



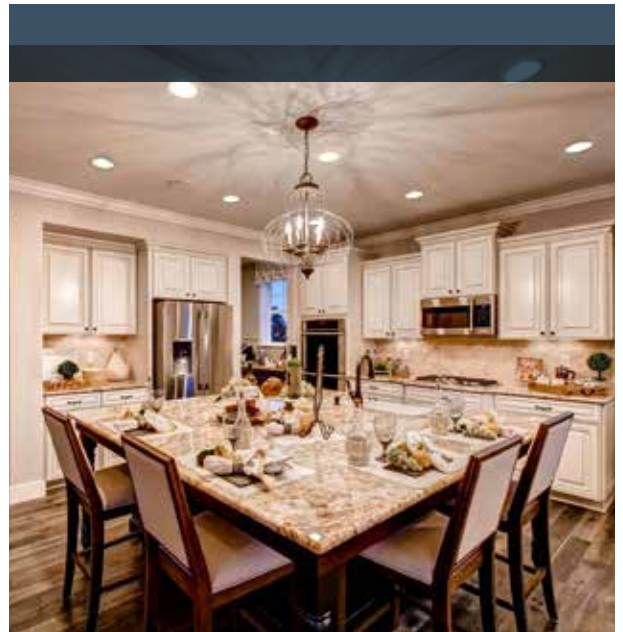
2019



Your **2019**
Benefits Guide.

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This document is an outline of the coverage proposed by the carrier(s), based on information provided by Colten. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.





Welcome to your **2019** Employee Benefits Guide.

Colten recognizes the importance of providing a comprehensive benefits program. That is why all our employees working 30 hours or more each week are benefit eligible employees. These benefits help provide employees and their family members opportunities to maintain their health and overall wellness. Employees eligible for these benefits are eligible the first of the month following 30 days of employment unless otherwise noted.

In this Benefit Guide employees will be able to review:

- A description of Colten's comprehensive Employee Benefit Program
- Important annual notices that Colten must provide all benefit eligible employees
- Important phone numbers and websites to help employees manage their benefits

For complete details of each benefit plan refer to the full text of the official Summary Plan Descriptions or contact Colten's Human Resources Department.

Please review this Benefits Guide to further understand your benefit enrollment options and please retain this Benefits Guide for reference throughout the year. Benefits are subject to eligibility requirements and may be subject to change.

If you need further assistance, contact Marcus Abramowitz:

Phone: 303.507.9937

Email: mabramowitz@Coltenhomes.com

Lastly, we encourage all employees to read this entire Benefits Summary before you enroll!

Benefit Eligibility

Colten employees who are working full-time (minimum 30 hours per week) are considered benefit eligible employees. Your benefit coverage is effective for active employees on the first day of the month following thirty (30) consecutive days of employment.

Plan Year: April 1, 2019 through March 31, 2020.

Qualifying Events

When you make a benefit election, it will remain in effect for the Entire plan year (April 1 through March 31). You may be able to make limited changes to your elections if you experience a "Qualifying event" and the change is consistent with your change in family status.

Qualifying Events include:

- Marriage, divorce or legal separation
- Gain or loss of an eligible dependent for reasons such as birth, adoption, court order, disability, death or reaching the dependent child age limit.
- Significant changes in employment or benefit coverage that affect you or your spouse's benefit eligibility.

You only have **31 days** from the date of the qualifying event to request a change. You will not be able to make the change if you miss this deadline.

Not sure if you have a qualifying event? Need help changing your elections? Please contact Marcus Abramowitz at 303.507.9937.

Open Enrollment Deadline

The deadline for the 2019 plan year annual enrollment is Friday, March 22, 2019. After this deadline you will not be able to make any changes to your benefits. Your next opportunity will be the 2020 annual enrollment period or if you experience a qualifying event mid-year. For mid-year enrollments, Marcus Abramowitz will communicate your enrollment deadline.



Monthly Employee Contribution Rates.

FREE!

(Employee Only)

Colten will cover the cost
of employee-only cover-

Medical Premiums - Monthly

Employee Only	\$0.00
Employee + Spouse	\$671.96
Employee + Children	\$464.26
Family	\$1,124.02

FREE!

