



**BENEFIT PLANS EFFECTIVE
JANUARY 1, 2026 - DECEMBER 31, 2026**

YOUR 2026 RETIREE BENEFITS

BENEFITS

BUILT FOR YOU

At Loveland Fire Rescue Authority, we care about you. That's why we offer a comprehensive suite of benefits that support you in retirement. In addition to reviewing LFRA Retiree benefits, we encourage you to look at [Via Benefits](#) (p. 36)- a benefit concierge service offered to employees that have terminated (or are planning to terminate) from CEBT coverage. Via Benefits helps you find a plan that covers you and your family or research your benefit options post-employment.

Understanding your benefits and knowing how to use them is just as important as having access to them. Review this guide to learn about the benefits available to you for the 2026 plan year (January 1, 2026-December 31, 2026). Then choose the options that are best for you and your family.

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WHO IS ELIGIBLE?

To be eligible for Loveland Fire Rescue Authority retiree benefits you must (1) be covered by CEBT medical insurance at the date of retirement, (2) retire from the Authority at or after age 55, and (3) have completed 20 or more years of services as a benefit eligible employee with the Authority, including any years of service completed with Loveland Fire prior to the Authority's organization on January 1, 2012.

Many of our plans offer coverage for eligible dependents, including:

- Your Legal Spouse
- Civil Union Partner
- Your children up to age 26

At the end of the month a retired employee becomes eligible for Medicare or the receipt of retirement pension benefits from the Fire and Police Pension Association and/or PERA, coverage on the Authority's medical insurance plan will be terminated for the retiree and the retiree's spouse and dependents (if elected.)

Retired employees who terminate coverage in the plan after enrolling, and outside the normal provisions of COBRA, will no longer be eligible to participate in the plan.

CHANGING YOUR BENEFITS

New Retirees

As a new retiree, you must enroll in benefits within 30 days following the loss of CEBT coverage as an LFRA employee. If you do not enroll within 30 days, you will not be able to participate in retiree coverage. Don't forget to fill out the [Other Insurance Information](#) form if you will be covering dependents on your plan. This form needs to be filled out annually in order for claims to not be held up and processed.

Qualifying Events and Dropping Dependents: Generally, you may only make or change your existing benefit elections as a new retiree or during the annual open enrollment period. However, you may drop a dependent at anytime and they will be covered through the end of the month or change your benefit elections during the year if you experience one of the following qualifying life events. To request a change, contact [LFRA Human Resources](#).

1. Change in marital status

- Marriage
- Death of spouse
- Divorce
- Legal separation

2. Change in number of dependents

- Marriage
- Birth
- Death
- Adoption of child or placement of a child for adoption

3. Change in coverage status

- Loss or gain of other coverage by the retiree or dependent

4. Change in individual coverage status due to aging out

- In the event that a covered individual loses eligibility on their parent's plan, due to aging out (26)



You have 30 days from the qualified life event to make changes to your coverage. Depending on the type of event, you may need to provide proof of the event (ie. marriage license, birth certificate etc.). You do not need to provide documentation if your only change is to drop a dependent(s) off your current plan, but documentation will always be required if adding dependents outside of open enrollment.



WHAT IS CEBT?

The Colorado Employer Benefit Trust (CEBT) is a self-funded, governmental multiple employer trust that provides employee benefits for over four hundred thirty seven (437) public entities, with over 37,000 employees and dependents covered in the state of Colorado. The CEBT plan offers health, dental, vision and life coverage to the participating groups.

WHO IS WTW?

Willis Towers Watson (WTW) is the broker / administrator for the CEBT. It provides customer service for plan participants to obtain answers on claims and benefits questions at (800) 332-1168 or (303) 773-1373. Willis Towers Watson has service representatives that make periodic visits to the participating groups to answer questions. In addition, the Trust administrator markets for prospective new members. Finally, Willis Towers Watson handles the eligibility and premium invoice process between the Trust and the participating employers.

WHAT ARE THE ROLES OF UMR, CVS CAREMARK, DELTA DENTAL & VISION SERVICE PLAN (VSP)?

CEBT has contracted with these managed health care companies to provide claims processing and provider network access:

UMR provides third party claim payment services and access to the United Healthcare provider networks for CEBT members who have medical coverage.

CVS Caremark provides the pharmacy payment and access to their provider network for CEBT members who have medical coverage using the United Healthcare provider network.

Delta Dental of Colorado provides third party dental claim payment services and access to their Dental PPO and Premier networks.

Vision Service Plan (VSP) provides the vision payment and access to their provider network for CEBT members who have vision coverage.

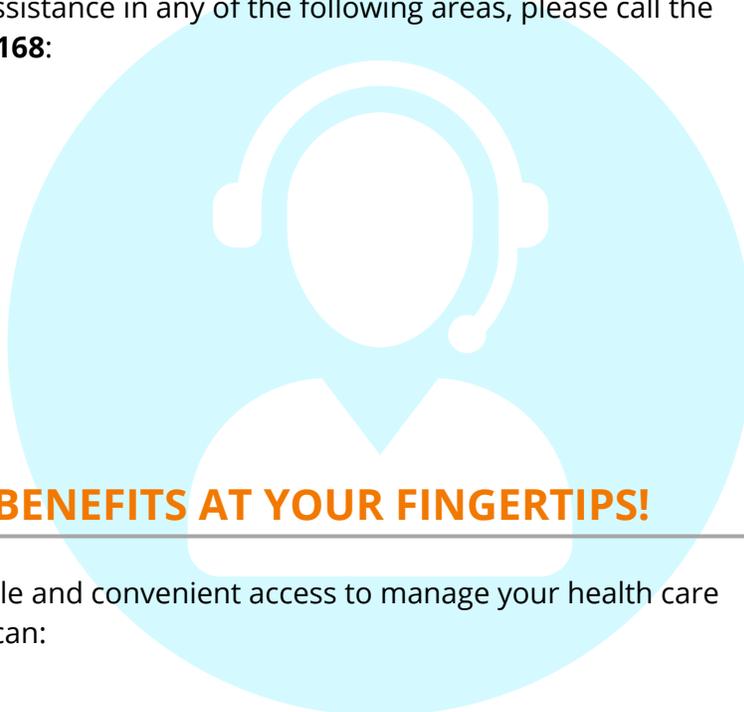
Much of your day to day correspondence, such as Explanations of Benefits (EOB) and requests for further information, will come from UMR. Additionally, you will receive ID cards from UMR, CVS Caremark and Delta Dental, but not from VSP. VSP does not utilize cards.



NEED HELP WITH A CLAIM?

CEBT has a customer service team of ten individuals to assist CEBT clients with a variety of benefit information. The Customer Service Representatives are housed right in Willis Towers Watson offices. Their hours of operation are Monday – Friday 7:30am – 4:30pm (except Friday they close at 4:00 pm). If you need assistance in any of the following areas, please call the customer service line at **1-800-332-1168**:

- Benefit information
- Claim resolution
- Claim status
- Explanation of Benefits
- Deductibles
- Order ID cards



THE CEBT MOBILE APP: BENEFITS AT YOUR FINGERTIPS!

The CEBT mobile app gives you simple and convenient access to manage your health care benefits on the go. On the app, you can:



ENROLL IN BENEFITS

New features: Enroll in your benefits, view current plans and dependents, download benefits summaries, and process life event/open enrollment changes.



FIND A PROVIDER

Search for in-network providers and easily navigate to find more information regarding CEBT's Valued Partners.



VIEW & ORDER ID CARDS

Keep a version of your ID cards handy - Access or print your digital ID cards and order new ID cards.



CONNECT WITH CUSTOMER SERVICE

Ask a CEBT customer service representative benefit or claim questions through opening a case.

DOWNLOAD THE
'CEBT HEALTH PLAN' APP



DOWNLOAD
NOW



DOWNLOAD
NOW

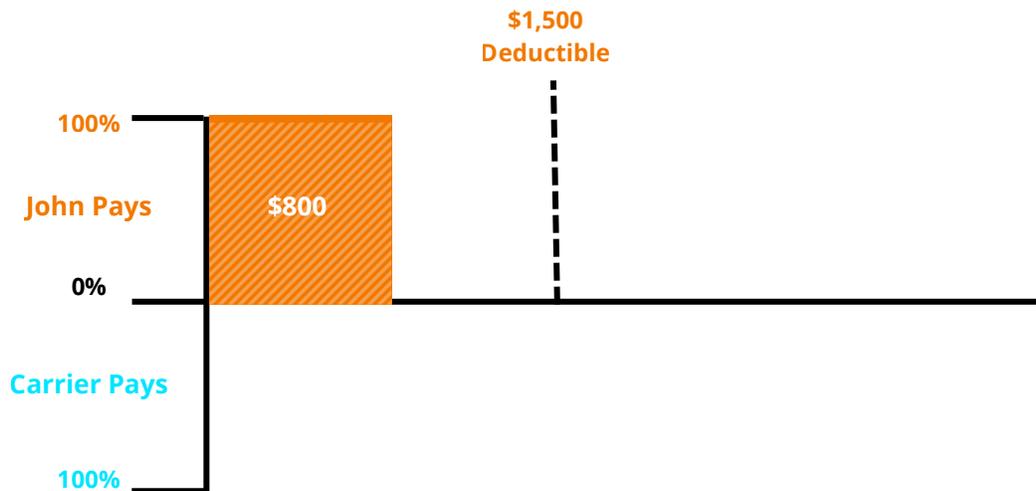


KEY BENEFIT TERMS

BENEFIT YEAR: The 12 months over which the benefits are paid and accumulated. The deductible and out of pocket maximums are accumulated over the Benefit Year and are reset to zero at the beginning of the next Benefit Year. For CEBT, the Benefit Year is January 1 – December 31.

