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Benefits

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The information in this guide is a general outline of the benefits offered under the Loveland Fire Rescue Authority’s benefits program. Specific details and plan limitations are provided in LFRA Board Resolution 89 including any associated amendments and the Summary Plan Descriptions (SPD), which is based on the official Plan Documents that may include policies, contracts and plan procedures. The Resolution and Plan Documents contain all the specific provisions of the plans. In the event that the information in this brochure differs from the Resolution or Plan Documents, the Resolution and Plan Documents will prevail.
Benefits Eligibility

LFRA’s current medical and life insurance benefits provider, Colorado Employer Benefit Trust (CEBT) allows participating local government employers to offer life insurance and medical insurance to members of the local government’s governing body.

**LFRA Board Members** currently serving on the Authority Board are eligible to elect coverage in the Authority’s medical insurance plan at any coverage level provided by the plan (for example individual, individual + spouse, individual + child(ren), or individual + family), as well as in a CEBT life insurance plan available to Board members.

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

- Your legal spouse including civil union partners
- Your children up to age 26, regardless of student, marital, or tax dependent status (including step, foster, adopted, or a child for whom you are the legal guardian)
- Your dependent children of any age who are physically or mentally unable to care for themselves.

*A Board member who terminates coverage in the plan after enrolling will no longer be eligible to participate in the plan until the next open enrollment period or qualifying event*.

**Enrollment**

You can sign up for benefits or change your benefit elections at the following times:

- Within 30 days of your initial eligibility date as a new LFRA Authority Board member.
- During the annual benefits open enrollment period; benefits are effective January 1 of the following year.
- Within 30 days of experiencing a qualifying life event; benefits are effective the date of your qualifying event.

The choices you make will remain the same through December 31 of the plan year unless you experience a qualifying life event*.

**Changing Your Benefits During the Year**

Due to IRS regulations, once you have made your medical, dental and vision plan elections for the plan year, you cannot change your benefits until the next annual open enrollment period. The only exception is if you experience a qualifying life event*. Election changes must be consistent with your life event and you may need to provide documentation dependent upon the type of event.

To request a benefits change, contact **LFRA Human Resources** within 30 days of the qualifying event*. Change requests received after 30 days cannot be accepted.

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*Qualifying life events include, but are not limited to:

- Marriage, divorce, or legal separation
- Birth or adoption of an eligible child
- Death of your spouse or covered child
- Qualified Medical Child Support Order
- Change in your child’s eligibility for benefits
- Change in your spouse’s work status that affects their benefits
Medical Insurance Plans

LFRA offers three (3) medical plan options through the Colorado Employer Benefit Trust (CEBT).

- **Exclusive Provider Organization (EPO)** plan offers in-network benefits only for most services – however along with the lowest premium cost, you’ll discover [United Healthcare](https://www.unitedhealthcare.com) has a large network of providers to choose from.
- **Preferred Provider Organization (PPO)** plans have higher premium costs however, offer both in- and out-of-network benefits.

**Monthly Medical Insurance Plan Costs**

LFRA Board Members 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 to the Authority, pursuant to the payment procedures set forth in Attachment A – such procedures may be amended from time to time. Except as otherwise required by federal or state law, failure to make payments as directed will result in termination from the plan.

<table>
<thead>
<tr>
<th>Plan</th>
<th>BOARD MEMBER PAYS (monthly)</th>
<th>CEBT PREMIUM (monthly)</th>
<th>2% LFRA Admin. Fee (monthly)</th>
</tr>
</thead>
<tbody>
<tr>
<td>EPO4 Plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$706.86</td>
<td>$693.00</td>
<td>$13.86</td>
</tr>
<tr>
<td>Individual + Spouse</td>
<td>$1,553.46</td>
<td>$1,523.00</td>
<td>$30.46</td>
</tr>
<tr>
<td>Individual + Child(ren)</td>
<td>$1,482.06</td>
<td>$1,453.00</td>
<td>$29.06</td>
</tr>
<tr>
<td>Family</td>
<td>$1,760.52</td>
<td>$1,726.00</td>
<td>$34.52</td>
</tr>
<tr>
<td>PPO4 Plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$778.26</td>
<td>$763.00</td>
<td>$15.26</td>
</tr>
<tr>
<td>Individual + Spouse</td>
<td>$1,710.54</td>
<td>$1,677.00</td>
<td>$33.54</td>
</tr>
<tr>
<td>Individual + Child(ren)</td>
<td>$1,634.04</td>
<td>$1,602.00</td>
<td>$32.04</td>
</tr>
<tr>
<td>Family</td>
<td>$1,945.14</td>
<td>$1,907.00</td>
<td>$38.14</td>
</tr>
<tr>
<td>PPO2 Plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$1,026.12</td>
<td>$1,006.00</td>
<td>$20.12</td>
</tr>
<tr>
<td>Individual + Spouse</td>
<td>$2,258.28</td>
<td>$2,214.00</td>
<td>$44.28</td>
</tr>
<tr>
<td>Individual + Child(ren)</td>
<td>$2,156.28</td>
<td>$2,114.00</td>
<td>$42.28</td>
</tr>
<tr>
<td>Family</td>
<td>$2,571.42</td>
<td>$2,521.00</td>
<td>$50.42</td>
</tr>
</tbody>
</table>