(Employee Only)

Colten will cover the cost
of employee-only cover-

Dental Premiums - Monthly

Employee Only	\$0.00
Employee + Spouse	\$51.22
Employee + Children	\$59.36
Family	\$114.61

\$6.26

(Employee Only)

Vision coverage is
provided as a voluntary
benefit

Vision Premiums - Monthly

Employee Only	\$6.26
Employee + Spouse	\$12.52
Employee + Children	\$12.65
Family	\$20.18

Important **Contact** Information.

Carrier/Benefit	Website	Phone Number
Cigna - Medical	www.mycigna.com	1.866.494.2111
Cigna - Dental	www.mycigna.com	1.866.494.2111
Cigna - Vision	www.mycigna.com	1.866.494.2111
ProFlex - FSA	www.proflextpa.com	1.855.847.9069
Lincoln - Life and AD&D	www.lfg.com	1.800.423.2765
Transamerica - 401(k)	www.ta-retirement.com	1.800.401.8726

Marcus Abramowitz
Phone: 303.507.9937
Email: mabramowitz@Coltenhomes.com

Medical Benefits.



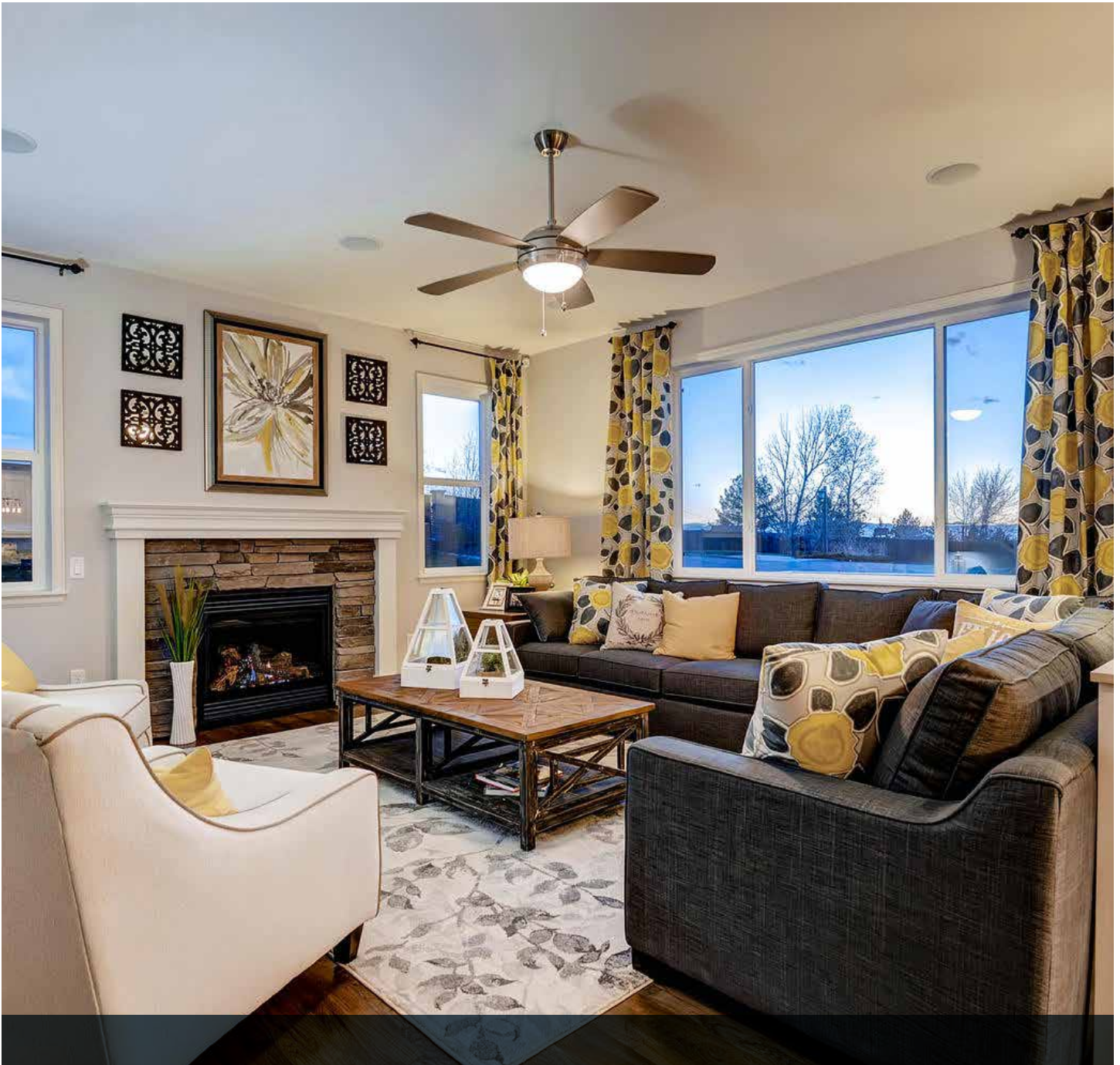
As medical care advances and treatments increase, health care costs also increase. The purpose of health insurance is to help you pay for care. It protects you and your family financially in the event of an unexpected serious illness or injury that could be very expensive. In addition, you are more likely to get routine and preventive care if you have health insurance.