DEDUCTIBLE: The amount you owe for health care services before your health insurance or plan begins to pay.

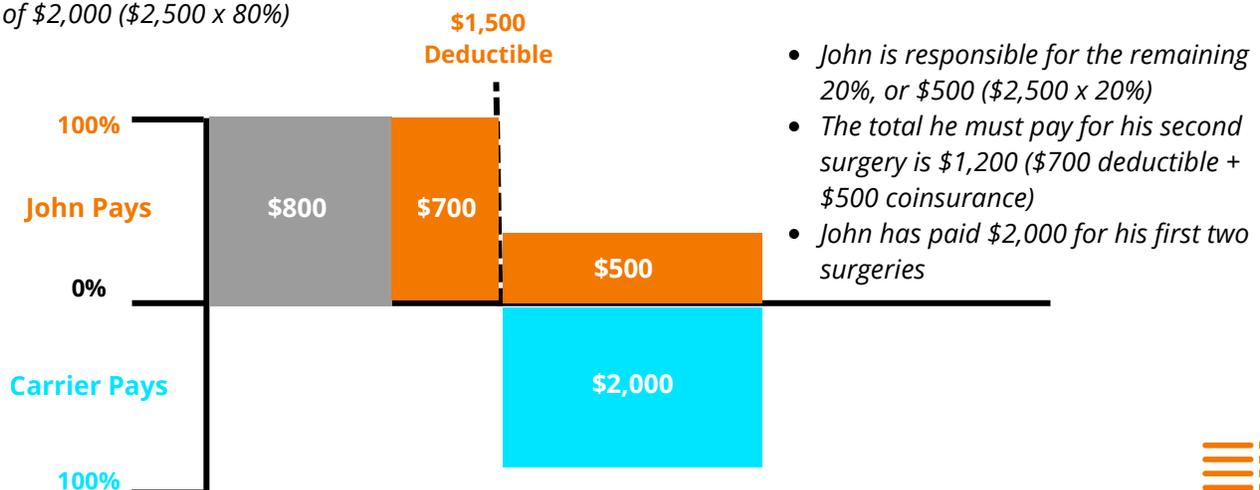
For example: John has a health plan with a \$1,500 annual deductible. He falls off his roof and needs three knee surgeries; the first of which is \$800. Because John hasn't paid anything toward his deductible this year, he is responsible for 100% of his first surgery. \$800 is applied to John's deductible.



COPAY: A fixed amount you pay for a covered health care service, usually due at the time you receive the service. The amount can vary by the type of covered health care service. The copay does not apply towards meeting the deductible but does count towards the out of pocket maximum.

CO-INSURANCE: Your share of the costs of a covered health service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance after you have met any deductible you owe.

For example: John's second surgery costs \$3,200. Because he's paid \$800 of his \$1,500 annual deductible, John is responsible for the first \$700 to meet his deductible. His plan will then cover 80% of the remaining cost, a total of \$2,000 ($\$2,500 \times 80\%$)



KEY BENEFIT TERMS

OUT OF POCKET MAXIMUM: The most you pay in a calendar year before your health plan begins to pay 100% of the allowed amount.

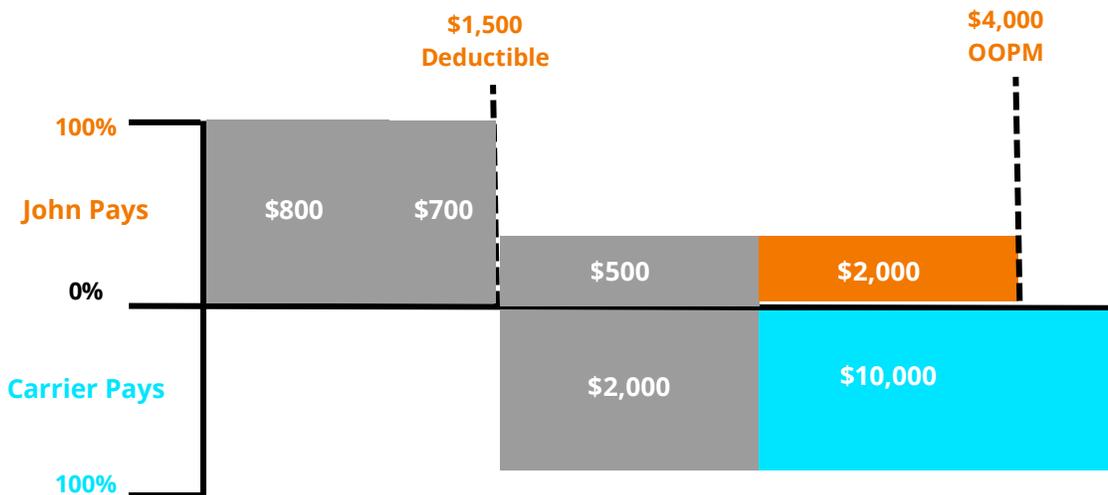
Items that count towards the out of pocket maximum:

- Copays
- Deductibles
- Co-insurance payments

Items that DO NOT count towards the out of pocket maximum:

- Your premium
- Balance-billed charges
- Charges your health insurance plan does not cover (i.e. plastic surgery and other excluded services)

Example: John's third surgery costs \$12,000; his plan has a \$4,000 OOPM. Because John already paid \$2,000 toward his OOPM for his first two surgeries, he only needs to spend \$2,000 before he hits his OOPM (\$4,000 - \$2,000). The plan pays the remaining \$10,000 (\$8,000 - \$2,000).



EOB-Explanation of Benefits: An explanation of benefits is a statement sent by a health insurance company to covered individuals explaining what medical treatments and/or services were paid for on their behalf.

FORMULARY: A list of prescription drugs covered by the health plan.

HEALTH SAVINGS ACCOUNT (HSA): A tax advantaged medical savings account available to those who are enrolled in a High Deductible Health Plan (HDHP). The funds contributed to the account are not subject to federal income tax. These funds may be used for a variety of medical, dental, and vision expenses. For a full list, visit www.irs.gov in IRS Publication 502.



KEY BENEFIT TERMS

IN-NETWORK: Doctors, clinics, hospitals and other providers with whom the health plan has an agreement to care for its members. Health plans cover a greater share of the cost for in-network health providers than for providers who are out-of-network.

OUT-OF-NETWORK: A health plan will cover treatment for doctors, clinics, hospitals and other providers who are out-of-network, but covered members will pay more out-of-pocket to use out-of-network providers than for in-network providers.

PCP - Primary Care Provider: A primary care physician is a physician who provides both the first contact for a person with an undiagnosed health concern as well as continuing care of varied medical conditions, not limited by cause, organ system, or diagnosis.

PLAN YEAR: LFRA's "benefit plan year" is January 1 – December 31. In terms of changes to each plan's benefits, CEBT's plan year is July 1 – June 30, which means any plan benefit changes, especially those mandated by the government are usually required no later than the beginning of CEBT's next plan year.

UCR – Usual, Customary and Reasonable: The amount that the plan will allow for a specific procedure or service. Also known as R&C (Reasonable and Customary). The member can be billed for these charges.

BALANCE BILLING: When a provider bills you for the difference between the provider's charge and what your health plan pays. Please note that an in-network provider contractually cannot balance bill you for covered services. Balance billed amounts do not apply toward your deductible or out-of-pocket maximum. See an example below of out-of-network charge with balance billing.

Example (<i>Out-of-Network</i>)		
Doctor charges	\$150	
UCR	\$100	
Coinsurance	80%/20%	
Plan coinsurance	\$80	\$100 x 80%
Your coinsurance	\$20	(\$100 x 20%)
Balance bill	\$50	\$150 - \$100
Total amount you pay	\$70	\$20 coinsurance + \$50 balance bill



MEDICAL COVERAGE



Eligible retirees of **Loveland Fire Rescue Authority** have the option to choose from three different medical plan options: EPO Select, PPO4, and HDHP5 offered through the Colorado Employer Benefit Trust (CEBT). Each plan includes comprehensive health care benefits, including free preventive care services and coverage for prescription drugs. These plans use either the **SelectColorado** or **United Choice Plus** networks. This is the network of doctors you will want to stay within in order to access your in-network level of benefits.

