GRANITE CONSTRUCTION (Salaried)
2025 Health Savings Account (HSA)
BC PPO $3,000/80/60

BC PPO Benefits

This summary of benefits has been updated to comply with federal requirements, including applicable provisions of the federal health care reform laws. As we receive additional guidance and clarification on the health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

This plan is an innovative type of coverage that allows an enrolled person to use a Health Savings Account to pay for routine medical care. The program also includes traditional health coverage, similar to a typical health plan that protects the enrolled person against large medical expenses.

The enrolled person can spend the money in the HSA account the way the enrolled person wants on routine medical care, prescription drugs and other qualified medical expenses. There are no copays or deductibles to satisfy first. Unused dollars can be saved from year to year to reduce the amount the enrolled person may have to pay in the future. If covered expenses exceed the enrolled person's available HSA dollars, the traditional health coverage is available after a limited out-of-pocket amount is paid by the enrolled person.

Certain Covered Services have maximum visit and/or day limits per year. The number of visits and/or days allowed for these services will begin accumulating on the first visit and/or day, regardless of whether your Deductible has been met.

The enrolled person is responsible for all costs over the plan maximums. Plan maximums and other important information appear in *italics*.

Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Explanation of Covered Expense

Plan payments are based on covered expense, which is the lesser of the charges billed by the provider or the following:

Participating Providers—Negotiated rates. Enrolled persons are not responsible for the difference between the provider's usual charges & the negotiated amount.

Non-Participating Providers & Other Health Care Providers *(includes those not represented in the PPO provider network)*—

The maximum allowable charge for professional or institutional services. You are responsible for any amount billed in excess of the maximum allowable charge and any expense not covered under this Plan.

When using non-participating providers, the enrolled person is responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay.

Calendar year deductible for all providers *(applicable to medical care & prescription drug benefits)*	
➢ Individual enrolled person	$3,000/individual enrolled person
➢ Enrolled family *(includes enrolled employee & one or more members of the employee's family; no coverage may be paid for any member of a family unless this $6,000 deductible is met)*	$6,000/enrolled family
Annual Out-of-Pocket Maximums *(in-network/out-of-network out-of-pocket maximums are exclusive of each other; includes calendar year deductible & prescription drug covered expense)*	
➢ Participating Providers & Other Health Care Providers	$4,000/individual enrolled person; $6,000/enrolled family/year
➢ Non-Participating Providers	$4,000/individual enrolled person; $6,000/enrolled family/year

The following do not apply to out-of-pocket maximums: costs in excess of the covered expense & non-covered expense. After an individual enrolled person or enrolled family *(includes enrolled employee & one or more members of the employee's family)* reaches the out-of-pocket maximum for all medical and prescription drug covered expense the individual enrolled person or enrolled family incurs during that calendar year, the individual enrolled person or enrolled family will no longer be required to pay a copay for the remainder of that year. The individual enrolled person or enrolled family remains responsible for costs in excess of the covered expense when provided by non-participating providers and other health care providers; non-covered expense.