**Medical Benefits Plan Comparison**

The table on the next page summarizes the key features of the medical plans offered by LFRA. Please refer to the [official plan documents](https://www.lfrafires.org) for additional information on coverage and exclusions.
<table>
<thead>
<tr>
<th>Medical Base Plan</th>
<th>PPO2</th>
<th>PPO4</th>
<th>EPO4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visit (Primary</td>
<td>Specialty)</td>
<td>$30 Copay</td>
<td>$30 Copay</td>
</tr>
<tr>
<td>Deductible (Single</td>
<td>Family)</td>
<td>$600</td>
<td>$1,200</td>
</tr>
<tr>
<td>Coinsurance (In</td>
<td>Out)</td>
<td>20% In</td>
<td>40% Out</td>
</tr>
<tr>
<td>Out of Pocket Single (In</td>
<td>Out)</td>
<td>$3,500</td>
<td>$7,000</td>
</tr>
<tr>
<td>Out of Pocket Family (In</td>
<td>Out)</td>
<td>$7,000</td>
<td>$14,000</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>Deductible + 20% to COP Max</td>
<td>Deductible + 20% to COP Max</td>
<td>$1,500 Copay</td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>Deductible + 20% to COP Max</td>
<td>Deductible + 20% to COP Max</td>
<td>$1,000 Copay Amb Surg Center $500 Copay</td>
</tr>
<tr>
<td>Rx Retail</td>
<td>Generic $20</td>
<td>Preferred $40</td>
<td>Non-Preferred $60</td>
</tr>
<tr>
<td>Rx Mail Order</td>
<td>2 X Copay</td>
<td>2 X Copay</td>
<td>2 X Copay</td>
</tr>
<tr>
<td>Preventative Visit</td>
<td>Covered 100%</td>
<td>Covered 100%</td>
<td>Covered 100%</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>$30 Copay</td>
<td>20 Visits per year</td>
<td>$40 Copay</td>
</tr>
<tr>
<td>Teledoc</td>
<td>Covered 100%</td>
<td>Covered 100%</td>
<td>Covered 100%</td>
</tr>
<tr>
<td>Telhealth</td>
<td>$30 Copay</td>
<td>$40 Copay</td>
<td>Applicable copay applies</td>
</tr>
<tr>
<td>Advanced Imaging</td>
<td>Deductible + 20% to COP Max</td>
<td>Deductible + 20% to COP Max</td>
<td>$750 Copay Freestanding facilities $400 Copay</td>
</tr>
<tr>
<td>X-ray</td>
<td>$30 Copay office setting</td>
<td>Outpatient setting</td>
<td>Deductible + 20% to COP Max</td>
</tr>
<tr>
<td>Lab</td>
<td>$30 Copay</td>
<td>$40 Copay</td>
<td>$45 Copay</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$75 Copay</td>
<td>$75 Copay</td>
<td>$75 Copay</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>Deductible + 20% to COP Max</td>
<td>Deductible + 20% to COP Max</td>
<td>$250 Copay</td>
</tr>
</tbody>
</table>
Medical Insurance *(continued)*

**Preventative Care**

The CEBT medical plans cover in- and out-of-network eligible charges for preventative care at 100%. This includes routine screenings, checkups, and immunizations in an effort to prevent illness, disease, or other health problems.

**Medication**

When you enroll in CEBT insurance, your prescription coverage program is provided by CVS Caremark. You can have a 90-day supply of your maintenance medication refilled at a 90-day network pharmacy for two times the retail copay.

**Health & Wellness Center**

CEBT, in partnership with Marathon Health, offers those enrolled in CEBT insurance expanded health and wellness services at no extra charge. The Centers are staffed by full-time licensed Physician Assistants (PA) and/or Nurse Practitioners (NP) and Medical Assistants.

There is absolutely no cost for any type of visit at a Center (including prescriptions dispensed onsite). Charges for any services not performed within the Centers will be submitted to your health plan by the Center provider and processed as any other claim (i.e. lab work sent offsite, prescriptions written to a pharmacy of your choice, x-rays, MRI’s, or referrals to providers outside the Center).

See more information on the following page.

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**Northern CO Locations**

**Loveland**

2889 N. Garfield Ave.
970-744-2866

**Greeley**

4675 W. 20th Street Rd., Unit B
970-373-4625

[my.marathon-health.com](http://my.marathon-health.com)
CEBT Health & Wellness Centers

Extensive service offerings to ignite your health journey:

Prevention
- Health Screenings
  - Annual exams
  - Blood pressure
  - Body mass index
  - Cholesterol
  - Glucose
  - School, camp, and sports physicals

Chronic Condition Coaching
- Arthritis
- Asthma
- COPD
- Depression
- Diabetes
- Heart health
- Low back pain
- Sleep apnea
- Educational offerings

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

Medications
- Common medications dispensed onsite
- Other prescriptions sent to pharmacies
- Preventive medications are provided at no charge
- Controlled substances such as narcotics are not dispensed at the health center
- Consultation required with a provider to ensure oversight of your medical treatment

Lab Services
Blood work and lab tests processed at the center include hemoglobin A1C, lipid panel, glucose, rapid strep, mono, urinalysis, oxygen saturation, and pregnancy. Additional lab tests can also be drawn and sent to an outside lab for processing.