You need health insurance because you cannot predict what your medical bills will be. In some years, your costs may be low. In other years, you may have very high medical expenses. If you have health insurance, you will have peace

of mind in knowing that you are protected from most of these costs. You should not wait until you or a family member becomes seriously ill to try to purchase health insurance.

We also know that there is a link between having health insurance and getting better health care. Research shows that people with health insurance are more likely to have a regular doctor and to get care when they need it.

Colten provides benefit-eligible employees with Medical Insurance through Cigna.



This plan uses a **provider network**. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work).

Check with your provider before you get services.

For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card.

The following is a summary of coverage and services under your Cigna medical plan. For a full description of your plan, refer to your Summary Plan Description.

Services	In-Network	Out-of-Network
Deductible Individual/Family	\$3,000/\$6,000	\$3,000/\$6,000
Out-of-Pocket Maximum Individual/Family (Includes deductibles and copays)	\$5,000/\$10,000	\$5,000/\$10,000
Coinsurance	100% coinsurance	80% coinsurance
Office Visit PCP Specialist	\$25 copay \$40 copay	80% coinsurance 80% coinsurance
Lab, X-Ray, Scans	100% coinsurance	80% coinsurance
Urgent Care	\$20 copay	80% coinsurance
Emergency Care	\$40 copay	80% coinsurance
Inpatient Hospital	100% coinsurance	80% coinsurance
Outpatient Surgery	100% coinsurance	80% coinsurance
Adult & Child Preventive Services	100% covered, no deductible	80% coinsurance
Mammogram, Pap Smear, Prostate Screening	100% covered, no deductible	80% coinsurance
Immunizations	100% covered, no deductible	80% coinsurance
Prescription Drugs - Retail (30 day) Generic Preferred Non-Preferred	\$0 copay \$30 copay \$60 copay	Not covered
Prescription Drugs - Mail (90 day) Generic Preferred Non-Preferred	\$0 copay \$75 copay \$150 copay	Not covered

Your **Online** Cigna Health Resources.

MyCigna.com

This convenient, secure website helps you take control of your health and make the most of your plan. Find participating doctors, hospitals and other healthcare professionals, download and print claim forms whenever you need them, view claims history and account transactions, and learn more about your plan and the coverage and programs available to you. Chart your progress on key health indicators; store your information where you can find it quickly and easily, and explore a range of health and wellness topics. Use interactive tools that help you learn about conditions, treatments and medications; take steps to stay healthy, and make informed healthcare decisions.

Cost Comparison Tools

Learn the facts to help you decide where to get care. Comparing costs and doctors, hospitals and other healthcare professionals can make a difference in the type and quality of services you receive—and what you ultimately pay. You can also get average price ranges for certain inpatient and outpatient procedures and radiology services such as MRIs and CT scans. Start by finding estimated costs in your region for common medical services and conditions.

Hospital Comparison Tools

Learn how hospitals rank by number of procedures performed, patient's average length of stay and cost. Get estimated average cost ranges for a procedure, including total charges and your out-of-pocket expense, based on a Cigna Healthcare coverage plan. Find hospitals that earn the "Centers of Excellence" designation based on effectiveness in treating selected procedures/conditions and cost.

