OPERATIONAL WATER MANAGEMENT THROUGH THE IMPLEMENTATION OF WATER-EFFICIENT TECHNOLOGY, AS DETERMINED BY A LOCAL GOVERNMENT WITH JURISDICTION OVER THE LARGE-LOAD DATA CENTER.

(7) (a) (I) ON-SITE BACKUP POWER SERVING A LARGE-LOAD DATA

CENTER MUST MAXIMIZE RELIANCE ON RENEWABLE RESOURCES AND RENEWABLE ENERGY STORAGE, TO THE EXTENT TECHNICALLY AND ECONOMICALLY FEASIBLE.

(II) A LARGE-LOAD DATA CENTER OPERATOR MAY RELY ON ON-SITE, COMBUSTION-BASED BACKUP GENERATION ONLY AFTER EVALUATING AND DEPLOYING NONCOMBUSTION BACKUP ALTERNATIVES TO THE MAXIMUM EXTENT PRACTICABLE.

(b) IF A LARGE-LOAD DATA CENTER USES ONE OR MORE ON-SITE COMBUSTION GENERATORS FOR BACKUP GENERATION, THE GENERATOR MUST:

(I) BE LIMITED TO USE IN AN EMERGENCY AND FOR REQUIRED TESTING AND MAINTENANCE. THE TOTAL AMOUNT OF USE FOR REQUIRED TESTING AND MAINTENANCE MUST BE FOR NO MORE THAN FIFTY HOURS PER YEAR.

(II) NOT BE USED FOR ROUTINE PEAK SHAVING, ECONOMIC DISPATCH, CAPACITY OR ANCILLARY SERVICE MARKETS, OR ANY NONEMERGENCY GRID SUPPORT; AND

(III) USE NONRESETTABLE METERS TO TRACK OPERATING HOURS.

(c) IF A LARGE-LOAD DATA CENTER USES ONE OR MORE ON-SITE COMBUSTION GENERATORS POWERED BY FUEL OIL FOR BACKUP GENERATION, THE GENERATOR MUST:

(I) MEET OR EXCEED THE UNITED STATES ENVIRONMENTAL PROTECTION AGENCY'S TIER 4 FINAL EMISSIONS STANDARDS FOR STATIONARY COMPRESSION-IGNITION ENGINES IN EFFECT ON THE EFFECTIVE DATE OF THIS SECTION;

(II) UTILIZE ULTRA-LOW SULFUR DIESEL; AND

(III) BE EQUIPPED WITH THE BEST AVAILABLE EMISSIONS CONTROL

TECHNOLOGIES TO ACHIEVE THE UNITED STATES ENVIRONMENTAL PROTECTION AGENCY'S TIER 4 FINAL EMISSIONS STANDARDS FOR STATIONARY COMPRESSION-IGNITION ENGINES IN EFFECT ON THE EFFECTIVE DATE OF THIS SECTION, INCLUDING DIESEL PARTICULATE FILTERS AND SELECTIVE CATALYTIC REDUCTION CONTROLS, WHICH MUST BE PROPERLY OPERATED AND MAINTAINED.

(d) IF A LARGE-LOAD DATA CENTER USES ONE OR MORE ON-SITE, GAS-POWERED COMBUSTION GENERATORS FOR BACKUP GENERATION:

(I) ANY STATIONARY SPARK-IGNITION ENGINES MUST MEET OR EXCEED THE UNITED STATES ENVIRONMENTAL PROTECTION AGENCY'S EMISSIONS STANDARDS FOR STATIONARY SPARK-IGNITION ENGINES IN EFFECT ON THE EFFECTIVE DATE OF THIS SECTION;

(II) ANY STATIONARY COMBUSTION TURBINES MUST MEET OR EXCEED THE UNITED STATES ENVIRONMENTAL PROTECTION AGENCY'S EMISSIONS STANDARDS FOR STATIONARY COMBUSTION TURBINES IN EFFECT ON THE EFFECTIVE DATE OF THIS SECTION; AND

(III) THE GENERATORS MUST EMPLOY THE BEST AVAILABLE METHANE LEAK DETECTION AND REPAIR PRACTICES AND PROHIBIT ROUTINE VENTING OR BYPASSING OF EMISSIONS CONTROLS.

40-2.5-104. Reporting to the department of public health and environment.

(1) NO LATER THAN JUNE 30, 2028, AND NO LATER THAN EACH JUNE 30 THEREAFTER, A LARGE-LOAD DATA CENTER OPERATOR SHALL REPORT TO THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT THE FOLLOWING INFORMATION FOR THE PREVIOUS CALENDAR YEAR FOR THE OPERATOR'S LARGE-LOAD DATA CENTER:

(a) TOTAL ANNUAL ELECTRICITY CONSUMPTION;

(b) PEAK LOAD;

(c) TOTAL ANNUAL ELECTRICITY SUPPLY SERVING THE LARGE-LOAD DATA CENTER, DISAGGREGATED BY:

(I) ELECTRICITY PURCHASED FROM OFF-SITE RENEWABLE RESOURCES, BY SOURCE;

(II) ELECTRICITY PURCHASED FROM OFF-SITE NONRENEWABLE RESOURCES, BY SOURCE;

(III) ELECTRICITY GENERATED ON SITE FROM RENEWABLE RESOURCES;

(IV) ELECTRICITY DISCHARGED ON SITE FROM RENEWABLE ENERGY STORAGE; AND

(V) ELECTRICITY GENERATED ON SITE FROM NONRENEWABLE RESOURCES, INCLUDING COMBUSTION-BASED BACKUP GENERATION;

(d) HOURLY CONSUMPTION OF ELECTRICITY PROVIDED FOR EIGHT THOUSAND SEVEN HUNDRED SIXTY HOURS;

(e) HOURLY ELECTRICITY SUPPLY FROM RENEWABLE RESOURCES FOR EIGHT THOUSAND SEVEN HUNDRED SIXTY HOURS;

(f) TOTAL INSTALLED CAPACITY OF:

(I) ON-SITE RENEWABLE RESOURCES, BY FUEL TYPE AND IN MEGAWATTS;

(II) ON-SITE RENEWABLE ENERGY STORAGE CAPACITY, IN MEGAWATTS AND IN MEGAWATT-HOURS; AND

(III) ON-SITE BACKUP GENERATION, BY FUEL TYPE AND IN MEGAWATTS;

(g) TOTAL ANNUAL HOURS OF OPERATION FOR EACH ON-SITE BACKUP GENERATOR, DISAGGREGATED BY FUEL TYPE AND BY USE CATEGORY, INCLUDING FOR EMERGENCY USE AND USE IN TESTING OR

MAINTENANCE;

(h) TOTAL ANNUAL DISCHARGE FROM RENEWABLE ENERGY STORAGE;

(i) POWER-USAGE EFFECTIVENESS;

(j) TOTAL ANNUAL WATER CONSUMPTION, INCLUDING PEAK WATER DEMAND PER DAY, TYPES OF COOLING TECHNOLOGIES EMPLOYED, AND EFFORTS TO IMPROVE ON-SITE WATER EFFICIENCY AND REUSE;

(k) TOTAL WATER INPUT IN CUBIC METERS THAT INCLUDES ALL WATER VOLUMES THAT ENTER THE LARGE-LOAD DATA CENTER THAT ARE USED FOR THE FUNCTIONS OF THE LARGE-LOAD DATA CENTER;

(l) THE SOURCES OF WATER FOR THE LARGE-LOAD DATA CENTER, INCLUDING MUNICIPAL WATER SUPPLY, GROUNDWATER, AND SURFACE WATER, AND WHETHER WATER FROM THE SOURCES IS POTABLE OR RECLAIMED. IF THE LARGE-LOAD DATA CENTER UTILIZES MORE THAN ONE WATER SOURCE, THE OPERATOR SHALL PROVIDE INFORMATION REGARDING WATER USAGE FROM EACH SOURCE AS A PERCENTAGE OF TOTAL WATER USAGE.