Privacy
The care you receive at the CEBT Health & Wellness Centers is confidential and protected by state and federal law.

Eligibility and Cost
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 (sick visits are $45 for members on the HDP only).
Additional Medical Benefits

Teladoc

Teladoc gives 24/7/365 access to U.S. board-certified doctors and pediatricians through the convenience of phone, video or mobile app visits. This is great for many non-emergency illnesses including flu, allergies, sinus infections and more. CEBT members, set up your account today so when you need care, a Teladoc doctor is just a call or click away. To enroll: download the app, click here or call (800) TELADOC (835-2362).

SurgeryPlus

CEBT members can use SurgeryPlus to obtain access to elite surgeons, a full concierge advocacy service, and financial rewards. Under LFRA’s PPO medical plans, CEBT will waive your deductible and coinsurance; under LFRA’s EPO medical plan, CEBT will waive your co-pay. CEBT members, click here for more information or call (855) 200-6675.

Healthcare Bluebook

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 Price (green) facilities. Get paid to save!

*A full list of additional medical benefits, along with information about each offering can be found at CEBT.org under “Partners/Providers”.

Dental Insurance

LFRA offers a dental insurance plan through CEBT/Delta Dental of Colorado. The Delta Dental Plan A offers in-and out-of-network benefits, allowing you the freedom to choose any provider however, you will enjoy the greatest out-of-pocket savings if you see a Delta Dental PPO dentist.

Monthly Dental Plan Costs

LFRA Board Members 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 to the Authority, pursuant to the payment procedures set forth in Attachment A – such procedures may be amended from time to time. Except as otherwise required by federal or state law, failure to make payments as directed will result in termination from the plan.

<table>
<thead>
<tr>
<th>Delta Dental Plan A</th>
<th>BOARD MEMBER PAYS (monthly)</th>
<th>CEBT PREMIUM (monthly)</th>
<th>2% LFRA Admin. Fee (monthly)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$40.80</td>
<td>$40.00</td>
<td>$0.80</td>
</tr>
<tr>
<td>Individual + Spouse</td>
<td>$83.64</td>
<td>$82.00</td>
<td>$1.64</td>
</tr>
<tr>
<td>Individual + Child(ren)</td>
<td>$104.04</td>
<td>$102.00</td>
<td>$2.04</td>
</tr>
<tr>
<td>Family</td>
<td>$140.76</td>
<td>$138.00</td>
<td>$2.76</td>
</tr>
</tbody>
</table>
Dental Insurance  
(continued)

Dental Plan Benefits Summary

The table below summarizes key features of the dental plan. Please refer to the Delta Dental Plan A official plan documents for additional information on coverage and exclusions.

<table>
<thead>
<tr>
<th>MAXIMUM BENEFIT Calendar Year Maximum</th>
<th>$2,000 per member, per calendar year</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALENDAR YEAR DEDUCTIBLE Applies to Basic and Major Services</td>
<td>Individual Deductible - $50 Combination of in and out-of-network. Family Deductible - $150 Combination of in and out-of-network.</td>
</tr>
<tr>
<td>PREVENTION FIRST PPO and Premier Networks Only</td>
<td>Diagnostic and Preventive services do not count against the annual maximum when you see a PPO or Premier provider for all services.</td>
</tr>
<tr>
<td>RIGHT START 4 KIDS PPO and Premier Networks Only</td>
<td>Covers children up to their 13th birthday at 100% with no deductible (for the same services outlined in the plan, up to the annual maximum, and subject to limitations and exclusions). The child must see a Delta Dental PPO or Premier provider to receive the 100% coinsurance. If an out-of-network provider is seen, the adult coinsurance levels will apply. Orthodontics, if selected as part of the group's plan, is not covered at 100% but at the plan's listed coinsurance.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PPO Dentist</th>
<th>Premier Dentist</th>
<th>Non-Par Dentist</th>
<th>COVERED SERVICES</th>
<th>BENEFIT INFORMATION (subject to Delta Dental guidelines)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DIAGNOSTIC AND PREVENTIVE SERVICES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Exams and Cleanings</td>
<td>Twice each in a calendar year. Two additional cleansings may be covered for those with a documented Evidence Based Dentistry (EBD) condition.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Periodontal Maintenance</td>
<td>Limited to 4 in a calendar year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sealants</td>
<td>Once per tooth in a 36-month period for unrestored permanent molars, through age 13.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bitewing X-Rays</td>
<td>Once in a calendar year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full Mouth X-Rays</td>
<td>Once in a 5-year period</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluoride</td>
<td>Twice in a calendar year, through age 15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Space Maintainers</td>
<td>One per quadrant, per lifetime to maintain space for eruption of permanent posterior teeth, through age 13</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIC SERVICES** (including occlusal guards)

| 80% | 80% | 80% |
| Fillings | Once per tooth in a 12-month period; composite (white) fillings |
| Simple Extractions |
| Oral Surgery |
| Endodontics/Periodontics |