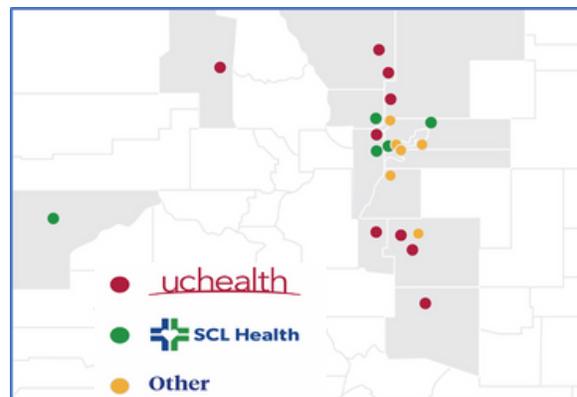
EPO Select

The ACO Select Colorado (Accountable Care Organization) was created in Colorado to deliver a highly collaborative, integrated model of care to provide a Best-In-Class network and to offer an affordable, differentiated care and member experience to improve the quality of care and reduce health care costs. The Select Colorado network is the network used on the the EPO Select plan and it is broken out into two different network levels for individuals to access medical care. Tier 1 providers include UHealth, Children’s Hospital, Optum, SCL Health, CU Medicine, New West Physicians and Monument Health. Any providers not designated as Tier 1 in your network search will be covered under the Tier 2 plan benefits. Tier 1 providers have been hand selected based on patient outcomes and coordinate health care amongst other Tier 1 providers. The SelectColorado Tier 1 network extends across 14 Colorado Counties*. If you receive care outside of one of these 14 counties claims will be processed as Tier 1, as well as any Emergency services. Election of a primary care provider (PCP) is required on this plan and will be listed on your medical ID card. A PCP is a vital part of your health journey and provider relationship to monitor ongoing care and to have a doctor to call with urgent questions.

To locate participating providers, go to the Providers and Partners tab on the CEBT website, click on the UMR option and select [Select Providers](#). If the provider is in-network and DOES NOT HAVE Tier 1 blue dot noted, then services will be paid at the Secondary Benefit Level (Tier 2) when services are received in the Select 14 Colorado Counties.

*Select Colorado Network

- | | |
|---------------|--------------|
| 1. Adams | 8. Jefferson |
| 2. Arapahoe | 9. Larimer |
| 3. Boulder | 10. Mesa |
| 4. Broomfield | 11. Pueblo |
| 5. Denver | 12. Routt |
| 6. Douglas | 13. Teller |
| 7. El Paso | 14. Weld |



PPO4

The PPO4 is a Preferred Provider Organization plan that uses the United Choice Plus network of contracted doctors and hospitals to choose from whenever care is needed. While you have access to out-of-network benefits on this plan, it is a good idea to find providers that are contracted with UnitedHealthcare in order to access your best level of benefits. You have a choice to go “in-network” with a provider in the United Choice Plus network which will include lower (negotiated) cost-sharing or “out-of-network” and pay a higher portion of the claims (with no discount).

After you meet your annual deductible, you are responsible for paying a portion of the remaining eligible expenses (your coinsurance) up to your annual out of pocket maximum (OOP). Once your OOP has been met, you are covered at 100% for the remaining calendar year. To locate in-state, in-network providers go to the Providers and Partners tab on the CEBT website, click on UMR and select [United Healthcare Providers](#).

HDHP5

The HDHP5 is a High Deductible Health Plan that uses the United Choice Plus network of contracted doctors and hospitals to choose from whenever care is needed. This Plan has the required elements for you to be able to contribute to a tax-advantaged Health Savings Account (HSA). With the HDHP5 plan, the annual deductible must be met before plan benefits are paid for services other than in-network preventive care services, which are fully covered. This plan offers both in and out-of-network benefits, but it is in your best interest to stay in-network to access your best level of benefits and pay the least amount out of you own pocket. To locate in-state, in-network providers go to the Providers and Partners tab on the CEBT website, click on UMR and select [United Healthcare Providers](#).

BEFORE YOU CHOOSE A PLAN, CONSIDER THIS:



Do you prefer to pay more for medical out of your paycheck, but less when you need care?



What planned medical services do you expect to need in the upcoming year?



Do you or any of your covered family members take any prescription medications on a regular basis?



CEBT MEDICAL PLANS

The tables below summarize the benefits of each medical plan.

The coinsurance amounts listed reflect the amount you pay. Please refer to the official [plan documents](#) for additional information on coverage and exclusions.

MEDICAL BASE PLAN	EPO Select		PPO4
	Tier 1	Tier 2	
Network	SelectColorado	SelectColorado	UHC Choice Plus
Office Visit (Primary Specialty)	\$0 Copay \$50 Copay	\$75 Copay \$125 Copay	\$40 Copay \$40 Copay
Deductible (Single Family)	Copay where indicated	Copay where indicated	\$1,500 \$3,000 Embedded
Coinsurance (In Out)	N/A	N/A	20% In *40% Out
Out of Pocket Single (In Out)	\$3,000	\$6,000	\$4,000 \$8,000
Out of Pocket Family (In Out)	\$6,000	\$12,000	\$8,000 \$16,000
Inpatient Hospital	\$1,000 Copay	\$3,000 Copay	Deductible + 20% to OOP Max
Outpatient Hospital	Amb Surg Center \$250 Copay Outpatient Hospital \$750 Copay	Amb Surg Center \$1,250 Copay Outpatient Hospital \$2,500 Copay	Deductible + 20% to OOP Max
Rx Retail	Generic \$20 Preferred \$40 Non-Preferred \$60	Generic \$20 Preferred \$40 Non-Preferred \$60	Generic \$20 Preferred \$40 Non-Preferred \$60
Rx Mail Order	2 X Copay	2 X Copay	2 X Copay
Preventative Visit	Covered 100%	Covered 100%	Covered 100%



CEBT MEDICAL PLANS

MEDICAL BASE PLAN	EPO Select		PPO4
	Tier 1	Tier 2	
Teladoc	Covered 100%	Covered 100%	Covered 100%
Telehealth	Covered 100%	Covered 100%	\$40 Copay
Advanced Imaging	\$500 Copay Free standing \$200	\$1,250 Copay Free standing \$800	Deductible + 20% to OOP Max
X-ray	Minor: \$25 Copay	Minor: \$25 Copay	\$40 Copay office setting Outpatient setting Deductible + 20% to OOP Max
Lab	\$25 Copay	\$25 Copay	\$40 Copay
Urgent Care	Covered 100%	Covered 100%	\$75 Copay
Emergency Care	\$250 Copay	\$250 Copay	Deductible + 20% to OOP Max

This comparison of coverage is intended only as a general description for the principle in network features of the benefit plans. If there are questions about a particular benefit or the coverage tier, please refer to the full plan document that is posted on the www.cebt.org website for specific coverage details.

*Charges are subject to Usual & Customary (U&C). These charges are considered in excess of the Reasonable Reimbursement, the Recognized Amount, the Usual and Customary charge, the Negotiated Rate, or the fee schedule. Exclusions under this category do not apply to payments that may be required under the No Surprises Act.

Preventative Services – will be processed following the Federal Patient Protection and Affordable Care Act. For more information on these services go to <https://www.cebt.org/benefit-booklets>.

PPO Note: Combination of PPO and Non PPO out of pocket limit will never exceed the Non PPO out of pocket limit.

PPO Plan deductibles fall under the definition of an Embedded deductible where any single member of a family doesn't have to meet the full family deductible for the after-deductible benefits to kick in. Once they meet the individual deductible, plan benefits will start to pay.



HIGH DEDUCTIBLE HEALTH PLAN OPTION

When you seek medical care under the High Deductible Health Plan, you pay for 100% of the services (up to the deductible amount) using funds from your Health Savings Account (HSA) or out of your pocket (remember that preventive care is paid at 100%). Once you meet the deductible, services are covered under the medical plans benefit schedule and you can use your HSA funds to pay for coinsurance, copays and eligible expenses not covered by the plan.

MEDICAL BASE PLAN	HDHP5
Network	UHC Choice Plus
Office Visit (Primary Specialty)	Deductible then covered 100%
Deductible (Single Family)	\$5,000 \$10,000 Embedded
Coinsurance (In Out)	0% In *40% Out
Out of Pocket Single (In Out)	\$5,000 \$10,000 Embedded
Out of Pocket Family (In Out)	\$10,000 \$20,000 Embedded
Inpatient Hospital	Deductible then covered 100%
Outpatient Hospital	Deductible then covered 100%
Rx Retail	Deductible then: Generic \$20 Preferred \$40 Non-Preferred \$60
Rx Mail Order	2 X Copay
Preventative Visit	Covered 100%
Teladoc	Covered 100%
Telehealth	Deductible then covered 100%
X-ray	Deductible then covered 100%



HIGH DEDUCTIBLE HEALTH PLAN OPTION

MEDICAL BASE PLAN	HDHP5
Lab	Deductible then covered 100%
Urgent Care	Deductible then covered 100%
Emergency Care	Deductible then covered 100%

This comparison of coverage is intended only as a general description for the principle in network features of the benefit plans. If there are questions about a particular benefit or the coverage tier, please refer to the full plan document that is posted on the www.cebt.org website for specific coverage details.