(m) WATER-USAGE EFFECTIVENESS; AND

(n) THE TOTAL AMOUNT OF INCENTIVES OR SUBSIDIES RECEIVED BY THE LARGE-LOAD DATA CENTER OPERATOR FROM LOCAL GOVERNMENTS, ECONOMIC DEVELOPMENT ORGANIZATIONS, OR OTHER ENTITIES FOR THE DEVELOPMENT OF THE LARGE-LOAD DATA CENTER.

(2) NOTWITHSTANDING SECTION 24-1-136 (11)(a)(I), THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT SHALL COMPILE THE INFORMATION REPORTED TO THE DEPARTMENT PURSUANT TO SUBSECTION (1) OF THIS SECTION AND PROVIDE AN ANNUAL REPORT TO THE GENERAL ASSEMBLY AND THE COMMISSION AND MAKE THE ANNUAL REPORT

PUBLICLY AVAILABLE ON THE DEPARTMENT'S WEBSITE.

40-2.5-105. Utility requirements - definition.

(1) AS USED IN THIS SECTION, UNLESS THE CONTEXT OTHERWISE REQUIRES, "UTILITY" INCLUDES:

(a) A COOPERATIVE ELECTRIC ASSOCIATION, AS DEFINED IN SECTION 40-9.5-102 (1);

(b) A MUNICIPAL ELECTRIC UTILITY; AND

(c) A WHOLESALE ELECTRIC COOPERATIVE, AS DEFINED IN SECTION 40-2-134 (2).

(2) (a) A UTILITY SHALL NOT INTERCONNECT OR SUPPLY ELECTRICITY TO A LARGE-LOAD DATA CENTER UNLESS THE LARGE-LOAD DATA CENTER OPERATOR HAS EITHER FIRST PROVIDED AN UP-FRONT PAYMENT OR ENTERED INTO A CONTRACT OF AT LEAST FIFTEEN YEARS WITH THE UTILITY, WHICH UP-FRONT PAYMENT OR CONTRACT MUST REQUIRE THE OPERATOR TO PAY FOR THE FOLLOWING:

(I) ALL OF THE COSTS ASSOCIATED WITH THE UTILITY CONSTRUCTING OR PROCURING GENERATION, TRANSMISSION, AND DISTRIBUTION INFRASTRUCTURE NECESSARY TO SUPPLY THE OPERATOR'S LARGE-LOAD DATA CENTER WITH ELECTRICITY;

(II) THE OPERATOR'S SHARE OF EXISTING GENERATION, TRANSMISSION, DISTRIBUTION, AND OTHER RESOURCES NEEDED TO SERVE THE OPERATOR'S LARGE-LOAD DATA CENTER AND OTHER ENERGY SUPPLY AND OPERATIONS INFRASTRUCTURE AND EQUIPMENT REQUIRED TO MAINTAIN GRID RELIABILITY AND OPERATIONAL PERFORMANCE FOR THE UTILITY'S OTHER CUSTOMERS; AND

(III) ALL OF THE COSTS OF RENEWABLE RESOURCE ELECTRICITY CURTAILMENTS AND RESERVE REQUIREMENTS ASSOCIATED WITH THE

OPERATOR'S RENEWABLE RESOURCE ELECTRICITY PURCHASES AND THE COSTS OF INFRASTRUCTURE AND INVESTMENTS REQUIRED TO MAINTAIN GRID SERVICE, STABILITY, AND RELIABILITY DUE TO STRESS ON THE ELECTRICAL SYSTEM CAUSED BY THE OPERATOR'S LARGE-LOAD DATA CENTER.

(b) IN ESTABLISHING COST ALLOCATION IN ELECTRICITY RATES, A UTILITY SHALL ACCOUNT FOR COST CAUSATION FOR LARGE-LOAD DATA CENTERS ACROSS ALL HOURS OF THE YEAR.

(c) A UTILITY MAY REQUIRE A LARGE-LOAD DATA CENTER IN THE UTILITY'S SERVICE TERRITORY WITH A SELF-SUPPLY OF ELECTRICITY TO ENTER INTO A CONTRACT OR PROVIDE UP-FRONT PAYMENTS FOR THE COSTS THAT THE LARGE-LOAD DATA CENTER IMPOSES ON THE UTILITY TO PROVIDE BACKUP POWER.

(3) A UTILITY SHALL NOT INTERCONNECT OR SUPPLY ELECTRICITY TO A LARGE-LOAD DATA CENTER ON OR AFTER JANUARY 1, 2031, UNLESS IT HAS VERIFIED THAT THE LARGE-LOAD DATA CENTER OPERATOR IS IN COMPLIANCE WITH THE HOURLY MATCHING REQUIREMENT DETERMINED BY THE COMMISSION PURSUANT TO SECTION 40-2.5-102.

(4) A UTILITY SHALL NOT OFFER ECONOMIC DEVELOPMENT RATES PURSUANT TO SECTION 40-3-104.3 TO LARGE-LOAD DATA CENTERS.

(5) (a) A UTILITY SHALL DEVELOP AND OFFER AT LEAST ONE OF THE FOLLOWING TO THE UTILITY'S CUSTOMERS THAT ARE LARGE-LOAD DATA CENTER OPERATORS:

(I) ONE OR MORE DEMAND RESPONSE PROGRAMS, WHICH PROGRAMS MUST NOT ALLOW THE USE OF DIESEL GENERATORS, THAT ENCOURAGE LARGE-LOAD DATA CENTER OPERATORS TO SIGNIFICANTLY REDUCE THE POWER DEMAND OF THE OPERATOR'S LARGE-LOAD DATA

CENTER DURING PEAK PERIODS THROUGH LOAD-SHIFTING, BATTERY STORAGE, UNINTERRUPTIBLE POWER SUPPLY, OR ON-SITE OR ZERO-EMISSIONS BACKUP GENERATION; OR

(II) FLEXIBLE CONNECTION TARIFFS OR OTHER TARIFFS THAT ENCOURAGE OR REQUIRE LARGE-LOAD DATA CENTER OPERATORS TO SIGNIFICANTLY REDUCE THE POWER DEMAND OF THE OPERATOR'S LARGE-LOAD DATA CENTER DURING PEAK PERIODS.

(b) A UTILITY MAY:

(I) PROVIDE EXPEDITED INTERCONNECTION TO A LARGE-LOAD DATA CENTER OPERATOR THAT COMMITS TO FLEXIBLE INTERCONNECTION OR COMMITS TO ACHIEVING AT LEAST EIGHTY-PERCENT HOURLY MATCHING OF RENEWABLE RESOURCES WITH THE LARGE-LOAD DATA CENTER'S ELECTRICITY CONSUMPTION BY 2030; AND

(II) REQUIRE FLEXIBLE INTERCONNECTION AS A CONDITION FOR INTERCONNECTION OF A LARGE-LOAD DATA CENTER.