**MAJOR SERVICES**

| 50% | 50% | 50% |
| Crowns | Once per tooth in 5-year period. Not a benefit under age 12. |
| Implants | Once per tooth in a 5-year period. Not a benefit under age 16. |
| Dentures, Bridges | Once in a 5-year period, only when existing prosthesis cannot be made serviceable. Fixed bridges or removable partials are not a benefit under age 16. |

**ORTHODONTICS $2,000 lifetime maximum**

| 50% | 50% | 50% |
| For covered employee, spouse and children to age 26 |

You are enrolled in a Delta Dental PPO plus Premier plan. You and your family members may visit any licensed dentist but will enjoy the greatest out-of-pocket savings if you see a Delta Dental PPO dentist. There are three levels of dentists to choose from:

- **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.

Members may add coverage once a year at Open Enrollment. Coverage may only be dropped by an employee or dependent with proof of qualifying event. This is a brief description of services covered under your dental plan. Please refer to the Plan Document for full plan details. If differences exist between this summary and the Plan Document, the Plan Document will govern.
Vision Insurance

LFRA offers a vision insurance plan through CEBT/Vision B (VSP). You have the freedom to choose any provider. However, you will maximize the plan benefits when you choose an in-network provider.

Monthly Vision Plan Costs

LFRA Board Members 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 to the Authority, pursuant to the payment procedures set forth in Attachment A – such procedures may be amended from time to time. Except as otherwise required by federal or state law, failure to make payments as directed will result in termination from the plan.

<table>
<thead>
<tr>
<th>BOARD MEMBER PAYS (monthly)</th>
<th>CEBT PREMIUM (monthly)</th>
<th>2% LFRA Admin. Fee (monthly)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$9.18</td>
<td>$9.00</td>
</tr>
<tr>
<td>Individual + Spouse</td>
<td>$12.24</td>
<td>$12.00</td>
</tr>
<tr>
<td>Individual + Child(ren)</td>
<td>$11.22</td>
<td>$11.00</td>
</tr>
<tr>
<td>Family</td>
<td>$20.40</td>
<td>$20.00</td>
</tr>
</tbody>
</table>

Vision Plan Benefits Summary

The table below summarizes key features of the vision plan. Please refer to the Vision B (VSP) official plan documents for additional information on coverage and exclusions.

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>DESCRIPTION</th>
<th>COPAY</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>WELLVISION EXAM</td>
<td>• Focuses on your eyes and overall wellness</td>
<td>$15</td>
<td>Every 12 months</td>
</tr>
<tr>
<td>PRESCRIPTION GLASSES</td>
<td>$150 featured frame brands allowance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FRAME</td>
<td>$80 frame allowance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LENSES</td>
<td>$80 Costco/Walmart frame allowance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lens Enhancements</td>
<td>• Standard progressive lenses</td>
<td>$0</td>
<td>Every 12 months</td>
</tr>
<tr>
<td>CONTACTS (INSTEAD OF GLASSES)</td>
<td>• $160 allowance for contacts; copay does not apply</td>
<td>Up to $60</td>
<td>Every 12 months</td>
</tr>
<tr>
<td>PRIMARY EYECARE</td>
<td>• Retinal screening for members with diabetes</td>
<td>$0</td>
<td>As needed</td>
</tr>
<tr>
<td>EXTRA SAVINGS</td>
<td>• Extra $20 to spend on featured frame brands. Go to vsp.com/offers for details.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glasses and Sunglasses</td>
<td>• 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Retinal Screening</td>
<td>• No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laser Vision Correction</td>
<td>• Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

YOUR COVERAGE WITH OUT-OF-NETWORK PROVIDERS

Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.

Coverage with a retail plan may be different or not apply. Log in to VSP.com to check your benefits for eligibility and to confirm in-network locations based on your plan type. VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization’s contract with VSP, the terms of the contract will prevail. Listed on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.
Life Insurance

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

LFRA Board Members 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 to the Authority, pursuant to the payment procedures set forth in Attachment A – such procedures may be amended from time to time. Except as otherwise required by federal or state law, failure to make payments as directed will result in termination from the plan.