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Preventative Services – will be processed following the Federal Patient Protection and Affordable Care Act. For more information on these services go to <https://www.cebt.org/benefit-booklets>

Embedded - Under this deductible definition, any single member of a family doesn't have to meet the full family deductible for the after-deductible benefits to kick in. Once they meet the individual deductible, plan benefits will start to pay.





PRESCRIPTION DRUG COVERAGE

The vendor that manages your prescriptions on the CEBT UnitedHealthcare plans EPO Select, PPO4, & HDHP5 is CVS Caremark. Please note that CVS is not the only pharmacy you have access to. You are able to use a pharmacy at King Soopers, Safeway, Walmart, Walgreens, etc. To review commonly prescribed medications and specialty medications or learn more about your pharmacy benefits visit the [CVS Caremark page](#) on the CEBT website.

If you would like to access CVS 90 day mail order for your maintenance medications (blood pressure, cholesterol, etc.), you will need to do so by calling them directly at 866-885-4944 or have your doctor send the prescription into the CVS mail order pharmacy. By using mail order you are able to get a 90 day supply for the cost of a 60 day supply. You can receive three months for the price of two!

Prescription Drugs (retail 30 day)	Prescription Drugs (mail order 90 day)
\$20 copay – Generic \$40 copay – Preferred Brand \$60 copay – Non- Preferred Brand/Specialty	\$40 copay – Generic \$80 copay – Preferred Brand \$120 copay – Non- Preferred Brand/Specialty

Here are six tips to help you save time and money on your medications:

- 1. Register at Caremark.com.** That way we can keep you up to date on new and unique ways to save.
- 2. Be sure any retail pharmacy you use is in your network.** Network pharmacies are included in your prescription plan to help keep costs low. If you fill out-of-network, you will have to pay 100% of the cost. Find a network pharmacy before you fill at **Caremark.com**.
- 3. Know which medications are covered.** Your plan's list of covered medications can help you and your doctor find the most cost-effective drug option. Find your plan's list of covered medications at **Caremark.com**.

4. Use the *Check Drug Cost* tool available at Caremark.com. You'll be able to do side-by-side comparison of your medications to see where you could be saving.

5. Ask your doctor if there is a generic option for your brand-name medication. Proven just as safe and effective as brand-name medications, generics may be an affordable option for your treatment.

6. Choose delivery by mail or pick up. We'll deliver your 90-day supplies anywhere you like, with no-cost shipping (and status alerts for tracking). Our discreet packages are tamper-proof, weather-proof and temperature controlled, so it's a safe option for you.

- OR -

Pick them up at any CVS Pharmacy (including those inside Target stores). Either way you get the same quality, price and convenience.

Find even more ways to save when you sign in at Caremark.com.



DENTAL COVERAGE

It's important to have regular dental exams and cleanings so problems are detected before they become painful – and expensive. Keeping your teeth and gums clean and healthy will help prevent most tooth decay and is an important part of maintaining your overall health. The CEBT dental plan uses the Delta Dental network. You can go to any dentist of your choosing with this plan, but it is in your best interest to find a Delta Dental provider. There are 3 different network levels you can access: **PPO Dentist**, **Premier Dentist**, and **Non-Participating Dentist**. You will receive the best benefit and the deepest discounts by choosing a PPO dentist. Delta Dental providers offer the greatest savings and protection from balance-billing for covered services. Please refer to the official [plan document](#) or for additional information on coverage and exclusions.

Locate a [Delta Dental network dentist here](#).

Savings Example for a Major Procedure*							
	Estimated Charge	Maximum Allowed Fees	Percentage Paid by Delta Dental	Amount Delta Dental Pays	Amount Dentist can Balance-Bill	Total Amount You Pay	Your Total Cost Savings
PPO Network	\$1,200	\$850	50%	\$425	\$0	\$425	\$350
Premier Network	\$1,200	\$975	50%	\$487.50	\$0	\$487.50	\$225
Out of Network	\$1,200	\$700	50%	\$350	\$500	\$850	\$0

COVERED SERVICES	DENTAL A
Annual Max	\$2,000
Deductible (Single Family)	\$50 \$150
Preventative Services	Covered at 100% routine exams & cleanings 2 times per cal year, bitewing x-rays once per cal year, full mouth x-rays eligible once in a 5-year period
Basic Services	Covered at 80% emergency treatment, space maintainers, simple extractions, anesthesia and restorative fillings, oral surgery, endodontics, periodontics, root canal
Major Services	Covered at 50% crowns, partial or full dentures, implants
Orthodontia Services	Covered at 50% with lifetime max of \$2,000. Includes adults and dependent children through age 26

PPO Dentist - Payment is based on the PPO dentist's allowable fee, or the actual fee charged, whichever is less.

Premier Dentist - Payment is based on the Premier Maximum Plan Allowance (MPA), or the fee actually charged, whichever is less.

Non-Participating Dentist – Payment is based on the non-participating Maximum Plan Allowance. Members are responsible for the difference between the non-participating MPA and the full fee charged by the dentist. You will receive the best benefit by choosing a PPO dentist.



DENTAL COVERAGE



Prevention First: Delta Dental of Colorado knows that regular visits to the dentist can improve your oral health and your overall health. With our exclusive PREVENTION FIRST program, your diagnostic and preventive visits will not count against your annual maximum. This helps your benefits go further by extending your annual maximum dollars.

HOW PREVENTION FIRST HELPS YOU STRETCH YOUR BENEFIT DOLLARS:

Most of our dental plans cover preventive visits at 100%**, so you pay nothing out of pocket. But with **PREVENTION FIRST**, not only do you pay nothing, but you still have the money that Delta Dental pays available to you in your annual maximum. So in the example below, **it's like you have \$350 extra dollars a year to spend.**

	WITHOUT Prevention First	WITH Prevention First
Delta Dental Pays	\$350	\$350
You Pay	\$0	\$0
Annual Maximum Remaining	\$650	\$1,000

**Plan benefits and provider charges vary. The above sample assumes two routine check-ups with a PPO provider and \$1,000 annual maximum.



Right Start 4 Kids (RS4K): a plan design enhancement that removes most of the cost barriers to dental care by providing coverage for children up to their 13th birthday at 100% coinsurance for diagnostic & preventive, basic, and major services, with no deductible, when in-network providers are seen.* If an out-of-network provider is seen, the adult coinsurance levels will apply. Orthodontic services are available but are not eligible for the RS4K 100% coverage level.



100% COVERAGE*



NO DEDUCTIBLE



IN-NETWORK PROVIDERS



HEALTHY SMILES & BRIGHT FUTURES

* Right Start 4 Kids is subject to limitations, exclusions, and annual maximum. Check your benefits booklet for specific plan coverage as it varies from group to group.





VISION COVERAGE

The vision plan provides coverage for routine eye exams and pays for all or a portion of the cost of glasses or contact lenses. You can choose any provider; however, you always save money if you see in-network providers. CEBT offers vision benefits through VSP, which is the network of vision providers you can access. If you would like to find a provider, you are able to go to www.VSP.com. Right on the front page you can enter your zip code to pull up local providers. Please note that the benefit year is a rolling 12 months. The table below summarizes key features of the vision plan. Please refer to the official [plan summary](#) or for additional information on coverage and exclusions.



Even if you have perfect vision, an annual eye exam is important. Just by examining your eyes, a doctor can find warning signs of high blood pressure, diabetes, and more than 200 other major diseases.

COVERED SERVICES	VISION B
Carrier Network	VSP
Benefit Frequency	Exam and Lenses eligible every 12 months Frames eligible every 24 months 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last Well Vision Exam. Extra \$20 to spend on featured frame brands. Go to vsp.com/offers for details.
Routine Exam	\$15 Copay
Lenses, per pair	
Single	\$15 Copay
Bifocal	\$15 Copay
Trifocal	\$15 Copay
Lenticular	\$15 Copay
Frames	\$160 Allowance
Contact	\$160 Allowance

Exclusions: Benefits covered under Worker's Compensation Act, surgery or medical treatment of eyes, replacement of lost, stolen or broken lenses and/or frames, services and supplies for which you or your dependent are not required to pay, services and supplies not listed. This is only intended to highlight some of the pertinent provisions of the Group Plan; such Plan will control in all instances