My Health Assessment

Complete a confidential questionnaire that covers your current health conditions, family health history and lifestyle factors, and basic information such as weight, cholesterol level and blood pressure.

Use it as an important tool to help you reach your health goals. Review the results with your doctor to assess your overall health, talk about preventable and common conditions that may affect you, and develop steps for improvement.

Health Record

Keep track of your personal health information, including medical conditions, medications, allergies, surgeries, immunizations, and more.



It's free to download! Just search Cigna Health Benefits.





Dental Benefits.



Regular dental exams can help you and your dentist detect problems in the early stages when treatment is simpler and costs are lower. Keeping your teeth and gums clean and healthy will help prevent most tooth decay and periodontal disease, and is an important part of maintaining your medical health.

Cigna will be your dental carrier for the upcoming 2019 plan year. Rates for employee only enrollment are paid by Colten. Additional costs apply for dependent enrollment.

This is a brief description of the dental benefits. Please refer to the Summary Plan Description for complete policy provisions, limitations, and exclusions.

Coverage	In-Network	Out-of-Network
Deductible (Individual/Family)	\$0	\$50/\$150
Calendar Year Maximum	\$1,500	\$1,000
Preventive Services	100%	100%
Basic Services	90%	80%
Major Services	60%	50%
Orthodontia Services	60%	Not covered
Orthodontia Lifetime Maximum	\$1,500	Not covered

Sample Dental Procedure Listing.

Preventative & Diagnostic: Oral Evaluation, Bitewing X-rays, Full Mouth X-Rays or Panoramic, Routine Cleaning, Fluoride Treatments, Space Maintainers, Sealants

Basic Services: Oral Surgery, Periodontics (gum treatment), Endodontics (root canals), Extractions, Re-cementing Bridges, Crown or Inlays, Fillings, General Anesthesia, Antibiotic Drugs

Major Services: Gold Restorations (including Inlays, Onlays and Foil Fillings), Installation of Crowns, Bridges and Dentures, Repair of Crowns, Bridgework and Removable Dentures, Rebasing or Relining of Dentures



Vision Benefits.



Our eyes are incredibly complicated and even the slightest disruption in the lens, cornea, retina, or iris can drastically change your vision. The good news is that many vision conditions can be corrected through a comprehensive eye exam followed by the correct prescription for glasses or contact lenses. With the Vision Preferred Provider Organization plan (PPO) through Cigna, you and your family members have access to quality vision care.

The Cigna Vision Network offers one of the largest national routine vision networks, with 85,448+ optometrists and ophthalmologists at over 26,256 locations nationwide. This includes private practices, national, and regional retail locations. You have the option to go to a provider in-network or out-of-network, however you'll save the most money when you choose an in-network eye care provider.

Note: Please be aware that the Cigna Vision Network is different from the Cigna medical network. To find a provider, visit <https://cigna.vsp.com/eye-doctor.html> to find a location near you.

This is a brief description of your vision benefits. Please refer to the Summary Plan Description for complete policy provisions, limitations, and exclusions. Plan provisions are subject to change and may not be reflected in this guide.

Coverage	In-Network	Out-of-Network
Eye Exam (once every 12 months)	\$10 copay	Up to \$45
Materials	\$10 copay	Up to \$45
Lenses (once every 12 months) Single Vision Lenses Lined Bifocal Vision Lenses Lined Trifocal Vision Lenses Lined Lenticular Vision Lenses	100%	Up to \$40 Up to \$65 Up to \$75 Up to \$100
Frames (once every 24 months)	\$130 allowance	\$71 allowance
Contact Lenses (once every 24 months) Elective Medically Necessary	\$130 allowance 100%	\$105 allowance \$210 allowance





Where to go for Medical Care.

You may have alternatives other than the emergency room, allowing you to save significant dollars out of your own pocket. For more information about your medical plan coverage, limitations and exclusions, please refer to your Summary Plan Description.

When an accident, injury or illness occurs, it is important to quickly decide what type of care you need and where to go for treatment. In case of a real emergency, either dial 911 or choose a hospital based ER. These are fully integrated systems with all the necessary equipment and specialists under one roof.