<table>
<thead>
<tr>
<th>Age</th>
<th>BOARD MEMBER PAY (monthly)</th>
<th>Coverage</th>
<th>2% LFRA Admin. Fee (monthly)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under age 65</td>
<td>$2.83</td>
<td>$20,000</td>
<td>$0.20</td>
</tr>
<tr>
<td>65 – 69 years old</td>
<td>$1.70</td>
<td>$12,000</td>
<td>$0.28</td>
</tr>
<tr>
<td>70 – 74 years old</td>
<td>$0.99</td>
<td>$7,000</td>
<td>$0.26</td>
</tr>
<tr>
<td>75 – 79 years old</td>
<td>$0.71</td>
<td>$5,000</td>
<td>$0.48</td>
</tr>
<tr>
<td>80+ years old</td>
<td>$0.58</td>
<td>$4,000</td>
<td></td>
</tr>
</tbody>
</table>
ANNUAL NOTICES - 2022-2023 PLAN YEAR

PATIENT PROTECTION DISCLOSURE

The Colorado Employers Benefit Trust (CEBT) Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the CEBT at (303) 773-1373, (800) 332-1168 or www.cebt.org. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from CEBT or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology contact CEBT at (303) 773-1373, (800) 332-1168 or www.cebt.org.

WOMEN’S HEALTH AND CANCER RIGHTS ACT

The Women’s Health and Cancer Rights Act of 1998 requires group health plans to make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

- 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
- Treatment of physical complications of the mastectomy, including lymphedema

Our plan complies with these requirements. Benefits for these items generally are comparable to those provided under our plan for similar types of medical services and supplies. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by consultation between the attending physician and the patient. Our plan neither imposes penalties (for example, reducing or limiting reimbursements) nor provides incentives to induce attending providers to provide care inconsistent with these requirements. If you would like more information about WHCRA required coverage, you can contact Anthem at the number listed on the back of your ID card.

THE NEWBORNS’ AND MOTHERS’ HEALTH PROTECTION ACT

The Newborns’ and Mothers’ Health Protection Act of 1996 prohibits group and individual health insurance policies from restricting benefits for any hospital length of stay for the mother or newborn child in connection with childbirth; (1) following a normal vaginal delivery to less than 48 hours; and (2) following a cesarean section, to less than 96 hours. Health insurance policies may not require that a provider obtain authorization from the health insurance plan or the issuer for prescribing any such length of stay. Regardless of these standards, an attending health care provider may, in consultation with the mother, discharge the mother or newborn child prior to the expiration of such minimum length of stay.

Further, a health insurer or health maintenance organization may not:

- Deny to the mother or newborn child eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely to avoid providing such length of stay coverage
Provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum coverage
Provide monetary incentives to an attending medical provider to induce such provider to provide care inconsistent with such length of stay coverage
Require a mother to give birth in a hospital
Restrict benefits for any portion of a period within a hospital length of stay described in this notice

These benefits are subject to the plan’s regular deductible and co-pay. For further details, refer to your SPD.

GENETIC INFORMATION NONDISCRIMINATION (GINA) ACT
The Genetic Information Nondiscrimination Act protects applicants and employees from discrimination based on genetic information in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment. GINA also restricts employers’ acquisition of genetic information and strictly limits disclosure of genetic information. Genetic information includes information about genetic tests of applicants, employees, or their family members; the manifestation of diseases or disorders in family members (family medical history); and requests for or receipt of genetic services by applicants, employees, or their family members. Our Plan complies with these requirements.

NOTICE OF ADVERSE BENEFIT DETERMINATION
Employer-sponsored group health plans are required to provide notice of an adverse benefit determination when a claim is first denied.

- In the case of a claim filed after medical services are provided, notice of the adverse benefit determination is required within 30 days of receipt of the claim, except that one 15-day extension is allowed if proper notice of the need for extension is provided.
- In the case of a claim filed before medical services are provided (e.g., if pre-authorization is required to obtain full benefits) the notice of adverse benefit determination with respect to a non-urgent claim is required within 15 days of receipt of a non-urgent Care claim, except that one 15-day extension is allowed if proper notice of the need for extension is provided.
- If the pre-service claim is for urgent care, the notice of adverse benefit determination generally is required within 24 hours of filing.

NOTICE OF FINAL INTERNAL ADVERSE BENEFIT DETERMINATION
Employer-sponsored group health plans are required to provide notice of a final internal adverse benefit determination when internal appeals procedures have been completed. This notice is similar to the notice of decision on appeal. The CEBT plan maintains two levels of internal appeals whereby this model notice is intended for use only after the second internal appeal if it results in an adverse benefit determination.

- In the case of a claim filed after medical services are provided, this notice is required within 60 days after the appeal is first filed (even if the plan has two appeal levels) and no extensions are allowed.
- In the case of a claim filed before medical services are provided (e.g., if pre-authorization is required to obtain full benefits), the notice of final internal adverse benefit determination with respect to a non-urgent claim is required within 30 days after the appeal is first filed (even if the plan has two appeal levels) and no extensions are allowed.
- If the pre-service claim is for urgent care, the notice of final internal adverse benefit determination generally is required within 72 hours after the appeal is first filed (even if the plan has two appeal levels) and no extensions are allowed.
NOTICE OF FINAL EXTERNAL REVIEW DECISION

Employer-sponsored group health plans are required to maintain an external review procedure, for certain types of claim denials, that meets certain requirements, including a notice of final decision. If your claim appeal is denied, you will be provided with a notice that contains a statement describing any voluntary appeal procedures or external review procedures offered by the Plan, including the time limits applicable to such procedures, and the claimant’s right to obtain information about those procedures. For adverse determinations of claim appeals subject to external review, the notice will include information about how to request an independent review through the external review procedure. An independent reviewer will review the matter and issue a written decision of the determination within the applicable timeframes; independent reviews may be subject to expedited review or extensions as necessary and appropriate.