THE COST OF YOUR BENEFITS

EPO Select			
	CEBT Monthly Premium	2% LFRA Admin Fee	Retiree Pays Monthly
Retiree	\$887.00	\$17.74	\$904.74
Retiree + Spouse	\$1,947.00	\$38.94	\$1,985.94
Retiree + Children	\$1,861.00	\$37.22	\$1,898.22
Family	\$2,210.00	\$44.20	\$2,254.20
PPO4			
	CEBT Monthly Premium	2% LFRA Admin Fee	Retiree Pays Monthly
Retiree	\$1,049.00	\$20.98	\$1,069.98
Retiree + Spouse	\$2,305.00	\$46.10	\$2,351.10
Retiree + Children	\$2,202.00	\$44.04	\$2,246.04
Family	\$2,621.00	\$52.42	\$2,673.42
HDHP5			
	CEBT Monthly Premium	2% LFRA Admin Fee	Retiree Pays Monthly
Retiree	\$742.00	\$14.84	\$756.84
Retiree + Spouse	\$1,634.00	\$32.68	\$1,666.68
Retiree + Children	\$1,561.00	\$31.22	\$1,592.22
Family	\$1,857.00	\$37.14	\$1,894.14

DENTAL			
	CEBT Monthly Premium	2% LFRA Admin Fee	Retiree Pays Monthly
Retiree	\$44.00	\$0.88	\$44.88
Retiree + Spouse	\$89.00	\$1.78	\$90.78
Retiree + Children	\$111.00	\$2.22	\$113.22
Family	\$151.00	\$3.02	\$154.02

VISION			
	CEBT Monthly Premium	2% LFRA Admin Fee	Retiree Pays Monthly
Retiree	\$6.00	\$0.12	\$6.12
Retiree + Spouse	\$11.00	\$0.22	\$11.22
Retiree + Children	\$12.00	\$0.24	\$12.24
Family	\$20.00	\$0.40	\$20.40

Retirees are responsible for the total premium cost of the plan as set by the insurance carrier plus a 2% Authority administrative fee. Such payment must be made by reimbursement of the Authority, pursuant to the payment procedures set forth in [Attachment A](#) (p.40-41) - such procedures may be amended periodically. Except as otherwise required by federal or state law, failure to make payments as directed will result in termination from the plan.





HEALTH SAVINGS ACCOUNT (HSA)

Retirees enrolling in the high deductible health plan option (HDHP5) are eligible for an HSA. With an HSA, you can put money aside to help offset your annual deductible and pay for qualified health care expenses.

START IT

Plans with a high deductible typically cost less than other plans so the money you save on premiums can be put into your HSA. With an HSA, you have more flexibility and control over your health care dollars. You can visit [HealthCare.gov](https://www.healthcare.gov) for ideas on how to set up an HSA.

BUILD IT

All of the money in your HSA is yours even if you change plans or drop your retiree coverage.

In 2026, the total of your contributions can be up to **\$4,400** for individual coverage and **\$8,750** for family coverage. If you are age 55 or older, you can contribute an additional **\$1,000** per year.

USE IT

You can withdraw your money tax-free at any time, as long as you use it for qualified expenses (a list can be found by visiting www.irs.gov and viewing Publication 502). When you turn age 65, your HSA dollars can be spent, without penalty, on any expense (taxes apply).

You can also save this money and hold onto it for future eligible health care expenses.

GROW IT

Unused money in your HSA will roll over, earn interest and grow tax-free over time.

You decide how to use the HSA money, including whether to save it or spend it for eligible expenses. When your balance is large enough, you can invest it – tax-free.

Eligibility Details

In order to fund an HSA you cannot:

- Be enrolled in a non-HSA-eligible medical plan (e.g., your spouse's HMO plan).
- Be claimed as a dependent on someone else's tax return.
- Be enrolled in Medicare, TRICARE, or TRICARE for Life.
- Have received Veterans Administration benefits in the previous three months, unless you received treatment for a condition that was/is related to your service.

For more information on health savings accounts, visit [www.IRS.gov](https://www.irs.gov) and view Publication 969.



CEBT HEALTH & WELLNESS CENTERS



The teams at the centers are licensed to diagnose, treat, and prescribe for a wide variety of common illnesses and injuries. In addition to sick care, you have access to a full range of health assessment and coaching services all from a location that is convenient for you and provide a direct savings in your out-of-pocket expenses. Make an appointment at my.marathon-health.com to get:

- **Access when you need it:** appointments usually available within two days or often same day.
- **Save Money:** no co-pays or bills for services provided at the health center for those on the EPO Select or PPO4 medical plans. (There is a \$45 cost for sick visits only for those on the HDHP5.)
- **Virtual & in-person appointments:** meet with a provider from your desk, on the go, or face to face, whichever is your preference. For those on the HDHP5, the \$45 sick visit cost is waived for virtual visits.
- **One-stop shopping:** labs drawn- onsite and many common medications can be prescribed and dispensed.
- **Complete help with your health:** Licensed clinicians are connected to community providers and immunization records, and have time to address all your health related questions.



Primary and preventive care

- Annual exams and preventive screenings
- Blood pressure screening
- Biometric screening (height, weight, blood glucose, and cholesterol)
- Condition management (diabetes, heart disease, COPD, and more)
- Mental health support (provider assessment for mental health concerns)
- Vaccines (Flu, TDAP, Shingrix, and more)



Immediate & sick care

- Bronchitis
- Common cold and cough
- Constipation
- Diarrhea
- Eye infections
- Headache
- Joint pain
- Nausea and vomiting
- Nosebleed
- Sinus infections
- Skin infections
- Strep throat



Family care (ages 2+)

- School and sports physicals
- Minor injuries (cuts, scrapes, and minor burns)
- Sick care (fever, flu, vomiting, pink eye, cough, and more)



Lab services

- Basic metabolic panel
- Blood draws and sample collection
- Cholesterol
- Hemoglobin A1c
- Pregnancy test
- Screening for diabetes
- Urinalysis
- *Additional lab tests can also be drawn and sent to an outside lab for processing*

Employees, spouses, and dependents ages 2 and older who are on the medical plan are eligible to use the virtual and in-person services provided at any of the CEBT Health & Wellness Centers. Services include primary and preventive care such as annual physicals, school and sports physicals, wellness visits, chronic condition coaching, and health coaching. There is no cost to patients for services delivered at the health centers (non-preventative, in-person visits are \$45 for members on the HDHP only).



CEBT Health & Wellness Centers
To view locations or schedule an appointment, visit:
my.marathon.health

The care you receive by Marathon Health is confidential and protected by state and federal law.
*These services are representative and do not constitute a comprehensive list of all available offerings.

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02052025ALL



Lantern is a supplemental benefit for non-emergency surgeries which provides high-quality care, concierge-level member service and lower costs. CEBT wants members to get the best care possible and will limit or waive member's out-of-pocket costs if you use Lantern. This benefit is available to those enrolled in the CEBT EPO Select, PPO4, or HDHP5 medical plans. Click [here](#) to learn more.



Lighting Your Path to the Right Surgical Care

What is Lantern?

Lantern can help you get the best care when you need planned, non-emergency surgery. This money-saving benefit is available at no additional cost to you as part of your benefits.

Here's What's Covered

In partnership with CEBT, we cover the most expensive costs associated with surgery, so you'll pay less for your procedure when you use your Lantern benefit. Your coverage includes:*

- Dedicated support and guidance
- Personalized matching with the best surgeon for your unique needs
- Consults and appointments with your Lantern surgeon
- Anesthesia, procedure and facility (hospital) fees

Let Us Guide You Back to Health

3 Steps to the Best Care

STEP 1

Call a Care Advocate to get started. They'll share more information about your benefits and ask about the care you're looking for.

STEP 2

Based on your needs, your Care Advocate will match you with a hand-picked list of excellent surgeons.

STEP 3

After you choose a surgeon, your Care Advocate will help set up appointments and guide you through every step of the experience.

Call Us to Learn More at (855) 200-6675

* Testing, scans, imaging, durable medical equipment, and physical therapy expenses may not be included. However, coverage may be available through your medical plan.
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In the event of a medical emergency, call 911 or visit your nearest emergency room.





CEBT
Benefit by Trust



Frequently Asked Questions

You can be sure you're getting the best surgical care with Lantern. And here's the best part: it's already included as part of your coverage through your employer. Learn how this money-saving benefit can work for you.

What does Lantern cover?

- Dedicated support and guidance
- Personalized matching with the best surgeon for your unique needs
- Consults and appointments with your Lantern surgeon
- Anesthesia, procedure and facility (hospital) fees

How do I access the benefit?

If you have questions about the benefit, or if you or one of your dependents need surgery, you may be required to work with one of our surgeons, so make us your first call. To learn more, contact your Lantern Care Advocate today at (855) 200-6675.

Does Lantern cost me anything?

You're automatically enrolled in the benefit as part of the medical benefits offered by CEBT at no additional cost to you.

Who will help me through this process?

Your benefit includes guided access from a Lantern Care Advocate who will:

- Provide personalized support throughout your surgical journey.
- Educate you on the benefit, with an understanding of your surgical need.
- Provide you with the resources to help you make the best decisions regarding your care, including how to find the best surgeon in our network.

How do I know if a surgery is covered?

Contact us at (855) 200-6675 to confirm whether your procedure is covered.

How do I find the right surgeon?

With an understanding of your healthcare needs, your Care Advocate will provide a list of the best surgeons in our network so you can choose the one that's right for you.

If I already have a surgeon, how do I know if they are in the Lantern network?