Lifetime Maximum	Unlimited

Covered Services	Traditional Health Coverage Enrolled Person Copay In-Network	Out-of-Network *(Enrolled is also responsible for charges in excess of covered expense)*
Hospital Medical Services *(subject to utilization review for inpatient services; a $500 penalty will be applied for lack of pre-certification; waived for emergency admissions)*		
➢ Semi-private room, meals & special diets, & ancillary services	20%	40%
➢ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	20%	40%
Ambulatory Surgical Centers		
➢ Outpatient surgery, services & supplies	20%	40%
Hemodialysis		
➢ Outpatient hemodialysis services & supplies	20%	40%
Skilled Nursing Facility *(subject to utilization review)* *(Limited to 100 days/calendar year)*		
➢ Semi-private room, services & supplies	20%	40%
Hospice Care		
➢ Inpatient or outpatient services for enrolled persons; family bereavement services	20%	40%
Home Health Care		
➢ Services & supplies from a home health agency *(limited to combined maximum of 120 visits/calendar year, one visit by home health aide equals four hours or less; not covered while enrolled person receives hospice care)*	20%	40%
Home Infusion Therapy		
➢ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	20%	40% *(benefit limited to $600/day)*
Physician Medical Services		
➢ Office & home visits	20%	40%
➢ Hospital & skilled nursing facility visits	20%	40%
➢ Surgeon & surgical assistant; anesthesiologist or anesthetist	20%	40%
Diagnostic X-ray & Lab		
➢ MRI, CT scan, PET scan & nuclear cardiac scan *(subject to utilization review)*	20%	40%
➢ Other diagnostic x-ray & lab	20%	40%
Preventive Care Services *Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician*		
➢ Routine physical exams *(birth through age six)*	No copay *(deductible waived)*	40%
➢ Immunizations *(birth through age six)*	No copay *(deductible waived)*	40%
➢ Routine physical exams, immunizations, diagnostic X-ray & lab for routine physical exam *(members 7 years old and older)*	No copay *(deductible waived)*	40%
➢ Women's Preventive *(Including but not limited to female contraceptives, including oral contraceptive, female sterilization and breast pump)*	No copay/exam *(deductible waived)*	40%
➢ Adult preventive services *(including mammograms, Pap smears, prostate cancer screenings & colorectal cancer screenings)*	No copay *(deductible waived)*	40%
Physical Therapy, Physical Medicine & Occupational Therapy, including Chiropractic Services *(limited to 24 visits/calendar year)*	20%	40%
Speech Therapy		
➢ Outpatient speech therapy following injury or organic disease	20%	40%
Acupuncture		
➢ Services for the treatment of disease, illness or injury *(limited to 12 visits/calendar year)*	20%[1]	40%[1]
Temporomandibular Joint Disorders		
➢ Splint therapy & surgical treatment	20%[2]	

[1] Acupuncture services can be performed by a certified acupuncturist (C.A.), a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a podiatrist (D.P.M.), or a dentist (D.D.S.).

[2] These providers may not be represented in the PPO network in the state where the enrolled person receives services.