HIPAA SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents’ other coverage). However, you must request enrollment within 30 days after your 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. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Effective April 1, 2009 special enrollment rights also exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or your State Children’s Health Insurance Program (SCHIP) coverage; or
- If you or your dependents become eligible for premium assistance under an optional state Medicaid or SCHIP program that would pay the employee’s portion of the health insurance premium.

Note: In the two above listed circumstances only, you or your dependents will have 60 days to request special enrollment in the group health plan coverage.

As stated earlier in this notice, a special enrollment opportunity may be available in the future if you or your dependents lose other coverage. This special enrollment opportunity will not be available when other coverage ends, however, unless you provide a written statement now explaining the reason that you are declining coverage for yourself or your dependent(s). Failing to accurately complete and return this form for each person for whom you are declining coverage will eliminate this special enrollment opportunity for the person(s) for whom a statement is not completed, even if other coverage is currently in effect and is later lost. In addition, unless you indicate in the statement that you are declining coverage because other coverage is in effect, you will not have this special enrollment opportunity for the person(s) covered by the statement. (See the paragraph above, however, regarding enrollment in the event of marriage, birth, adoption or placement for adoption, loss of eligibility for Medicaid or state CHIP, and gaining eligibility for a state premium assistance subsidy through Medicaid or state CHIP.)

To request special enrollment or obtain more information, contact Loveland Fire Rescue Authority benefits department.
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’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebسا.dol.gov or call 1-866-444-EBSA (3272).

If you live in Colorado, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2022. Contact the State for more information on eligibility.

<table>
<thead>
<tr>
<th>COLORADO-Health First Colorado (Colorado’s Medicaid Program) &amp; Child Health Plan Plus (CHP+)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health First Colorado Website: <a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a></td>
</tr>
<tr>
<td>Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711</td>
</tr>
<tr>
<td>CHP+: <a href="https://www.colorado.gov/pacific/hcpf/child-health-plan-plus">https://www.colorado.gov/pacific/hcpf/child-health-plan-plus</a></td>
</tr>
<tr>
<td>(HIBI): <a href="https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program">https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program</a></td>
</tr>
<tr>
<td>HIBI Customer Service: 1-855-692-6442</td>
</tr>
</tbody>
</table>

To see if any other states have added a premium assistance program since January 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565
COBRA CONTINUATION OF COVERAGE RIGHTS

Under the federal law, known as COBRA, you and your dependents generally may continue medical, dental, and vision if coverage ends due to either:

- A reduction in the number of hours you work or
- Termination of your employment for any reason other than gross misconduct.

Your dependents may continue their medical, dental and vision coverage under this plan if their coverage ends for any of the following reasons:

- Your death
- You become entitled to Medicare
- Your divorce, annulment, or legal separation, provided the company is notified within 60 days
- Your dependent loses dependent status, provided the company is notified within 60 days

This is not a complete description of all COBRA-related provisions. You should consult your SPD for more details.

The following chart shows how long you can continue your COBRA coverage:

<table>
<thead>
<tr>
<th>If you lose coverage because ...</th>
<th>Then you can continue coverage for ...</th>
</tr>
</thead>
<tbody>
<tr>
<td>You are no longer eligible</td>
<td>18 months</td>
</tr>
<tr>
<td>You are no longer eligible and</td>
<td>29 months</td>
</tr>
<tr>
<td>either you or your dependent is</td>
<td></td>
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<tr>
<td>disabled (according to the</td>
<td></td>
</tr>
<tr>
<td>Social Security Administration)</td>
<td></td>
</tr>
<tr>
<td>within 60 days of your loss of</td>
<td></td>
</tr>
<tr>
<td>eligibility</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>If your dependent loses coverage because ...</th>
<th>Then your dependent can continue coverage for ...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Of your death</td>
<td>36 months</td>
</tr>
<tr>
<td>You become eligible for Medicare after your COBRA election begins</td>
<td>36 months</td>
</tr>
<tr>
<td>You and your spouse divorce</td>
<td>36 months</td>
</tr>
<tr>
<td>He or she is no longer a dependent (because of age or divorce)</td>
<td>36 months</td>
</tr>
</tbody>
</table>
HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how you may obtain a copy of the Plan’s Notice of Privacy Practices, which describes the ways that the Plan uses and discloses your protected health information.

CEBT (the “Plan”) provides health benefits to eligible participants of CEBT, and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains, and discloses health information about participating employees and dependents in the course of providing these health benefits. The Plan is required by law to provide notice to participants of the Plan’s duties and privacy practices with respect to covered individuals’ protected health information and has done so by providing to Plan participants a Notice of Privacy Practices, which describes the ways that the Plan uses and discloses protected health information.