• Telemedicine

How often have you needed medical care but couldn't get it because you were too busy, weren't near your doctor or needed help after hours? Cigna provides telemedicine services through MDLIVE and Amwell that lets you skip long waits and have a video doctor visit from the comfort and convenience of your own home or while you're on the go 24/7. Common conditions treated with Telemedicine include: Cold & Flu, Pink Eye, Sinus Infections, Rashes, and Allergies.

AmWell and MDLIVE are only available for medical visits. For covered services related to mental health and substance abuse, you have access to the Cigna Behavioral Health network of providers. Go to cignabehavioral.com to search for a video telehealth specialist.

• 24/7 Nurseline

Use the Nurseline when you are on-the-go or Out-of-Network. A registered nurse can answer your health questions wherever you are – any time, day or night. This service can also be used to determine where it is best to go for Medical Care.

• Primary Care Physician

If it isn't urgent, it's usually best to go to your primary care doctor. Your doctor knows you and your health history. He or she can access your medical records. Plus, your doctor can provide follow-up care and refer you to a specialist.

• Urgent Care

Sometimes, you may need care fast. If your primary care physician is unavailable, you may want to try an urgent care or retail health clinic in your network. Chances are you won't have to wait as long as you would at the ER. You may pay less, too. Urgent care centers typically treat things like sprains and strains, minor broken bones, minor infections, small cuts, sore throat, and rashes.

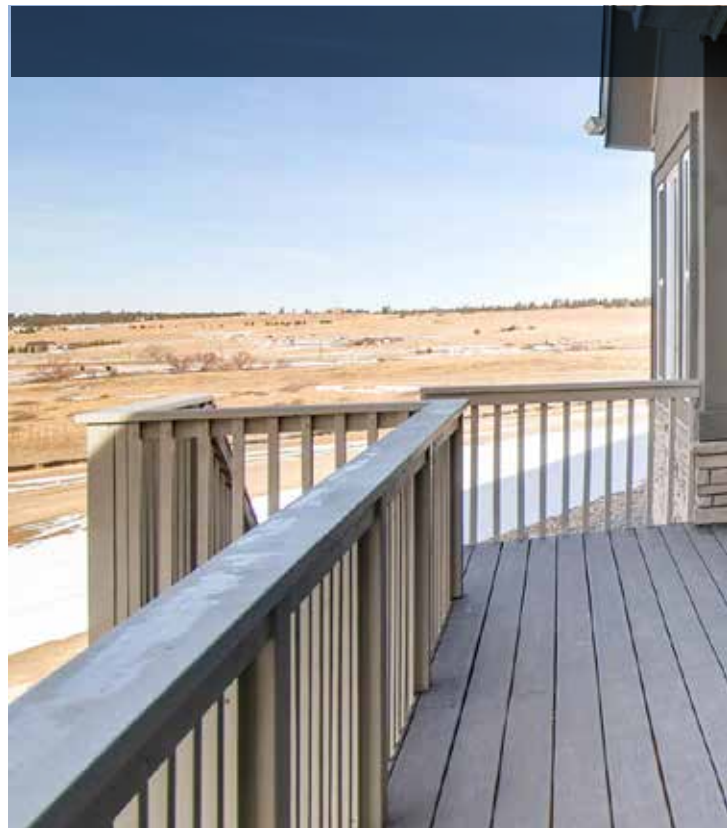
• Emergency Room

For life threatening or cases where immediate assistance is needed, seek out the closest ER near you. Common instances of ER use include heavy bleeding, large open wounds, major burns, spinal injuries, or severe head injury.

Flexible Spending Account. (FSA)

A Flexible Spending Account (FSA) allows you to pay for out-of-pocket medical, dental, vision and dependent care expenses with pre-tax dollars. All FSA contributions are deducted from your paycheck on a pre-tax basis, which can help reduce your taxes and increase your take-home pay. You save approximately 25% of each dollar spent on these expenses when you participate in an FSA.

There are two types of FSA plans available: **Medical FSA** and **Dependent Care FSA**. Employees that currently participate in the FSA plan must re-enroll in order to continue participating in the upcoming plan year.



FSA Eligibility

Full-time employees are eligible to enroll in the Medical FSA, the Dependent Care FSA or both, at open enrollment following 30 days of employment with Colten. Once you enroll in the FSA, you cannot change your contribution amount during the year unless you experience a Qualifying Life Event, such as marriage or the birth of a child.