(c) AN INTERCONNECTION AGREEMENT BETWEEN A UTILITY AND A LARGE-LOAD DATA CENTER OPERATOR MUST INCLUDE A REQUIREMENT FOR AN UP-FRONT PAYMENT OR SECURITY BY THE LARGE-LOAD DATA CENTER OPERATOR AND SIGNIFICANT MONTHLY DEMAND CHARGES, UNLESS THE OPERATOR PARTICIPATES IN A FLEXIBLE INTERCONNECTION TARIFF OR PROGRAM THAT PROVIDES SYSTEM BENEFITS FOR WHICH CORRESPONDING CHARGES MAY BE REDUCED WITHOUT CREATING CROSS-SUBSIDIZATION BY OTHER CUSTOMER CLASSES.

(6) (a) A UTILITY SHALL NOT INTERCONNECT OR SUPPLY ELECTRICITY TO A LARGE-LOAD DATA CENTER UNLESS THE UTILITY HAS DETERMINED AND ENSURES THAT THE ADDITION OF THE LARGE-LOAD DATA CENTER TO THE UTILITY'S SYSTEM:

(I) DOES NOT NEGATIVELY AFFECT THE UTILITY'S ABILITY TO PROVIDE RELIABLE ELECTRIC SERVICE TO EXISTING CUSTOMERS;

(II) DOES NOT NEGATIVELY AFFECT THE UTILITY'S ABILITY TO COMPLY WITH SECTION 25-7-105 OR THE RULES ADOPTED PURSUANT TO SECTION 25-7-105 OR THE UTILITY'S ACHIEVEMENT OF THE CLEAN ENERGY TARGETS DESCRIBED IN SECTION 40-2-125.5 (3), IF APPLICABLE, OR OTHER APPLICABLE CLEAN ENERGY AND EMISSIONS TARGETS, INCLUDING ECONOMY-WIDE TARGETS; AND

(III) DOES NOT INCREASE THE UTILITY'S GREENHOUSE GAS EMISSIONS FOR THE FIFTEEN YEARS AFTER THE ADDITION OF THE LARGE-LOAD DATA CENTER, COMPARED TO PROJECTED GREENHOUSE GAS EMISSIONS BY THE UTILITY WITHOUT THE ADDITION OF THE LARGE-LOAD DATA CENTER.

(b) ANY COSTS INCURRED BY A UTILITY IN MAKING THE DETERMINATION DESCRIBED IN SUBSECTION (6)(a) OF THIS SECTION MUST BE BORNE BY THE LARGE-LOAD DATA CENTER SEEKING INTERCONNECTION.

(7) (a) A UTILITY SHALL SOLICIT AND ACCEPT, IF OFFERED BY A LARGE-LOAD DATA CENTER OPERATOR, VOLUNTARY FINANCIAL CONTRIBUTIONS TO THE UTILITY'S INCOME-QUALIFIED ENERGY EFFICIENCY, ELECTRIFICATION, DEMAND RESPONSE, DISTRIBUTED ENERGY RESOURCES, OR VIRTUAL POWER PLANT PROGRAMS.

(b) IF A LARGE-LOAD DATA CENTER OPERATOR PROVIDES A VOLUNTARY FINANCIAL CONTRIBUTION, THE VOLUNTARY FINANCIAL CONTRIBUTION MUST SUPPLEMENT, RATHER THAN SUBSTITUTE, THE UTILITY'S FUNDING OF THE PROGRAMS DESCRIBED IN SUBSECTION (7)(a) OF THIS SECTION. A VOLUNTARY FINANCIAL CONTRIBUTION BY A LARGE-LOAD DATA CENTER OPERATOR IS NOT SUBJECT TO COST-EFFECTIVENESS

TESTING AND SHALL NOT BE COUNTED AS PART OF UTILITY EXPENDITURES RELATIVE TO ANY BUDGET CAPS FOR THE PROGRAMS DESCRIBED IN SUBSECTION (7)(a) OF THIS SECTION.

(c) A UTILITY THAT RECEIVES A VOLUNTARY FINANCIAL CONTRIBUTION FROM ONE OR MORE LARGE-LOAD DATA CENTER OPERATORS SHALL INCLUDE INFORMATION ABOUT THE VOLUNTARY FINANCIAL CONTRIBUTION, INCLUDING THE AMOUNT RECEIVED, HOW THE MONEY WAS USED, AND ANY DEMONSTRATED CUSTOMER OR GRID BENEFITS, IN THE UTILITY'S ANNUAL ENERGY EFFICIENCY AND ELECTRIFICATION REPORTS.

(8) (a) A UTILITY RATE-REGULATED BY THE COMMISSION WITH ONE OR MORE CUSTOMERS THAT ARE LARGE-LOAD DATA CENTER OPERATORS SHALL DESCRIBE THE UTILITY'S EFFORTS TO COMPLY WITH THIS SECTION IN THE UTILITY'S ANNUAL REPORT FILED WITH THE COMMISSION.

(b) A UTILITY RATE-REGULATED BY THE COMMISSION WITH ONE OR MORE CUSTOMERS THAT ARE LARGE-LOAD DATA CENTER OPERATORS SHALL PROVIDE MONTHLY REPORTING TO THE COMMISSION ON THE FOLLOWING:

(I) NUMBER AND CAPACITY OF NEW LARGE-LOAD DATA CENTER INTERCONNECTION REQUESTS;

(II) NUMBER AND CAPACITY OF NEW LARGE-LOAD DATA CENTER INTERCONNECTION REQUESTS REJECTED BY THE UTILITY OR WITHDRAWN;

(III) TOTAL CAPACITY OF NEW LARGE-LOAD DATA CENTER INTERCONNECTION REQUESTS IN QUEUE WITH A SIGNED INTERCONNECTION AGREEMENT; AND

(IV) NUMBER AND CAPACITY OF NEW LARGE-LOAD DATA CENTER CUSTOMER INTERCONNECTIONS COMPLETED AND IN OPERATION.

(9) NOTHING IN THIS SECTION PROHIBITS THE COMMISSION FROM ADOPTING A TARIFF FOR LARGE-LOAD DATA CENTER OPERATORS, OR A SUBSET OF LARGE-LOAD DATA CENTER OPERATORS, THAT INCLUDES MORE STRINGENT REQUIREMENTS THAN THIS SECTION.

40-2.5-106. Model local codes by the department of local affairs - site assessments.