To receive a copy of the Plan’s Notice of Privacy Practices you should contact Willis Towers Watson, who has been designated as the Plan’s administrator and contact for all issues regarding the Plan’s privacy practices and covered individuals’ privacy rights. You may also access the Notice of Privacy Practices on CEBT’s website: https://cebt.org/resources/resource-center. You can reach customer service at:

<table>
<thead>
<tr>
<th>CEBT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date: July 2022</td>
</tr>
<tr>
<td>Name of Entity/Sender: CEBT</td>
</tr>
<tr>
<td>Contact-Position/Office: Customer Service</td>
</tr>
<tr>
<td>Address: 555 17th Street Ste 2050</td>
</tr>
<tr>
<td>Denver, CO 80202</td>
</tr>
<tr>
<td>Phone Number: (303) 773-1373 or (800) 332-1168</td>
</tr>
</tbody>
</table>
Important Notice from CEBT
About Your Prescription Drug Coverage and Medicare
Creditable Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with CEBT and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. CEBT has determined that the prescription drug coverage offered by CEBT Plan is, on average for all plan participants expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later to decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current CEBT coverage will not be affected. You can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage; [See pages 7-9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.]

When Will You Pay a Higher Premium (Penalty) To Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with CEBT and don’t join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium
may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage

For further information call Medicare. NOTE: You’ll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through CEBT changes. You may also request a copy of this notice at any time.

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call (1-877-486-2048).

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: 7/1/2022
Name of Entity/Sender: CEBT
Address: 555 17th Street, Ste. 2050
Denver, CO 80202
Phone Number: (303) 773-1373 or (800) 332-1168
PART A: General Information
When key parts of the health care law took effect in 2014, there was a new way to buy health
insurance: The Health Insurance Marketplace. To assist you as you evaluate options for you and
your family, this notice provides some basic information about the Marketplace and employment-
based health coverage offered by your employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits
your budget. The Marketplace offers "one-stop shopping" to find and compare private health
insurance options. You may also be eligible for a tax credit that lowers your monthly premium
right away. Open enrollment for health insurance coverage through the Marketplace begins in
November each year for coverage starting as early as the immediately following January 1.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does
not offer coverage, or offers coverage that doesn’t meet certain standards. The savings on your
premium that you’re eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards,
you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your
employer’s health plan. However, you may be eligible for a tax credit that lowers your monthly
premium or a reduction in certain cost-sharing if your employer does not offer coverage to you
at all or does not offer coverage that meets certain standards. If the cost of a plan from your
employer that would cover you (and not any other members of your family) is more than 9.5%1
of your household income for the year, or if the coverage your employer provides does not meet
the “minimum value” standard set by the Affordable Care Act, you may be eligible for a tax credit.2

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage
offered by your employer, then you may lose the employer contribution (if any) to the employer-
offered coverage. Also, this employer contribution - as well as your employee contribution to
employer-offered coverage - is often excluded from income for Federal and State income tax
purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary
plan description or contact Willis Towers Watson at 1-800-332-1168 or 303-773-1373.

The Marketplace can help you evaluate your coverage options, including your eligibility for
coverage through the Marketplace and its cost. Please visit HealthCare.gov for more
information, including an online application for health insurance coverage and contact
information for a Health Insurance Marketplace in your area.

1 As that percentage is adjusted by inflation from time to time.
2 An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit
costs covered by the plan is no less than 60 percent of such costs.
PART B: Information about Health Coverage Offered by Your Employer

NOTE FROM CEBT: CONTACT YOUR EMPLOYER FOR THE COMPLETED PART B OF THIS NOTICE

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

<table>
<thead>
<tr>
<th>3. Employer name</th>
<th>4. Employer Identification Number (EIN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loveland Fire Rescue Authority</td>
<td>45-4127084</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Employer address</th>
<th>6. Employer phone number</th>
</tr>
</thead>
<tbody>
<tr>
<td>410 East 5th Street</td>
<td>(970) 962-2370</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. City</th>
<th>8. State</th>
<th>9. ZIP code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loveland</td>
<td>Colorado</td>
<td>80537</td>
</tr>
</tbody>
</table>

10. Who can we contact about employee health coverage at this job?

LFRA Human Resources

11. Phone number (if different from above) | 12. Email address
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><a href="mailto:LFRAHumanResources@lfra.org">LFRAHumanResources@lfra.org</a></td>
</tr>
</tbody>
</table>

* Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - [ ] All employees. Eligible employees are:
  
  - [ ] Some employees. Eligible employees are:
    - Regular benefited employees scheduled to work at least 20 hours per week
    - LFRA Board Members
    - Early retirees covered by LFRA insurance at the date of retirement, who are 55 and have completed 20 or more years of service at LFRA at date of retirement

- With respect to dependents:
  - [x] We do offer coverage. Eligible dependents are:
Annual Notices (continued)

1. A covered employee's lawful spouse, as defined by the State where you reside, provided that:
   a. The spouse is not legally separated from the employee, and
   b. The employee is eligible to claim a marital status of married on their current Federal Income Tax Return as a result.