Medical FSA

This FSA account allows you to set aside pre-tax dollars to help pay for certain out-of-pocket expenses such as deductibles, coinsurance, copays and eligible prescribed over-the-counter medications and medical supplies. The maximum amount you can contribute to this account is \$2,700 per year. This account is pre-funded at the beginning of the year. The amount you intend to contribute for the year will be available on the first day the account is open. This is a "Use It or Lose It" account; however, you can rollover up to \$500 of unused funds to the next plan year. Any unused funds over \$500 will be forfeited. Eligible expenses include, but are not limited to:

- Doctor visits
- Specialists visits
- Prescription Drugs
- Medically necessary over-the-counter drugs
- Chiropractic services
- Psychiatric care
- Dental/Vision expenses
- Laser vision or Eye Corrective Surgery
- Surgery
- Surgery Fees

Dependent Care FSA

This FSA account allows you to set aside pre-tax dollars to help pay for dependent care services (child or elder) for your eligible dependents. This account cannot be used to cover health care expenses incurred by your dependents. The maximum amount you can contribute to this account is \$5,000 per year, per family or \$2,500 for a married person filing separately. This account is not pre-funded, you can only use funds you have contributed to the account at any given time. This is a "Use It or Lose It" account. Any amount left in your account at the end of the year, will be forfeited. Eligible expenses include, but are not limited to:

- Child Daycare services
- Adult Daycare services
- Baby Sitters
- Extended Day programs
- Expenses for Preschool/Nursery
- Before and After School care
- Summer Day Camp
- Au Pair services



Life and AD&D Insurance.

Basic Life and Accidental Death & Dismemberment (AD&D)

Your family will be protected by Basic Life and Accidental Death & Dismemberment (AD&D) insurance in the amount of 1x salary to a maximum of \$100,000 for all active non-commission employees and \$50,000 for all active commission and sales employees, at no cost to you.



Disability Benefits.



What is Short-Term Disability?

Disability insurance is private insurance that replaces some of your income if an injury or illness prevents you from working. Disability insurance is important because it can ease the financial burden on a household when someone has a serious illness or injury. The main difference between disability insurance and workers' compensation insurance is that for disability insurance, the injury or illness does not need to be work-related.

Short-Term Disability (STD)

Colten provides all employees with STD coverage through Lincoln at no cost. Short-term disability insurance (STD) helps protect employee income during extended work absences and can help employees pay the bills when they cannot work due to a covered claim. Examples of common covered claims include:

- Rehabilitation
- Maternity Leave
- Runner's Knee
- Whiplash
- Tennis Elbow
- Surgery Recovery
- Bunion Removal
- Carpal Tunnel
- Stress/Anxiety
- Tendonitis
- Herniated Disks
- Broken Bones

This STD benefit provides compensation of 60% your weekly salary up to \$2,000. STD is used in the event of an accident or illness after a defined waiting period of 8 days. The maximum benefit period is 13 weeks. The Lincoln's STD plan can help maintain productivity by helping employees stay on the job. If they do incur an illness or injury, Lincoln can provide the resources employees need to help them return to work as soon as they are reasonably able.*

**some restrictions apply for commissioned sales and commissioned mortgage employees.*





401k **Retirement** Plan.



All regular (full-time and part-time) employees who have completed sixty (60) days of employment are eligible to participate in the 401(k) savings plan. You may contribute up to 100% of your annual salary, up to the IRS 2019 annual limit of \$19,000. You also have the flexibility to change salary contribution percentages every pay period.

Employer Match

The company will match 100% of your contributions, dollar for dollar, up to 3% of eligible pay, plus 50% of each additional dollar greater than 3% and no more than 5% of eligible pay.

Catch up contributions are accounted for when calculating employer matching contributions. In addition, the company may contribute a discretionary matching contribution to the plan.

Vesting Schedule

You are immediately 100% vested in the company's non-discretionary contributions to the plan.

The company may match the contributions you make to the plan during the year. The match amount is discretionary and will be determined at the end of the plan year. The company's discretionary matches follow the vesting schedule illustrated on this page.