Covered Services	Traditional Health Coverage Enrolled Person Copay In-Network	Out-of-Network *(Enrolled is also responsible for charges in excess of covered expense)*
Pregnancy & Maternity Care		
➢ Physician office visits	20%	40%
➢ Prescription drug for elective abortion *(mifepristone)*	20%	40%
Normal delivery, cesarean section, complications of pregnancy & abortion *(newborn routine nursery care covered when natural mother is enrolled employee or spouse/domestic partner)*		
➢ Inpatient physician services	20%	40%
➢ Hospital & ancillary services	20%	40%
Infertility Treatment *(subject to $10,000 lifetime maximum for medical services; separate $10,000 lifetime maximum for pharmacy services.)*	20%	40%
➢ Invitro fertilization, artificial insemination, GIFT, ZIFT and related lab services		
Organ & Tissue Transplants *(subject to utilization review; a $500 penalty will be applied for lack of pre-certification)*		
➢ Inpatient services provided in connection with non-investigative organ or tissue transplants	20%	Not Covered
➢ Transplant travel expense for an authorized, specified transplant at a *CME (recipient & companion transportation limited to $10,000 per transplant.)*	No copay deductible waived	
➢ Unrelated donor search, limited to $30,000 per transplant		
Bariatric Surgery *(subject to utilization review; a $500 penalty will be applied for lack of pre-certification, medically necessary surgery for weight loss, only for morbid obesity, covered only when performed at Centers of Medical Excellence [CME])*		
➢ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity	20%	Not covered
➢ Bariatric travel expense when enrolled person's home is 50 miles or more from the nearest bariatric *CME (enrolled person's transportation to and from CME limited to $130/person/trip for 3 trips [pre-surgical visit, initial surgery and one follow-up visit]; one companion's transportation to and from CME limited to $130/person/trip for 2 trips [initial surgery and one follow-up visit]; hotel for enrolled person and one companion limited to one room double occupancy and $100/day for 2 days/trip, or as medically necessary, for pre-surgical and follow-up visit; hotel for one companion limited to one room double occupancy and $100/day for duration of enrolled person's initial surgery stay for 4 days; other reasonable expenses limited to $25/day/person for 4 days/trip)*	No copay deductible waived	
Cardiac Surgery, Orthopedic Surgery (includes Spine Surgery, Knee and Hip Replacement) *(Subject to utilization review; a $500 penalty will be applied for lack of pre-certification.*		
➢ Inpatient services provided in connection with medically necessary surgery at a Blue Distinction Center of Medical Excellence+(BDC+)	0%	40%
➢ Inpatient services provided in connection with medically necessary surgery at a NON- Blue Distinction Center of Medical Excellence+(BDC+)	20%	40%
Diabetes Education Programs *(requires physician supervision)*		
➢ Teach enrolled persons & their families about the disease process, the daily management of diabetic therapy & self-management training	20%	40%
Prosthetic Devices		
➢ Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; wigs for alopecia resulting from chemotherapy or radiation therapy; & therapeutic shoes & inserts for enrolled persons with diabetes	20%	40%
Durable Medical Equipment		
➢ Rental or purchase of DME including hearing aids, dialysis equipment & supplies *(hearing aids benefit available for one hearing aid per ear every three years)*	20%	40%
Related Outpatient Medical Services & Supplies		
➢ Ground or air ambulance transportation, services & disposable supplies	20%[1]	
➢ Blood transfusions, blood processing & the cost of unreplaced blood & blood products	20%[1]	
➢ Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)*	20%[1]	
Emergency Care		
➢ Emergency room services & supplies	20%	20%
➢ Inpatient hospital services & supplies	20%	20%
➢ Physician services	20%	20%

Covered Services	Traditional Health Coverage Enrolled Person Copay In-Network	Out-of-Network *(Enrolled is also responsible for charges in excess of covered expense)*
Mental or Nervous Disorders and Substance Abuse		
Inpatient hospital & outpatient day treatment center *(subject to utilization review; a $500 penalty will be applied for lack of pre-certification, waived for emergency admissions)*	20%	40%
➢ Inpatient physician visits	20%	40%
➢ Outpatient physician visits	20%	20%

In addition to the benefits described above, coverage may include additional benefits, depending upon the enrolled person's home state. The benefits provided in this summary are subject to federal laws. There are some states that require more generous benefits be provided to their residents, even if the master policy was not issued in their state. If the enrolled person's state has such requirements, we will adjust the benefits to meet the requirements.
This Summary of Benefits is a brief review of benefits. Once enrolled, enrolled persons will receive a Summary Plan Description of Insurance, which explains the exclusions and limitations, as well as the full range of covered services of the plan in detail.

BC HSA —Exclusions and Limitations

Benefits are not provided for expenses incurred for or in connection with the following items:

Not Medically Necessary. Services or supplies that are not medically necessary, as defined.

Experimental or Investigative. Any experimental or investigative procedure or medication. But, if enrolled person is denied benefits because it is determined that the requested treatment is experimental or investigative, the enrolled person may request an independent medical review, as described in the Summary Plan Description.

Outside the United States. Services or supplies furnished and billed by a provider outside the United States, unless such services or supplies are furnished in connection with urgent care or an emergency.

Crime or Nuclear Energy. Conditions that result from (1) the enrolled person's commission of or attempt to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for the treatment of illness or injury arising from the release of nuclear energy.

Unenrolled. Services received before the enrolled person's effective date. Services received after the enrolled person's coverage ends, except as specified as covered in the Summary Plan Description.

Excess Amounts. Any amounts in excess of covered expense.

Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, whether or not the enrolled person claims those benefits.