2. A covered employee's Civil Union partner, who meets the requirements of Colorado's Civil Union Act. Please note that coverage for Civil Union partners is only available if elected by your contributing employer.

3. A covered employee's married or unmarried: natural born, blood related child; step-child; foster child; a Civil Union's child (if Civil Union partner coverage was elected by your contributing employer); legally adopted child; child placed in the employee's legal guardianship by court order; or a child placed with the employee for the purpose of adoption and for which the employee has a legal obligation to provide full or partial support; whose age is less than the limited age.

   The limiting age for each dependent child is their 26th birthday.

☐ We do not offer coverage.

☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

   ** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here’s the employer information you’ll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?
   ☐ Yes (Continue)

   13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? __________ ________ (mm/dd/yyyy) (Continue)

☐ No (STOP and return this form to employee)
Annual Notices (continued)

14. Does the employer offer a health plan that meets the minimum value standard*?
   □ Yes (Go to question 15)   □ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
   a. How much would the employee have to pay in premiums for this plan? $___________
   b. How often? □ Weekly □ Every 2 weeks □ Twice a month □ Monthly
      □ Quarterly □ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?
   □ Employer won't offer health coverage
   □ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard. *(Premium should reflect the discount for wellness programs. See question 15.)*
   a. How much would the employee have to pay in premiums for this plan? $_______
   b. How often? □ Weekly □ Every 2 weeks □ Twice a month □ Monthly
      □ Quarterly □ Yearly

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)
ATTACHMENT A

BOARD MEMBER MEDICAL INSURANCE AND LIFE INSURANCE PROGRAM

Election and Payment Procedures

Effective June 27, 2018

A current Loveland Fire Rescue Authority ("Authority") Board member is eligible to elect coverage in the Authority's medical insurance or life insurance plans pursuant to Authority Resolution 89 Establishing a Board Member Medical Insurance and Life Insurance Program, subject to the election and payment procedures set forth below.

1. Election and Initial Payment

The initial coverage starting July 1, 2018 is considered a special enrollment period. Coverage must be elected by July 31, 2018.

If coverage is elected by July 31, 2018, the Board member 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. The Board member may be eligible to elect coverage in the next open enrollment period or through a qualifying life event.

2. Subsequent Monthly Payments

The current premium amounts are shown on the Board Member Health Insurance Premium Rates document available from the Authority's Human Resources office. Premium amounts may change in the future. Any participating Board member 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 Board member'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 Board member 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. The Board member may be eligible to elect coverage during the next open enrollment period or through a qualifying life event.
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. Board members 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 Board member’s payment is returned or denied due to insufficient funds or otherwise.
## Important Contact Information

### LFRA Human Resources

Email: LFRAHumanResources@lfra.org  
Amy Meyer, HR Analyst: 970-962-2870  
Andrea Wright, HR Manager: 970-962-2825

<table>
<thead>
<tr>
<th>Provider / Plan</th>
<th>Contact Number</th>
<th>Website / Email</th>
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<tbody>
<tr>
<td><strong>Dental</strong></td>
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<tr>
<td>Delta Dental Plan A</td>
<td>800-332-1168</td>
<td><a href="http://www.deltadental.com">www.deltadental.com</a></td>
</tr>
<tr>
<td><strong>Life Insurance</strong></td>
<td></td>
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<tr>
<td><strong>Medical</strong></td>
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<tr>
<td>CEBT Healthcare Bluebook</td>
<td>800-332-1168</td>
<td><a href="http://www.cebt.org">www.cebt.org</a></td>
</tr>
<tr>
<td>Surgery Plus</td>
<td>800-341-0504</td>
<td><a href="http://www.healthcarebluebook.com">www.healthcarebluebook.com</a></td>
</tr>
<tr>
<td>Teladoc</td>
<td>855-200-6675</td>
<td><a href="http://cebt.surgeryplus.com">cebt.surgeryplus.com</a></td>
</tr>
<tr>
<td></td>
<td>800-835-2362</td>
<td><a href="http://member.teladoc.com/cebt">member.teladoc.com/cebt</a></td>
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<tr>
<td><strong>Prescriptions</strong></td>
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<tr>
<td>CVS Caremark</td>
<td>800-332-1168</td>
<td><a href="http://www.caremark.com">www.caremark.com</a></td>
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<tr>
<td><strong>Vision</strong></td>
<td></td>
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<tr>
<td>Vision B (VSP)</td>
<td>800-332-1168</td>
<td><a href="http://www.vsp.com">www.vsp.com</a></td>
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<tr>
<td><strong>Wellness Center</strong></td>
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</tr>
<tr>
<td>Marathon Health – Greeley</td>
<td>970-373-4625</td>
<td><a href="http://my.marathon-health.com">my.marathon-health.com</a></td>
</tr>
<tr>
<td>Marathon Health – Loveland</td>
<td>970-744-2866</td>
<td><a href="http://my.marathon-health.com">my.marathon-health.com</a></td>
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</tbody>
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