The Company's discretionary contributions are vested as follows:

Years of Vesting Service	Vesting %
Less than 2 Years	0%
2 Years but <3 Years	20%
3 Years but <4 Years	40%
4 Years but <5 Years	60%
5 Years but <6 Years	80%
6+ Years	100%

Catch-Up Contributions

If you are at least age 50 or will become age 50 before the end of the calendar year, you may elect to defer additional amounts (called catch-up contributions) to the plan as of January 1st of that year. The additional amounts may be deferred regardless of any other limitation on the amount that you may defer to the plan. The maximum catch-up contribution that you can make in 2019 is \$6,000 in addition to the 2019 limit of \$19,000 (for a total contribution of \$25,000).

Important Notices.

Federal regulations require Colten to provide benefit eligible employees with the following notices:

Private Health Information

The Health Insurance Portability and Accountability Act (HIPAA) provides you certain rights to privacy concerning your health information. The regulations designate certain types of information as Protected Health Information (PHI). It applies to all health benefit plans. Confidential health information that identifies (or could be used to identify) you is kept completely confidential.

This individually identifiable health information PHI will not be used or disclosed without your written authorization, except as described in the Plan's HIPAA Privacy Notice or as otherwise permitted by federal and state health information privacy laws. A copy of the Plan's Notice of Privacy Practices that describes the Plan's policies, practices and your rights with respect to your PHI under HIPAA is available from your medical plan provider.

Healthcare providers (medical professionals) and health plans, including Colten health plan representatives, are restricted in their use of PHI to purposes of treatment, payment, and healthcare operations and as required by national public health activities. Written authorization is required to use or disclose your PHI pertaining to your medical, dental, prescription drug, employee assistance program and healthcare spending accounts outside of these purposes.

You may receive a form requesting your authorization to use your PHI for another purpose. Should you grant this authorization, your PHI is still protected from use and disclosure by any party other than the one(s) to whom you grant written authorization, and from use and disclosure by authorized parties for any purpose other than the one you specifically authorized.

Women's Health and Cancer Rights Act

Colten's medical plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services. These services include:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications resulting from mastectomy (including lymphedema)

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply to the mastectomy. For more information, contact your medical plan provider.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself and your dependents in Colten's health plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards you or your dependents' other coverage). However, you must request enrollment within 31 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Individual Coverage Mandate

Effective January 1, 2014, federal law requires that you have Health Care coverage. You can enroll in Colten's health plan, or you may want to consider visiting www.healthcare.gov for information on health plans available through the Healthcare Marketplace in your area. Please note that the plan provided by Colten meets the affordability and minimum value requirements for employee only coverage, and therefore you will not be eligible for a tax credit through the Marketplace for that tier of enrollment.

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. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through

their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

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, you can contact your State Medicaid or CHIP office to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit 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, you can contact your local state Medicaid or CHIP office for more information.

COLORADO-Medicaid

Medicaid Website: <http://www.colorado.gov/>

Medicaid Phone: 800.221.3943

For all other states: 877.267.2323, Ext. 61565

Notice Of Creditable Prescription Drug Coverage Medicare Part D

Colten provides a “Notice of Creditable Prescription Drug Coverage” to all participants. This notice states that under Colten’s medical plan, you have prescription drug coverage that is, on average, as generous as the standard Medicare prescription Drug Coverage.

To see if any more States have added a premium assistance program since July 31, 2013, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor - Employee Benefits Security Administration

www.dol.gov/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, Ext. 61565

Summary Plan Description (SPD)

This guide does not provide all of the details about the benefits programs. More information is available in each program’s Summary Plan Description (SPD). In addition to receiving your SPDs after enrolling, they are available at any time by request to Marcus Abramowitz at 303.507.9937.

Summary of Benefits and Coverage (SBC)

Effective for plan renewals after January 1, 2012, the Patient Protection and Affordable Care Act requires employers that offer health coverage to provide a uniform Summary of Benefits and Coverage (SBC) to people who apply for and enroll in the health plan. This document contains the following:

- Four-page overview of plan benefits, cost sharing and limitations
- Required set of examples of how the plan works
- Phone number and internet address for obtaining copies of plan documents
- A Standard glossary of medical and insurance terms must also be available

The SBC will be updated each plan renewal to reflect applicable plan changes.