Call your Care Advocate and they will be able to confirm whether your current surgeon is in our network.

What will my surgery cost?

Many Lantern members pay little-to-nothing out of pocket for their procedure. To maximize your savings, call your Care Advocate as soon as possible to confirm the details of your benefit and what you'll be responsible for covering, if anything.

What happens after my surgery?

Your Care Advocate will follow up and ensure you received the highest quality care and schedule any post-procedure appointments.

What isn't covered by Lantern?

Testing, scans, imaging, durable medical equipment, and physical therapy expenses may not be included. However, coverage may be available through your medical plan.

Call us to learn more at:

(855) 200-6675



TELADOC

Teladoc
HEALTH

Teladoc provides 24/7/365 access to U.S. board certified doctors through the convenience of phone or video consults for members on the **EPO Select, PPO4, & HDHP5**. It's an affordable alternative to costly urgent care and ER visits when you need care fast. CEBT pays for the full cost of the consult so there is **NO COPAY** for members on the **EPO Select, PPO4, & HDHP5**. Click [here](#) to learn more.



Skip the trip to the ER.
Talk to a doctor by phone or video.

When it's not an emergency, you've got Teladoc. Our doctors are here for you 24/7, by phone or video.



Avoid the long wait times of an urgent care or the ER



Our licensed physicians help with conditions like the flu, bronchitis, rashes, sinus infections, and more



Talk to a doctor from wherever you are for free

Feel better for free without leaving the house.

Visit Teladoc.com/CEBT | Call 1-800-TELADOC (835-2362)

Download the app



Made available by
CEBT
Benefit by Trust

SAVINGS

Healthcare Bluebook is a cost transparency tool that members can use to shop for healthcare and get rewarded! If a member uses the service and visits a green or fair price provider, they could receive a reward in the form of a debit card varying from \$25-\$1,500. Click [here](#) to learn more.

You're probably overpaying for care and don't even know it

Prices for the same procedure can vary up to 500% depending on where you go. It's true!

With Healthcare Bluebook you can see price information on hundreds of procedures in your area with a simple search. Plus, you can earn rewards for using **Fair PriceSM** (green) facilities. Get paid to save... It's easy!



SAVINGS

Same procedure, different facilities.
The choice is clear!



Check It Out:

healthcarebluebook.com/cc/CEBT

800-341-0504

Download the App:



Mobile Code: CEBT



Take a minute to walk through these simple instructions, so that you have quick access to Healthcare Bluebook on all your devices. Anytime, anywhere!

1 IT PAYS TO BE PREPARED... GEAR UP! BE EMPOWERED!

On your PC, laptop and tablet:
Login to Healthcare Bluebook and bookmark the search page for quick access.

healthcarebluebook.com/cc/CEBT

On your mobile phone:
Download the app and login so you'll have Bluebook with you anytime you need to schedule a procedure.

Mobile Code: CEBT



3 USE HEALTHCARE BLUEBOOK AND KNOW WHERE TO GO

Search for your procedure in Healthcare Bluebook, use a **Fair Price™** (green) facility, and save big bucks on care, and get a reward.



- GO HERE**
- Reasonable Rates Imaging Center (~ 2 miles)
 - XTRA Imaging (~ 3 miles)
- NOT HERE**
- Too Much Medical Center (~ 1 mile)

FOR EXAMPLE PURPOSES

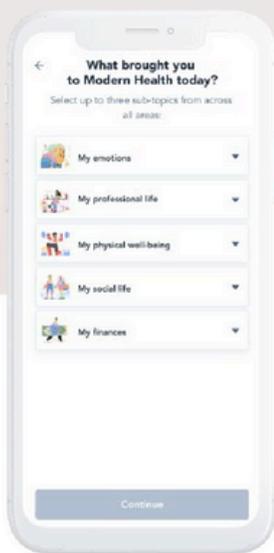


MENTAL HEALTH RESOURCES

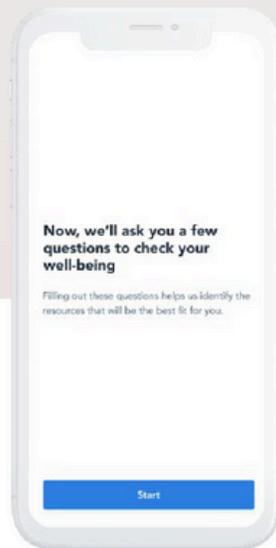


We recognize that many things can impact how we show up day-to-day—including our emotions, careers, relationships, health, and finances. ModernHealth makes it simple for you to get support in the areas that matter most to you. [Click here](#) to learn more.

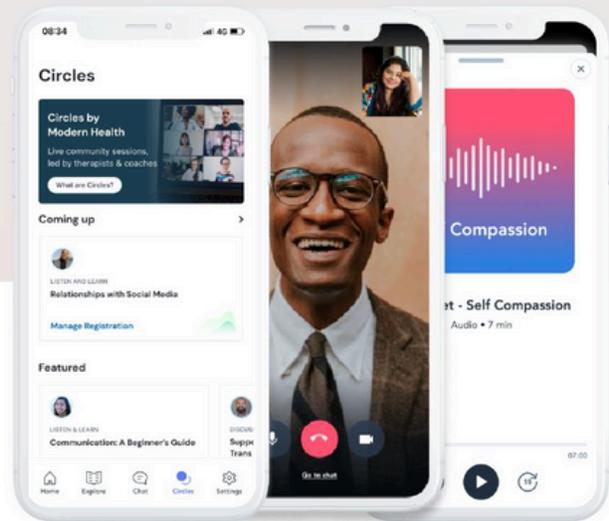
Once you register for Modern Health, you will receive some guidance below that can help you determine which level of care may be best for your unique needs.



1. Let us know what you'd like help with.



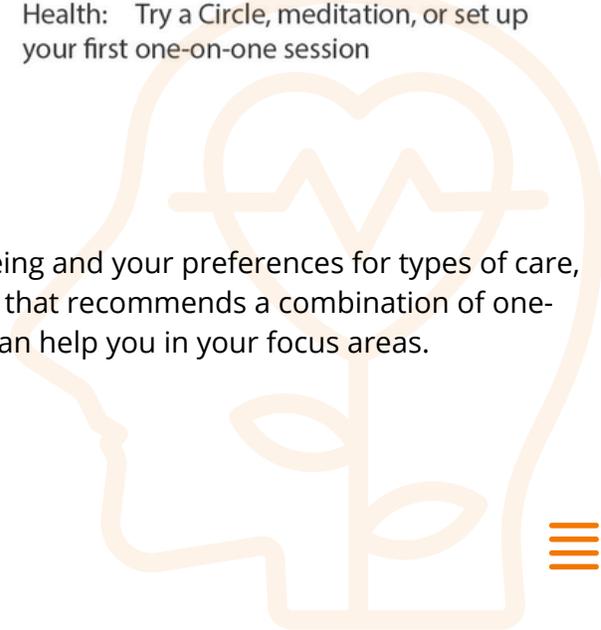
2. Let us know how you're doing.



3. Check out ways you can use Modern Health: Try a Circle, meditation, or set up your first one-on-one session

What Modern Health offers

Once you answer a few questions about your well-being and your preferences for types of care, Modern Health will develop a personalized care plan that recommends a combination of one-on-one, group, and self-serve digital resources that can help you in your focus areas.



Your CEBT Benefits Through Modern Health:

Care options	What is this?	How can this help?	What's included?	How to access:
<u>Guided Meditations</u>	Guided, silent, or music-based meditations	Practice mindfulness and find calm, in just 5 minutes per day, on your own schedule	Unlimited access	Access through the Modern Health web or mobile app <u>here</u>
<u>Digital Programs</u>	Topical wellness programs and exercises	Build mental health into your routine, in just 5 minutes per day, on your own schedule	Unlimited access	Access through the Modern Health web or mobile app <u>here</u>
<u>Circles</u>	Live, topic-based community sessions led by therapists and coaches	Learn, share, connect, and heal with others on topics that impact our well-being	Unlimited access	Access through the Modern Health web or mobile app <u>here</u>
<u>Coaching</u>	1-1 video sessions with certified coaches who help you gain awareness and move toward goals	Learn evidence-based techniques from coaches specializing in mental health, parenting, work, relationships, financial well-being, and more.	8 sessions per year	Access through the Modern Health web or mobile app <u>here</u>
<u>Therapy</u>	1-1 video sessions with licensed therapists	Receive treatment for concerns that may be highly impacting your day-to-day mental health	8 sessions per year	Access through the Modern Health web or mobile app <u>here</u>

Start for free today!

Scan this QR to get started. Or visit my.modernhealth.com.
Company code: CEBT



MENTAL HEALTH RESOURCES

LFRA cares about your total well-being. This is why as a retiree, you have access to Dr. Teresa Richards and the Peer Support Team indefinitely.