(1) (a) ON OR BEFORE JUNE 30, 2027, THE DEPARTMENT OF LOCAL AFFAIRS SHALL PUBLISH MODEL CODES FOR THE DEVELOPMENT OF LARGE-LOAD DATA CENTERS. THE MODEL CODES MUST CONSIDER, AT A MINIMUM, BEST PRACTICES FOR THE FOLLOWING:

(I) UPDATING LOCAL ZONING LAWS TO RESPOND TO THE PROLIFERATION OF LARGE-LOAD DATA CENTERS;

(II) AVOIDING AND MITIGATING POTENTIAL NEW IMPACTS TO RESIDENTS FROM NOISE, LIGHT, AIR, ELECTROMAGNETIC FIELDS, AND OTHER SOURCES OF POLLUTION, INCLUDING FROM ON-SITE BACKUP GENERATION;

(III) UPDATING PUBLIC ENGAGEMENT PROCESSES RELATED TO LARGE-LOAD DATA CENTER DEVELOPMENT;

(IV) ESTABLISHING WATER AND LAND USE POLICY MECHANISMS AND DEVELOPMENT REVIEW PROCESSES TO ALIGN LARGE WATER USER DEVELOPMENT WITH SUSTAINABLE WATER MANAGEMENT, INCLUDING WATER-RELATED SITING CONSIDERATIONS, THE USE OF NONPOTABLE SUPPLIES AND ON-SITE WATER REUSE, AND WATER EFFICIENCY TOOLS AND TECHNOLOGY. THE POLICY MECHANISMS AND DEVELOPMENT REVIEW PROCESSES MAY INCLUDE:

(A) ESTABLISHING ADDITIONAL REQUIREMENTS FOR LARGE WATER USERS;

(B) IMPLEMENTING WATER DEMAND OFFSET OR NET NEUTRAL GROWTH POLICIES;

(C) ADOPTING WATER ALLOCATION POLICIES WITH QUANTIFIED WATER RESOURCES FOR WATER INTENSIVE INDUSTRIAL GROWTH;

(D) REQUIRING CONSERVATION PLANS WITH IDENTIFIED EFFICIENCY AND REUSE BEST PRACTICES IN WATER SERVICE APPLICATIONS; OR

(E) DEVELOPING REPORTING GUIDANCE AND TEMPLATES FOR WATER AND WASTE USE STREAMS;

(V) REQUIRING A LARGE-LOAD DATA CENTER DEVELOPER TO PROVE TO A LOCAL GOVERNMENT IN ITS DEVELOPMENT PERMIT APPLICATION HOW THE LARGE-LOAD DATA CENTER PROJECT WILL FIT WITHIN LOCAL GOVERNMENT STRATEGIC PLANNING AND LAWS WITH CLEAR AND TRANSPARENT TIMELINES, PLANS, AND ACCOUNTABILITY MEASURES;

(VI) CREATING AND IMPLEMENTING COMMUNITY BENEFIT AGREEMENTS, INCLUDING RECOMMENDATIONS FOR PUBLIC ENGAGEMENT; AND

(VII) IMPLEMENTING REPORTING REQUIREMENTS TO LOCAL GOVERNMENTS AND IMPACTED COMMUNITIES RELATED TO ON-SITE FOSSIL FUEL GENERATION.

(b) THE DEPARTMENT OF LOCAL AFFAIRS SHALL CONDUCT A ROBUST STAKEHOLDER AND ENGAGEMENT PROCESS IN DEVELOPING THE MODEL CODES DESCRIBED IN SUBSECTION (1)(a) OF THIS SECTION, INCLUDING ENGAGEMENT WITH:

(I) STATE AGENCIES, INCLUDING THE AIR POLLUTION CONTROL DIVISION AND THE WATER QUALITY CONTROL DIVISION IN THE

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT, THE COMMISSION, THE OFFICE, AND THE DEPARTMENT OF NATURAL RESOURCES;

(II) COLORADO CONSUMER PROTECTION ORGANIZATIONS;

(III) STATEWIDE LABOR AND TRADE ASSOCIATIONS;

(IV) STATEWIDE ENERGY AND CLIMATE ORGANIZATIONS;

(V) COLORADO AGRICULTURAL INTERESTS;

(VI) DISPROPORTIONATELY IMPACTED COMMUNITIES;

(VII) LARGE-LOAD DATA CENTER DEVELOPERS;

(VIII) LARGE-LOAD DATA CENTER OPERATORS;

(IX) TRIBAL GOVERNMENTS;

(X) MUNICIPAL WATER UTILITIES; AND

(XI) MUNICIPAL ELECTRIC UTILITIES AND COOPERATIVE ELECTRIC ASSOCIATIONS.

(c) THE DEPARTMENT OF LOCAL AFFAIRS SHALL EVALUATE, UPDATE, AND REVIEW THE MODEL CODES DESCRIBED IN SUBSECTION (1)(a) OF THIS SECTION EVERY FIVE YEARS AFTER THE DATE OF THE PUBLISHING OF THE MODEL CODES.

(2) WITH ITS DEVELOPMENT PERMIT APPLICATION FOR A LARGE-LOAD DATA CENTER, A LARGE-LOAD DATA CENTER DEVELOPER SHALL SUBMIT A SITE ASSESSMENT TO THE LOCAL GOVERNMENT REVIEWING THE DEVELOPMENT PERMIT APPLICATION. A SITE ASSESSMENT MUST INCLUDE DESCRIPTIONS OF:

(a) ANTICIPATED TOTAL WATER FOOTPRINT, INCLUDING DIRECT AND INDIRECT WATER USAGE AND TOTAL WATER INPUT IN CUBIC METERS;

(b) PLANNED WATER SOURCES, INCLUDING INFORMATION REGARDING WATER USAGE FROM EACH SOURCE AS A PERCENTAGE OF TOTAL WATER USAGE;

(c) ANTICIPATED ON-SITE AIR EMISSIONS, INCLUDING EMISSIONS OF GREENHOUSE GASES; TOXIC AIR CONTAMINANTS, AS DEFINED IN SECTION 25-7-109.5 (1)(i); AND CRITERIA POLLUTANTS, AS DEFINED IN SECTION 43-1-128 (2)(b);

(d) ANY POTENTIAL IMPACTS ON AGRICULTURAL, HISTORIC, AND CULTURAL RESOURCES WITHIN THE LOCAL GOVERNMENT'S JURISDICTION;

(e) EFFORTS TO LOCATE BACKUP GENERATION AND OTHER SOURCES OF AIR, NOISE, AND LIGHT POLLUTION AS FAR AS REASONABLY POSSIBLE FROM RESIDENCES, SCHOOLS, AND HEALTH CLINICS; AND

(f) A DESCRIPTION OF INITIAL AND ONGOING OPPORTUNITIES FOR PUBLIC ENGAGEMENT.

(3) NOTHING IN THIS SECTION ESTABLISHES, ALTERS, IMPAIRS, OR NEGATES THE ABILITY OF A LOCAL GOVERNMENT TO REGULATE LAND USE RELATED TO LARGE-LOAD DATA CENTERS; EXCEPT THAT A LOCAL GOVERNMENT SHALL NOT ALLOW LARGE-LOAD DATA CENTERS TO BE ZONED AS A USE BY RIGHT.

40-2.5-107. Disproportionately impacted communities - cumulative impacts analysis - review of development permit application by local governments - community engagement - community benefit agreements.

(1) (a) IF THE SITING OF A LARGE-LOAD DATA CENTER IS PROPOSED IN A DISPROPORTIONATELY IMPACTED COMMUNITY OR IF AN OPERATOR OF A DATA CENTER IN A DISPROPORTIONATELY IMPACTED COMMUNITY THAT EXISTS BEFORE THE EFFECTIVE DATE OF THIS SECTION PLANS TO EXPAND THE DATA CENTER'S PEAK LOAD SUCH THAT THE DATA CENTER WILL BECOME A LARGE-LOAD DATA CENTER, THE LARGE-LOAD DATA CENTER DEVELOPER OR LARGE-LOAD DATA CENTER OPERATOR, AS APPLICABLE,

SHALL UNDERGO A CUMULATIVE IMPACTS ANALYSIS BEFORE THE DEVELOPMENT OR EXPANSION BEGINS.