Government Treatment. Any services the enrolled person actually received that were provided by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if the enrolled person is not required to pay for them or they are given to the enrolled person for free.

Services of Relatives. Professional services received from a person living in the enrolled person's home or who is related to the enrolled person by blood or marriage, except as specified as covered in the Summary Plan Description.

Voluntary Payment. Services for which the enrolled person is not legally obligated to pay. Services for which the enrolled person is not charged. Services for which no charge is made in the absence of insurance coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:

1. it must be internationally known as being devoted mainly to medical research;
2. at least 10% of its yearly budget must be spent on research not directly related to patient care;
3. at least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. it must accept patients who are unable to pay; and
5. two-thirds of its patients must have conditions directly related to the hospital's research.

Not Specifically Listed. Services not specifically listed in the plan as covered services.

Private Contracts. Services or supplies provided pursuant to a private contract between the enrolled person and a provider, for which reimbursement under Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Inpatient Diagnostic Tests. Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. Mental or nervous disorders or substance abuse, including rehabilitative care in relation to these conditions, except as specified as covered in the Summary Plan Description.

Nicotine Use. Smoking cessation programs or treatment of nicotine or tobacco use, except as specified as covered in the Summary Plan Description. Smoking cessation drugs, except as specified as covered in the Summary Plan Description.

Orthodontia. Braces and other orthodontic appliances or services.

Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prostheses, dental implants, dental services, extraction of teeth, or treatment to the teeth or gums, or treatment to or for any disorders for the jaw joint, except as specified as covered in the Summary Plan Description. Cosmetic dental surgery or other dental services for beautification.

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, except routine eye screenings provided as specified as covered in the Summary Plan Description. Eyeglasses or contact lenses, except as specified as covered in the Summary Plan Description.

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a home health agency, hospice, or home infusion therapy provider, as specified as covered in the Summary Plan Description.

Outpatient Speech Therapy. Outpatient speech therapy, except as specified as covered in the Summary Plan Description.

Cosmetic Surgery. Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.

Commercial Weight Loss Programs. Weight loss programs not approved by us, whether or not they are pursued under medical or *physician* supervision, unless specifically listed as covered in this *plan*. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs. This exclusion does not apply to *medically necessary* treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as described in the Summary Plan Description.

Sterilization Reversal. Reversal of sterilization.

Surrogate Mother Services. For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

Orthopedic Supplies. Orthopedic supplies, orthopedic shoes (other than shoes joined to braces), or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related feet complications as specified as covered in the Summary Plan Description.

Air Conditioners. Air purifiers, air conditioners or humidifiers.

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy. Custodial care or rest cures, except as specified as covered in the Summary Plan Description. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a skilled nursing facility, except as specified as covered in the Summary Plan Description.

Chronic Pain. Treatment of chronic pain, except as specified as covered in the Summary Plan Description.

Health Club Memberships. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a *physician*. This exclusion also applies to health spas.

Personal Items. Any supplies for comfort, hygiene or beautification.

Education or Counseling. Educational services or nutritional counseling, except as specified as covered in the Summary Plan Description. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa.

Food or Dietary Supplements. Nutritional and/or dietary supplements, except as provided in this *plan* or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not required either a written prescription or dispensing by a licensed pharmacist.

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specified as covered in the Summary Plan Description.

Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

Physical Therapy or Physical Medicine. Services of a physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement or as specified as covered in the Summary Plan Description.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs, medications and insulin, except as specified as covered in the Summary Plan Description. Non-prescription, over-the-counter patent or proprietary drugs or medicines, except as specified as covered in the Summary Plan Description. Cosmetics, health or beauty aids.

Diabetic Supplies. Prescription and non-prescription diabetic supplies except as specified as covered in the Summary Plan Description.

Private Duty Nursing. Inpatient or outpatient services of a private duty nurse.

Lifestyle Programs. Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition, except as specified as covered in the Summary Plan Description. This exclusion will not apply to cardiac rehabilitation programs approved by us.