Staff Psychologist

Dr. Teresa Richards is a Licensed Psychologist that has worked with Loveland firefighters, police officers, and civilian staff since 2014. She provides free and confidential psychological services to all LFRA employees and their immediate family members, including individual and couples' therapy, for work-related and personal concerns. Dr. Richards is also the Clinical Supervisor for LFRA's Peer Support Team and provides monthly training for the team.



Contact Dr. Richards

Office: (970) 962-2040

Email: teresa.richards@LFRA.org

Cell (for urgent needs): (970) 420-2793

Peer Support Team (PST)

Traditionally, emergency services personnel have turned to each other for support. Peer counseling is based upon the philosophy that often the best person to help is another person in the same career. Acting under the guidance and oversight of the Staff Psychologist, members of the Peer Support Team are specifically trained in peer support and are available to all employees of the Authority and their immediate families. Issues discussed during peer support, on-scene support, and other PST interactions are considered confidential within the limits of C.R.S. 13-90-107(m).



Contact Peer Support

For a list of Peer Support Team members and contact information, [click here](#)



Digital Disease Management Program



Omada is a virtual care program that combines data-powered human coaching, connected devices, peer support and tailored curriculum to help members achieve their health goals and make sustainable lifestyle changes. The digital care solution offers four programs that focus on pre-diabetes (prevention), diabetes, hypertension, & musculoskeletal issues. Click [here](#) to learn more.

NEW: Omada® now supports weight loss, joint & muscle pain, diabetes, and high blood pressure.

Create lasting change with Omada.
All at no cost to you.

What you'll get with Omada:

- ✓ Dedicated health coach & care team
- ✓ Interactive weekly lessons
- ✓ Smart devices, delivered to your door
- ✓ Healthier lifestyle in 10 minutes a day | anywhere, anytime
- ✓ Long term results through habit & behavior change

Do what works for you

Find healthy habits and routines that work for you.

24/7 access to support

From weekly lessons to online community, get all the tools you need to face any challenge head-on.

You decide what 'healthy' means

Try new things you actually enjoy, rather than avoiding foods you "can't eat" or things you "shouldn't do."

The best part?

If you or your family member (18+ for prevention, diabetes, hypertension programs, 13+ for joint and muscle health) are on a CEBT PPO or EPO medical plan and are eligible for any of the Omada programs offered by CEBT, your membership is covered. Members on HDHP plans may have a small fee for the Omada Joint and Muscle Health program.

It only takes a few minutes to get started:

omadahealth.com/cebt

With Omada, there's a program for you



Weight loss & overall health



Joint & muscle pain



Diabetes



High blood pressure

CEBT
Benefit by Trust



Shift your mindset, *change* *your health*



Remove the barriers between you and recovery with Omada® for Joint & Muscle Health.

What you'll get:

- ✓ A dedicated licensed Physical Therapist
- ✓ Treatment plan from head to toe
- ✓ Unlimited 1:1 chats and video visits with your PT
- ✓ Free exercise kit with all the tools you need

Do what works for you

Find healthy habits and routines that work for you.

24/7 access to support

From weekly lessons to online community, get all the tools you need to face any challenge head-on.

You decide what 'healthy' means

Try new things you actually enjoy, rather than avoiding foods you "can't eat" or things you "shouldn't do."

The best part?

If you or your family member (13+) are on a CEBT PPO or EPO medical plan and are eligible for any of the Omada programs offered by CEBT, your membership is covered. Members on HDHP plans may have a small fee for the Omada Joint and Muscle Health program.

It only takes a few minutes to get started:

omadahealth.com/cebt

With Omada, there's
a program for you



Joint & muscle
health

CEBT
Benefit by Trust

*The program features described are specific to the complete version of Omada for Joint & Muscle Health, which includes a physical therapist. Members not experiencing a relevant injury or musculoskeletal condition may instead receive a preventive version of Omada for Joint & Muscle Health, which includes different features and does not include a physical therapist.





A UnitedHealthcare Company

UMR CANCER RESOURCE SERVICES (CRS)

A program designed for personal support following a cancer diagnosis. Cancer Resource Services (CRS) will provide guidance, direction, and support through tenured oncology nurses as well as access to quality Cancer Centers of Excellence (COE).



Personal support following a complex cancer diagnosis

Effective treatment of advanced cancers can be complicated, involving multiple health care providers and procedures over an extended period of time.

Cancer Resource Services (CRS), provided through your benefits plan, can help coordinate all aspects of your care, so you can focus on your health and achieve the best outcome possible.

Participants in this program are assigned a personal case manager who will treat you as a person, not a condition. Our case managers are registered nurses with experience in cancer care and will serve as your advocate through the conclusion of your treatment.

This includes:

- Taking time to guide you through the complexities of cancer care and your treatment options
- Helping you manage your symptoms and common side effects from chemotherapy and other medications
- Working directly with your benefits plan to determine whether certain procedures or clinical trials will be covered
- Providing assistance in accessing care through an Optum Cancer Centers of Excellence (COE) facility
- Making sure you and your family have the support network you need on your road to recovery

Connect with UMR CARE

If you plan to seek services from Roswell in New York or Huntsman in Utah, you must enroll with UMR CARE. If you are not accessing one of these facilities, we still encourage you to contact the UMR CARE team to help connect you with the appropriate care for your situation.

Please call the number on the back of your health plan ID card to reach UMR CARE.



Optum Cancer COEs deliver

Optum's national network of leading cancer centers offers:

- Expertise in rare and complex cancers
- Expanded treatment options
- Shorter stays and fewer complications
- Improved outcomes and financial savings





A UnitedHealthcare Company

UMR MATERNITY CARE

Get the support you need when considering having a baby, or you are already expecting. UMR Maternity CARE can explain how to reduce your risk of complications and prepare you to have a successful, full-term pregnancy and a healthy baby.



Is your family growing?

Get the support you deserve

Whether you are considering having a baby or are already expecting, UMR Maternity CARE can explain how to reduce your risk of complications and prepare you to have a successful, full-term pregnancy and a healthy baby.

How we can help

Healthier women are more likely to have healthy babies. If you're thinking about starting a family, our experienced OB/GYN nurses will help you understand your personal health risks and empower you to take action before you become pregnant. When the time arrives, our registered nurses will support you with timely prenatal education and follow-up calls, and will refer you to case management if a serious condition arises. Your CARE nurse will call you each trimester during your pregnancy and once after your baby is born.

If you are pregnant and are identified as high-risk, a CARE nurse will monitor your condition and work to reduce your claims costs throughout your pregnancy and the post-delivery period.

You can self-enroll in Maternity CARE or pre-pregnancy coaching, or you'll be contacted and invited to participate if you're identified as pregnant through a clinical health risk assessment, utilization review or other program referrals.



It pays to participate

You'll receive an incentive gift* as a thank you for participating in the program, sent to you after your delivery.

* To be eligible for the free incentive gift you must enroll during your first or second trimester and continue to actively participate in the program each trimester of your pregnancy.





A UnitedHealthcare Company

UMR MATERNITY CARE

Once enrolled, you'll receive ...

One-on-one phone calls with a nurse who:

- Provides comprehensive pre-pregnancy and prenatal assessments
- Shares educational information before you become pregnant and throughout your pregnancy
- Encourages you to call with any questions or concerns and continues to reach out each trimester and again after your delivery to see how you and your baby are doing
- Sends a courtesy letter informing your physician that you're in the program

Guidance for your support person:

You may also choose to identify a support person who can receive an education call and electronic educational packet. The packet includes information to help them support you through your pregnancy, labor and delivery, and postpartum.

No-cost educational materials in the mail:

You can choose from a selection of high-quality books and other materials containing helpful information about pregnancy, pre-term labor, childbirth, breast-feeding and infant care.

CARE ON THE GO:

The CARE app, powered by Vivify Health, allows us to meet members where they are by connecting them to CARE nurses through their mobile device. Our nurses can view individual health metrics from self-reported data or synchronized monitoring devices and are able to virtually connect with members by text, email or face-to-face via streaming video. It's free and confidential.

No cost:

Maternity CARE is a valuable benefit provided by your employer at no additional cost to you.

Confidential:

UMR takes confidentiality very seriously. It's important to know that we won't share any identifiable, personal health information with your employer. Your employer receives group information only. UMR CARE programs operate in compliance with all federal and state privacy laws.