(b) IN CONDUCTING THE CUMULATIVE IMPACTS ANALYSIS DESCRIBED IN SUBSECTION (1)(a) OF THIS SECTION, A DEVELOPER OR OPERATOR SHALL CONTRACT WITH A THIRD-PARTY CONTRACTOR SELECTED BY THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT TO PERFORM THE CUMULATIVE IMPACTS ANALYSIS IN A SCIENTIFICALLY RIGOROUS MANNER. THE COSTS OF THE THIRD-PARTY CONTRACTOR MUST BE BORNE ENTIRELY BY THE DEVELOPER OR OPERATOR.

(2) IN REVIEWING, APPROVING, DENYING, OR AMENDING A DEVELOPMENT PERMIT APPLICATION FOR A LARGE-LOAD DATA CENTER THAT IS IN A DISPROPORTIONATELY IMPACTED COMMUNITY OR IS PROPOSED TO BE IN A DISPROPORTIONATELY IMPACTED COMMUNITY, INCLUDING A DEVELOPMENT PERMIT MODIFICATION THAT WOULD CAUSE A DATA CENTER IN A DISPROPORTIONATELY IMPACTED COMMUNITY TO BECOME A LARGE-LOAD DATA CENTER, THE APPLICABLE LOCAL GOVERNMENT SHALL CONSIDER THE APPLICANT'S CUMULATIVE IMPACTS ANALYSIS. IF THE LOCAL GOVERNMENT FINDS THAT THE LARGE-LOAD DATA CENTER PROPOSED BY THE APPLICATION WILL HAVE NET NEGATIVE CUMULATIVE IMPACTS ON A DISPROPORTIONATELY IMPACTED COMMUNITY, THE LOCAL GOVERNMENT SHALL CONSIDER IF MITIGATION STRATEGIES DESCRIBED BY THE APPLICANT ARE SUFFICIENT TO AVOID THE NEGATIVE IMPACTS IDENTIFIED IN THE CUMULATIVE IMPACTS ANALYSIS. THE LOCAL GOVERNMENT MAY CONSULT WITH THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT REGARDING THE RESULTS OF THE CUMULATIVE IMPACTS ANALYSIS AND PROPOSED MITIGATION STRATEGIES. IN REVIEWING, APPROVING, DENYING, OR AMENDING AN APPLICATION, THE

LOCAL GOVERNMENT SHALL INCLUDE A PLAIN LANGUAGE SUMMARY OF ITS DETERMINATION.

(3) (a) PRIOR TO APPLYING FOR A DEVELOPMENT PERMIT FOR A LARGE-LOAD DATA CENTER THAT IS IN A DISPROPORTIONATELY IMPACTED COMMUNITY OR IS PROPOSED TO BE IN A DISPROPORTIONATELY IMPACTED COMMUNITY, INCLUDING A DEVELOPMENT PERMIT MODIFICATION THAT WOULD CAUSE A DATA CENTER IN A DISPROPORTIONATELY IMPACTED COMMUNITY TO BECOME A LARGE-LOAD DATA CENTER, THE LARGE-LOAD DATA CENTER DEVELOPER OR LARGE-LOAD DATA CENTER OPERATOR, AS APPLICABLE, SHALL:

(I) HOST A MINIMUM OF THREE PUBLIC HEARINGS OR COMMENT PERIODS AT LEAST SIXTY DAYS PRIOR TO SUBMITTING THE DEVELOPMENT PERMIT APPLICATION. AT LEAST ONE OF THE PUBLIC HEARINGS OR COMMENT PERIODS MUST BE HELD WITHIN THE DISPROPORTIONATELY IMPACTED COMMUNITY WHERE THE DEVELOPER OR OPERATOR PLANS TO OPERATE THE LARGE-LOAD DATA CENTER OR IS CURRENTLY OPERATING THE DATA CENTER.

(II) SCHEDULE VARIABLE TIMES OF DAY AND DAYS OF THE WEEK FOR OPPORTUNITIES FOR PUBLIC INPUT ON THE PROJECT, INCLUDING AT LEAST ONE TIME ON SATURDAY OR SUNDAY, ONE TIME AFTER 5 P.M., AND ONE TIME BEFORE 12 NOON;

(III) PROVIDE PUBLIC NOTICE AT LEAST THIRTY DAYS BEFORE ANY PUBLIC HEARING OR BEFORE THE START OF ANY COMMENT PERIOD, WHICH PUBLIC NOTICE MUST INCLUDE THE TIME, PLACE, AND LOCATION OF THE PUBLIC HEARING AND A SUMMARY OF THE PROJECT AND MAY BE PROVIDED THROUGH SEVERAL DIFFERENT OUTLETS AND LOCATIONS, INCLUDING:

(A) SCHOOLS;

(B) HEALTH CLINICS;

(C) SOCIAL MEDIA;

(D) SOCIAL AND ACTIVITY CLUBS;

(E) LOCAL GOVERNMENTS;

(F) TRIBAL GOVERNMENTS;

(G) RELIGIOUS OR CIVIC ORGANIZATIONS;

(H) COMMUNITY-BASED ENVIRONMENTAL JUSTICE ORGANIZATIONS; OR

(I) OTHER LOCAL SERVICES;

(IV) PROVIDE OUTREACH MATERIALS TRANSLATED INTO THE TOP TWO LANGUAGES SPOKEN IN THE DISPROPORTIONATELY IMPACTED COMMUNITY WHERE THE DEVELOPER OR OPERATOR PLANS TO DEVELOP OR OPERATE OR IS OPERATING THE LARGE-LOAD DATA CENTER, WHICH MATERIALS INFORM THE DISPROPORTIONATELY IMPACTED COMMUNITY ABOUT OPPORTUNITIES TO PROVIDE INPUT ON THE PROJECT, THE RIGHTS OF THE COMMUNITY, THE POSSIBLE OUTCOMES OF THE PROJECT, AND ANY UPCOMING PUBLIC HEARINGS OR COMMENT PERIODS; AND

(V) IMPLEMENT OTHER BEST PRACTICES FOR OUTREACH AND ENGAGEMENT SET FORTH IN SECTION 24-4-109 (3)(b).

(b) DURING A PUBLIC HEARING OR COMMENT PERIOD DESCRIBED IN THIS SUBSECTION (3), THE LARGE-LOAD DATA CENTER DEVELOPER OR LARGE-LOAD DATA CENTER OPERATOR SHALL EXPLICITLY DISCLOSE THE RESULTS OF THE CUMULATIVE IMPACTS ANALYSIS CONDUCTED BY A THIRD-PARTY CONTRACTOR PURSUANT TO SUBSECTION (1) OF THIS SECTION. THE DEVELOPER OR OPERATOR SHALL ALSO DESCRIBE THE EFFORTS THAT THE DEVELOPER OR OPERATOR WILL MAKE TO REDUCE ANTICIPATED NEGATIVE IMPACTS TO THE DISPROPORTIONATELY IMPACTED

COMMUNITY OR ITS ENVIRONMENT FROM THE PROPOSED LARGE-LOAD DATA CENTER PROJECT.

(4) (a) IF A LARGE-LOAD DATA CENTER IS PROPOSED IN A DISPROPORTIONATELY IMPACTED COMMUNITY OR IF AN OPERATOR OF A DATA CENTER IN A DISPROPORTIONATELY IMPACTED COMMUNITY THAT EXISTS BEFORE THE EFFECTIVE DATE OF THIS SECTION PLANS TO EXPAND THE DATA CENTER'S PEAK LOAD SUCH THAT THE DATA CENTER WILL BECOME A LARGE-LOAD DATA CENTER, THE DEVELOPER OR OPERATOR, AS APPLICABLE, SHALL ENTER INTO A LEGALLY BINDING AND PUBLICLY DISCLOSED COMMUNITY BENEFIT AGREEMENT WITH THE DISPROPORTIONATELY IMPACTED COMMUNITY BEFORE THE DEVELOPMENT OR EXPANSION BEGINS.

(b) (I) DURING COMMUNITY BENEFIT AGREEMENT NEGOTIATIONS, THE DEVELOPER OR OPERATOR SHALL CONSULT WITH THE LOCAL GOVERNMENT WITH JURISDICTION OVER THE LARGE-LOAD DATA CENTER OR PROPOSED LARGE-LOAD DATA CENTER PROJECT AND A COALITION OF AT LEAST THREE COMMUNITY-BASED ORGANIZATIONS WITHIN A TWO-MILE RADIUS OF THE LARGE-LOAD DATA CENTER OR PROPOSED LARGE-LOAD DATA CENTER PROJECT. THE DEVELOPER OR OPERATOR SHALL HOST A SERIES OF AT LEAST FIVE MEETINGS WITH KEY STAKEHOLDER GROUPS IDENTIFIED BY THE LOCAL GOVERNMENT AND COALITION. AT LEAST TWO OF THE MEETINGS MUST OFFER THE OPPORTUNITY FOR PUBLIC COMMENT. THE MEETINGS MUST COMPLY WITH THE BEST PRACTICES FOR OUTREACH AND ENGAGEMENT SET FORTH IN SECTION 24-4-109 (3)(b).

(II) IN NEGOTIATING A COMMUNITY BENEFIT AGREEMENT, THE PARTIES SHALL CONSIDER:

(A) THE PRIORITIZATION OF DISPROPORTIONATELY IMPACTED

COMMUNITIES THROUGH FIRST-SOURCE HIRING PROGRAMS, REVENUE SHARING, COMMUNITY PROGRAM FUNDING, COMMUNITY OR PUBLIC OWNERSHIP REQUIREMENTS, AND OTHER STATE-INITIATED MECHANISMS; AND

(B) REGULAR EQUITY IMPACT ASSESSMENTS, PROTECTIONS FOR RENTERS AND SMALL BUSINESSES, AND PUBLIC DASHBOARDS FOR DISCLOSURE OF INFORMATION DEEMED RELEVANT BY THE COALITION OF COMMUNITY ORGANIZATIONS DESCRIBED IN SUBSECTION (4)(b)(I) OF THIS SECTION.

(c) (I) A COMMUNITY BENEFIT AGREEMENT SHOULD AIM TO AVOID AND MITIGATE NEGATIVE IMPACTS FROM THE LARGE-LOAD DATA CENTER, DRIVE INVESTMENTS AND SERVICES REQUESTED BY DISPROPORTIONATELY IMPACTED COMMUNITIES, AND SUPPORT LOCAL WORKFORCE DEVELOPMENT.

(II) A COMMUNITY BENEFIT AGREEMENT MAY CONTEMPLATE A COMMUNITY BENEFIT FUND TIED TO PROJECT SCALE, ENVIRONMENTAL AND PUBLIC HEALTH, LONG-TERM SUBSIDIES AND MONITORING, AND SUPPORTING HOUSING, BROADBAND, HEALTH-CARE AND CHILD CARE CENTERS, AND COMMUNITY RESILIENCE.

(d) A LOCAL GOVERNMENT MAY DETERMINE APPROPRIATE PENALTIES FOR NONCOMPLIANCE WITH A COMMUNITY BENEFIT AGREEMENT.

40-2.5-108. Labor standards.

(1) A LARGE-LOAD DATA CENTER OPERATOR SHALL:

(a) PROVIDE PREVAILING WAGES, AS DEFINED IN SECTION 24-92-201 (6) AND DETERMINED BY THE DIRECTOR OF THE DEPARTMENT OF PERSONNEL PURSUANT TO SECTION 24-92-205 (1), TO EMPLOYEES THAT

ARE FULLY EMPLOYED, AS DEFINED IN SECTION 8-70-103 (12.5);

(b) PARTICIPATE IN AN APPRENTICESHIP PROGRAM REGISTERED WITH THE UNITED STATES DEPARTMENT OF LABOR OR A STATE APPRENTICESHIP AGENCY RECOGNIZED BY THE UNITED STATES DEPARTMENT OF LABOR;

(c) REQUIRE PARTICIPATION IN THE "OSHA 10" CLASS OR A CLASS OFFERED BY THE FEDERAL OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION COMPRISED OF SUBSTANTIALLY SIMILAR CONTENT;

(d) COMPLY WITH ANY APPLICABLE WORKPLACE SITE SAFETY PLAN REQUIREMENTS OF THE FEDERAL OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION; AND

(e) NOT HAVE A DOCUMENTED PATTERN OF WAGE THEFT OR MISCLASSIFICATION OF EMPLOYEES, AS DEFINED IN SECTION 8-72-114 (2)(f).

SECTION 3. Applicability. This act applies to conduct occurring on or after the effective date of this act.

SECTION 4. Safety clause. The general assembly finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, or safety or for appropriations for the support and maintenance of the departments of the state and state institutions.

Second Regular Session
Seventy-fifth General Assembly
STATE OF COLORADO

INTRODUCED

LLS NO. 26-0408.02 Owen Hatch x2698 **SENATE BILL 26-103**

SENATE SPONSORSHIP

Kolker and Marchman,

HOUSE SPONSORSHIP

(None),

Senate Committees
Education

House Committees

A BILL FOR AN ACT

CONCERNING PUBLIC SCHOOLS, AND, IN CONNECTION THEREWITH, CREATING A SPECIALIZED SCHOOL POLICY FOR AT-RISK STUDENTS AND REQUIRING SUBDIVISIONS TO SET ASIDE LAND FOR PUBLIC SCHOOLS.

Bill Summary

(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at http://leg.colorado.gov.)

The bill requires school districts and charter schools to adopt a policy that directs additional resources and supports toward at-risk public school students. The policy may implement the utilization of

community-school-based learning programs, as well as wraparound services, after-school programs, and tutoring services, among other community-focused programs.