GET STARTED



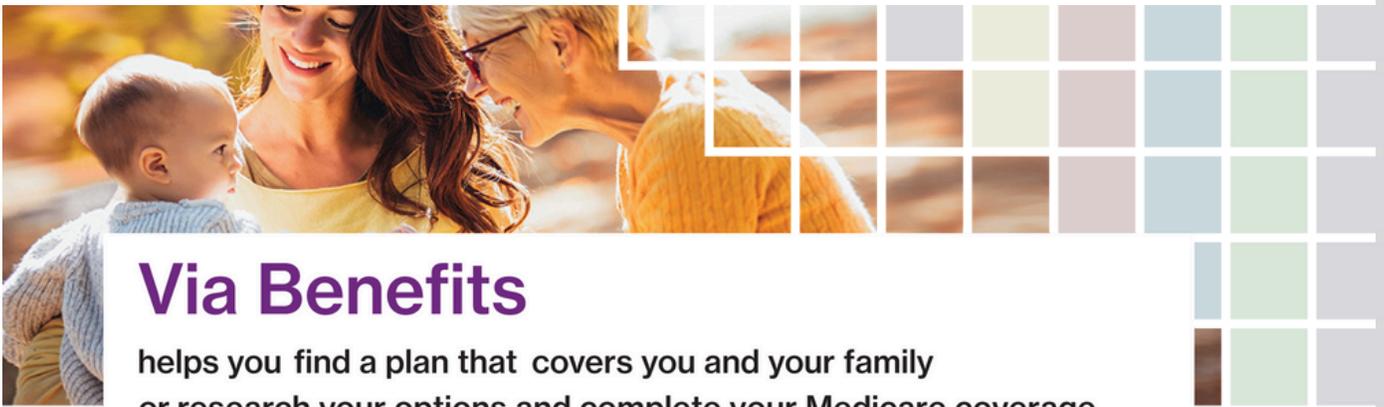
Your first step is to enroll in the Maternity CARE program.

Call 1-888-438-8105 OR **Scan the QR code** to complete the enrollment form online.



Post-Employment Benefits Concierge

Via Benefits offers a post-employment benefit concierge service to assist former employees that have terminated (or are planning to terminate) from CEBT coverage. Plans offered include Pre-65 plans from the individual marketplace as well as Post-65 Medicare Advantage plans and Medicare Supplemental plans. Former employees will now have more options and flexibility to choose coverage that is right for them, secure long-term stability, and unlock potential for cost savings. This service is at no cost to you. Click [here](#) to learn more.



Via Benefits

helps you find a plan that covers you and your family
or research your options and complete your Medicare coverage

When you use Via Benefits you get access to:

-  An easy-to-use online experience
-  Friendly phone support
-  A robust recommendation engine
-  Efficient, accurate enrollment
-  Objective guidance
-  Support after you enroll



Go online to find plans:

Pre-65: marketplace.viabenefits.com/ColoradoPublicEmployers

Post-65: my.viabenefits.com/ColoradoPublicEmployers

Call, and ask for Via Benefits

833-414-1452 (TTY:711)

Monday through Friday, 6:00 a.m. until 7:00 p.m. Mountain time



CONTACT INFORMATION

To learn more about your benefits, use the contact information below.

Medical, Dental, Vision - CEBT	
Member Services	303-773-1373 or 1-800-332-1168
Website	www.cebt.org

CVS Caremark	
Mail Order	866-885-4944
Website	www.caremark.com

Teladoc	
Member Services	1-800-Teladoc (835-2362)
Website	https://www.cebt.org/teladoc

Healthcare Bluebook	
Member Services	1-800-341-0504
Access Code	CEBT
Website	https://www.cebt.org/healthcare-bluebook

Lantern	
Member Services	1-855-200-6675
Website	https://www.cebt.org/lantern

Omada Health - Digital Disease Management Program	
Member Services	888-409-8687
Website	https://www.cebt.org/omada

UMR Cancer Resource Services Program	
Member Services	866-494-4502

CEBT Health and Wellness Centers	
Greeley Address	4675 W. 20th Street Road, Unit B Greeley, CO 80634
Greeley Phone#	970-373-4625
Loveland Address	2889 N. Garfield Ave, Loveland, CO 80538
Loveland Phone#	970-744-2866

Via Benefits	
Pre-65 Website	marketplace.viabenefits.com/ColoradoPublicEmployers
Post-65 Website	my.viabenefits.com/ColoradoPublicEmployers
Phone	833-414-1452



CONTACT INFORMATION

Peer Support Team	
Peer Support Team	Members and Contact Information
Dr. Teresa Richards	970-962-2040 (o); 970-420-2793 (c)

LFRA Human Resources	
Email	LFRAHumanResources@lfra.org
Matt Ledbetter, HR Assistant	970-962-3199
Amy Meyer, HR Coordinator	



CEBT HEALTH PLAN REGULATORY NOTICES

As part of federal requirements, employers and health plan sponsors are required to supply benefit eligible members with communications containing information of their rights, opportunities, and obligations in regard to their health benefit plan. The following notices are available on the CEBT Website and meet the Plan requirements for these regulatory notices. Each notice listed has a direct link to the document on the website for easy accessibility.

BENEFIT BOOKLETS

<https://www.cebt.org/benefit-booklets>

SPD – Summary Plan Description is the full written plan document for each separate plan.

SBC – Summary of Benefits and Coverage is a summary outlining the primary benefits of each separate plan as required by the Affordable Care Act.

HIPAA NOTICE OF PRIVACY POLICY

- This notice describes CEBT’s policies and practices with respect to disclosing Protected Health Information (“PHI”). (Go to “Compliance Notices”.)



The following notices are located here:

<https://cebt.org/resources/resource-center>

COBRA GENERAL RIGHTS NOTICE

- This notice provides newly covered individuals with their rights to COBRA continuation coverage if/when their coverage should terminate.

ANNUAL & OTHER REGULATORY NOTICES

- The Annual Notice is a booklet of compiled notices which are to be distributed annually to meet the employer and Plan Sponsor federal notice requirements. The notices included in this booklet are:
 - Patient Protection Disclosure
 - Women’s Health and Cancer Rights Act
 - The Newborns’ and Mothers’ Health Protection Act
 - Genetic Information Nondiscrimination (GINA) Act
 - Notice of Adverse Benefit Determination
 - Notice of Final Internal Adverse Benefit Determination
 - Notice of External Review Decision
 - HIPAA Special Enrollment Notice
 - Premium Assistance Under Medicaid and Children’s Health Insurance Program (CHIP)
 - COBRA Continuation of Coverage Rights
 - HIPAA Notice of Privacy Practices
 - Medicare Part D Notice of Creditable Coverage
 - Marketplace Coverage Options
- Other Regulatory Notices include:
 - Section 1557-Nondiscrimination Notice
 - CEBT 2022 No Surprise Billing Notice
 - Medicaid and the Children’s Health Insurance Program (CHIP) Notice



ATTACHMENT A

RETIREE MEDICAL INSURANCE PROGRAM *Election and Payment Procedures*

Effective June 27, 2018

Retired employees of the Loveland Fire Rescue Authority ("**Authority**") are eligible to elect coverage in the Authority's medical insurance plan pursuant to Authority Resolution R-90 Establishing a Retiree Medical Insurance Program, subject to the election and payment procedures set forth below.

1. Election and Initial Payment

Coverage must be elected within 30 days following the loss of CEBT coverage as an LFRA employee. When coverage is elected, the retiree has 45 days from the date of the election to pay the initial premiums, plus a 2% Authority administrative fee. Once the initial premium payment is received, the Authority will notify the insurance carrier to instate coverage back to the initial effective date. If the initial payment for coverage is not made in full within 45 days after the date of election, or a payment is submitted but is returned or denied for insufficient funds or other reason, or cannot be processed before the expiration of the grace period, coverage will be cancelled and the retiree will no longer be eligible to participate in the plan.

2. Subsequent Monthly Payments

The current premium amounts are shown on the Retiree Health Insurance Premium Rates document available from the Authority's Human Resources office. Premium amounts may change in the future. Any participating retiree will be notified of any premium changes. Monthly payments, including premiums and the 2% Authority administrative fee, are due to the Authority at the address identified in section 4 on the first day of each month for that month's coverage.

Reminder statements may be provided as a convenience. It is the retiree's responsibility to remit the correct monthly amount due on a timely basis, even if the reminder statement has not been received.

3. Grace Periods for Monthly Payments

Although monthly payments are due on the first day of each month of coverage, the retiree will be given a grace period of 30 days after the first day of the month to make each monthly payment. If the payment is hand-delivered or postmarked more than 30 days after the due date, coverage will be cancelled and payment will be refused or refunded. Coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. If a monthly payment is not made before the end of the grace period for the month in which it is due, coverage will be cancelled and the retiree will no longer be eligible to participate in the plan.

4. Remittance Address

Initial and subsequent monthly payments must be mailed or hand-delivered to:



**Loveland Fire Rescue Authority
410 E. Fifth Street
Loveland, CO 80537**

If mailed, payment is considered to have been made on the date it is postmarked. Retirees are advised to hand-deliver any payment if it is uncertain whether the payment will be postmarked by the date due. If hand-delivered, payment is considered to have been made when it is received by the Authority office at the address above.

Weekends and Holidays

If the due date falls on a weekend or Authority-recognized holiday, payment will be accepted the following business day.

Insufficient Funds

Payments will not be considered to have been made by mailing or hand-delivery if the retiree's payment is returned or denied due to insufficient funds or otherwise.





This benefit summary provides selected highlights of the Loveland Fire Rescue Authority benefits program. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment at the Company. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between any information provided through this summary and the actual terms of the policies, contracts and plan documents are governed by the terms of these policies, contracts and plan documents. Loveland Fire Rescue Authority reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The Plan Administrator has the authority to make these changes.