Subdivision regulations adopted by a board of county commissioners must include land set aside for public schools of a school district.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Legislative declaration. (1) The general assembly finds and declares that:

(a) Colorado law recognizes community schools as evidence-based, democratic public-school models that integrate academics, family engagement, health services, and community partnerships;

(b) Under current law, the community school model appears primarily as a last-resort accountability intervention, becoming available after schools have entered priority improvement or turnaround status;

(c) Due to systemic inequities, the needs of Black, Latino, and low-income students are unmet far more often and far earlier than accountability systems recognize;

(d) The state must be proactive in allowing schools and families to adopt the community school framework before crisis emerges, thereby strengthening public schools and ensuring all students have access to high-quality schools; and

(e) School district contracting and metro-district land gifts have enabled privatization that diverts public education dollars and governance to private parties. These gaps must be addressed to preserve transparency, oversight, and equity.

(2) This act establishes early pathways for schools to adopt proven

community school strategies and supports equitable school success across Colorado.

SECTION 2. In Colorado Revised Statutes, **add** 22-32.5-112 as follows:

22-32.5-112. Achieving community commitment to equitable school success policy - required - definition.

(1) AS USED IN THIS SECTION, UNLESS THE CONTEXT OTHERWISE REQUIRES, "ACCESS POLICY" OR "POLICY" MEANS A POLICY DESCRIBED IN SUBSECTION (2) OF THIS SECTION.

(2) (a) ON OR BEFORE JULY 1, 2027, EACH INSTITUTE CHARTER SCHOOL, DISTRICT CHARTER SCHOOL, AND LOCAL BOARD OF EDUCATION, FOR ITS SCHOOLS THAT ARE NOT DISTRICT CHARTER SCHOOLS, SHALL ADOPT AND IMPLEMENT AN ACHIEVING COMMUNITY COMMITMENT TO EQUITABLE SCHOOL SUCCESS POLICY, TO BE KNOWN AS AN ACCESS POLICY, THAT DIRECTS ADDITIONAL RESOURCES AND SUPPORTS TO AT-RISK STUDENTS, AND SHALL POST THE POLICY ON THE SCHOOL'S OR SCHOOL DISTRICT'S WEBSITE.

(b) THE POLICY MAY INCLUDE:

(I) PARTNERSHIPS WITH COMMUNITY ORGANIZATIONS TO INCREASE ACCESS TO HEALTH CLINICS, LEGAL SERVICES, AND COLLEGE OPPORTUNITIES FOR STUDENTS AND THE COMMUNITY;

(II) INTEGRATED STUDENT SUPPORT AND WRAPAROUND SERVICES INFORMED BY THE ASSET AND NEEDS ASSESSMENT DESCRIBED IN SECTION 22-32.5-103 (1.5)(a), INCLUDING, BUT NOT LIMITED TO, INCREASING COUNSELORS, CASEWORKERS, AND OTHER MENTAL HEALTH PROFESSIONALS;

(III) EXTENDED LEARNING TIME WITH AFTER-SCHOOL, TUTORING,

AND OTHER SUMMER PROGRAMS;

(IV) STRATEGIES TO SUPPORT TEACHER RETENTION AND PAY, INCLUDING INCREASING PLANNING TIME AND OPPORTUNITIES TO COLLABORATE MEANINGFULLY WITH COLLEAGUES AND FUNDING PROFESSIONAL DEVELOPMENT ADVANCEMENT OPPORTUNITIES;

(V) FAMILY AND COMMUNITY ENGAGEMENT STRATEGIES THAT REFLECT CULTURAL AND LINGUISTIC DIVERSITY, INCLUDING BILINGUAL AND DUAL-LANGUAGE SUPPORTS, TRANSLATORS, AND FAMILY LIAISONS; AND

(VI) THE AT-RISK MEASURE DESCRIBED IN SECTION 22-54-104.6.

SECTION 3. In Colorado Revised Statutes, 30-28-101, **add** (6.5) as follows:

30-28-101. Definitions.

As used in this part 1, unless the context otherwise requires:

(6.5) "PUBLIC SCHOOL" MEANS A PUBLIC SCHOOL OF A SCHOOL DISTRICT.

SECTION 4. In Colorado Revised Statutes, 30-28-133, **amend** (4) introductory portion, (4)(a) introductory portion, (4)(a)(II) introductory portion, and (4)(a)(II)(A) as follows:

30-28-133. Subdivision regulations.

(4) Subdivision regulations adopted by the board of county commissioners pursuant to this section ~~shall~~ MUST also include, ~~as~~ AT a minimum, provisions governing the following matters:

(a) Sites and land areas for PUBLIC schools and parks when ~~such~~ THEY are reasonably necessary to serve the proposed subdivision and the future residents. ~~thereof. Such~~ THE provisions may include:

(II) Dedication of the sites and land areas to the county, to a

school district, or to the public or, in lieu ~~thereof~~ OF DEDICATION, payment of a sum of money not exceeding the fair market value of the sites and land areas or a combination of ~~such~~ dedication and ~~such~~ payment; except that the value of the combination ~~shall~~ MUST not exceed the fair market value of the sites and land areas. Any sums, when required, or ~~moneys~~ MONEY to be paid to the board of county commissioners pursuant to this ~~paragraph (a)~~ SUBSECTION (4)(a) may, if approved by the board of county commissioners, be paid directly to a school district. If the sites and land areas are dedicated to the county, to a school district, or the public, the board of county commissioners may, at the request of the affected entity, sell the land. The subdivider ~~shall have~~ HAS a right of first refusal to purchase all or a portion of ~~any~~ land dedicated by the subdivider to a county, school district, or other public entity pursuant to this ~~subparagraph (II)~~ SUBSECTION (4)(a)(II) before the land is sold, transferred, or conveyed to ~~any~~ A party other than a school district. Prior to selling or otherwise transferring ownership of the land, the county, school district, or other public entity selling the land shall provide written notice to the subdivider of its intention to sell or transfer ownership of all or any portion of the land. The subdivider ~~shall~~ then ~~have~~ HAS sixty days to provide written notice to the county, school district, or other public entity of the subdivider's interest in purchasing all or a portion of the land to be sold. THE PARTIES MUST MUTUALLY AGREE TO THE TERMS AND CONDITIONS FOR the purchase of the land by the subdivider; ~~shall be upon such terms and conditions and for such consideration as the parties may mutually agree;~~ however, in no event shall the purchase price exceed the fair market value of the land at the time the subdivider dedicated the land to the county, school district, or other public entity. Any right of first

refusal created pursuant to this ~~subparagraph (II) shall expire~~ SUBSECTION (4)(a)(II) EXPIRES twenty years ~~from~~ AFTER the date the land was dedicated by the subdivider to a county, school district, or other public entity. Except as provided in subsection (4.3) of this section, any ~~such~~ sums, when required, or ~~moneys~~ MONEY paid to the board of county commissioners from the sale of the dedicated sites and land areas ~~shall~~ MUST be held by the board of county commissioners:

(A) For the acquisition of reasonably necessary sites and land areas or for other capital outlay purposes for PUBLIC schools or parks;

SECTION 5. Safety clause. The general assembly finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, or safety or for appropriations for the support and maintenance of the departments of the state and state institutions.

Second Regular Session
Seventy-fifth General Assembly
STATE OF COLORADO

INTRODUCED

LLS NO. 26-0176.01 Alison Killen x4350 **SENATE BILL 26-105**

SENATE SPONSORSHIP

Hinrichsen,

HOUSE SPONSORSHIP

Martinez and Mauro,

Senate Committees
Local Government & Housing

House Committees

A BILL FOR AN ACT

CONCERNING COUNTY EXECUTIVE OFFICERS, AND, IN CONNECTION THEREWITH, REQUIRING CORONERS, CLERKS AND RECORDERS, AND ASSESSORS TO DISCLOSE THEIR FINANCIAL INTERESTS IN REGULATED BUSINESSES; REQUIRING CORONERS TO DISCLOSE AN AGGREGATE NUMBER OF REMAINS REFERRALS TO DEATH-CARE SERVICE PROVIDERS; AND CREATING AN EXTRAORDINARY REMOVAL MECHANISM FOR COUNTY EXECUTIVE OFFICERS.

Bill Summary

(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at

http://leg.colorado.gov.)

The bill requires coroners, clerks and recorders, and assessors (county officers) to file written disclosures of their financial interest in specified businesses regulated by their respective offices within 30 days of taking office or 30 days of acquiring the financial interest, whichever is later. The filing is a public record. A county officer who has disclosed a financial interest may not participate in an official action that would directly and specifically affect that business in which the county officer has a financial interest.

The bill also requires coroners to annually disclose, on an aggregate basis, the number of referrals of remains made by the corner to any mortuary, funeral home, crematory, or other death-care provider. No personal identifying information related to the decedent or the decedent's family may be disclosed.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. In Colorado Revised Statutes, **add** 30-10-114 as follows:

30-10-114. County officer financial interest in regulated businesses - disclosure required - coroner - clerk and recorder - assessor - requirements - limitation on official actions - disclosure of aggregate referrals of remains by coroner - definition.

(1) AS USED IN THIS SECTION, UNLESS THE CONTEXT OTHERWISE REQUIRES, "FINANCIAL INTEREST" MEANS AN OWNERSHIP INTEREST, EMPLOYMENT RELATIONSHIP, MANAGEMENT ROLE, CONTRACTUAL RELATIONSHIP, OR OTHER DIRECT PECUNIARY INTEREST.

(2) A COUNTY OFFICER DESCRIBED IN THIS SECTION WHO HAS A FINANCIAL INTEREST IN A BUSINESS THAT IS SUBJECT TO REGULATION OR OVERSIGHT BY THE OFFICE OF THE COUNTY OFFICER SHALL DISCLOSE THAT INTEREST IN WRITING IN ACCORDANCE WITH THIS SECTION.

(a) A COUNTY CORONER SHALL DISCLOSE ANY FINANCIAL INTEREST IN A MORTUARY, FUNERAL HOME, CREMATORY, EMBALMING SERVICE, OR

OTHER DEATH-CARE BUSINESS THAT MAY BE SUBJECT TO REFERRAL, INVESTIGATION, OVERSIGHT, OR OTHER OFFICIAL ACTION BY THE CORONER'S OFFICE.

(b) A COUNTY CLERK AND RECORDER SHALL DISCLOSE ANY FINANCIAL INTEREST IN AN AUTOMOBILE DEALERSHIP, MOTOR VEHICLE BROKER, OR OTHER MOTOR VEHICLE SALES BUSINESS SUBJECT TO TITLING, REGISTRATION, OR RELATED OFFICIAL ACTION BY THE CLERK AND RECORDER.

(c) AN ASSESSOR SHALL DISCLOSE ANY FINANCIAL INTEREST IN A REAL ESTATE BROKERAGE, PROPERTY MANAGEMENT COMPANY, TITLE INSURANCE COMPANY, APPRAISAL FIRM, OR OTHER REAL ESTATE-RELATED BUSINESS THAT MAY BE AFFECTED BY VALUATION, CLASSIFICATION, OR ASSESSMENT DECISIONS OF THE ASSESSOR'S OFFICE.

(3) A COUNTY OFFICER WHO IS REQUIRED BY SUBSECTION (2) OF THIS SECTION TO DISCLOSE A FINANCIAL INTEREST IN A REGULATED BUSINESS SHALL FILE THEIR WRITTEN DISCLOSURE STATEMENT, IN A FORM TO BE DETERMINED BY THE BOARD OF COUNTY COMMISSIONERS, WITH THE COUNTY CLERK AND RECORDER NO MORE THAN THIRTY DAYS AFTER TAKING OFFICE OR NO MORE THAN THIRTY DAYS AFTER ACQUIRING THE FINANCIAL INTEREST, WHICHEVER OCCURS LATER. A DISCLOSURE STATEMENT FILED PURSUANT TO THIS SECTION IS A PUBLIC RECORD.

(4) A COUNTY OFFICER WHO HAS DISCLOSED A FINANCIAL INTEREST PURSUANT TO THIS SECTION SHALL NOT PARTICIPATE IN ANY OFFICIAL ACTION THAT WOULD DIRECTLY AND SPECIFICALLY AFFECT THE BUSINESS IN WHICH THE OFFICER HAS THE FINANCIAL INTEREST.

(5) (a) IN CASES IN WHICH THE COUNTY CORONER IS REQUIRED BY LAW TO ARRANGE FOR THE DISPOSITION OF HUMAN REMAINS DUE TO THE

ABSENCE OF A KNOWN NEXT OF KIN OR OTHER RESPONSIBLE PERSON, THE CORONER SHALL DISCLOSE, ON AN AGGREGATE BASIS, THE NUMBER OF REFERRALS MADE TO EACH MORTUARY, FUNERAL HOME, CREMATORY, OR OTHER DEATH-CARE PROVIDER.

(b) THE DISCLOSURE REQUIRED BY SUBSECTION (5)(a) OF THIS SECTION MUST BE MADE AT LEAST ANNUALLY, IN A FORM DETERMINED BY THE COUNTY CORONER, AND FILED WITH THE COUNTY CLERK AND RECORDER. THE DISCLOSURE IS A PUBLIC RECORD.

(c) A DISCLOSURE MADE PURSUANT TO THIS SUBSECTION (5) MUST NOT INCLUDE PERSONAL IDENTIFYING INFORMATION OF A DECEDENT OR ANY INFORMATION THAT WOULD REASONABLY IDENTIFY A DECEDENT.

(d) NOTHING IN THIS SUBSECTION (5) SHALL BE CONSTRUED TO REQUIRE A COUNTY CORONER TO ALTER EXISTING PROCEDURES FOR THE REFERRAL OR DISPOSITION OF HUMAN REMAINS OR TO LIMIT THE CORONER'S STATUTORY AUTHORITY IN CARRYING OUT OFFICIAL DUTIES.

(6) THIS SECTION APPLIES IN ADDITION TO, AND DOES NOT LIMIT, ANY CONFLICTS OF INTEREST, ETHICS, OR DISCLOSURE REQUIREMENTS FOR A COUNTY OFFICER IMPOSED BY OTHER STATE OR FEDERAL LAW.

SECTION 2. Act subject to petition - effective date. This act takes effect at 12:01 a.m. on the day following the expiration of the ninety-day period after final adjournment of the general assembly (August 12, 2026, if adjournment sine die is on May 13, 2026); except that, if a referendum petition is filed pursuant to section 1 (3) of article V of the state constitution against this act or an item, section, or part of this act within such period, then the act, item, section, or part will not take effect

unless approved by the people at the general election to be held in November 2026 and, in such case, will take effect on the date of the official declaration of the vote thereon by the governor.