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 90 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

Retirees are eligible for medical insurance who (1) are 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 service 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 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.

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 retired employee and the retired employee’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.

Enrollment

You can sign up for benefits within 30 days following the loss of CEBT coverage as an LFRA employee. After initial enrollment, you may change your benefit elections at the following times:

- 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.

*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 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

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 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 Type</th>
<th>Type</th>
<th>Monthly Premium</th>
<th>2% LFRA Admin. Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>EPO4 Plan</td>
<td>Individual</td>
<td>$706.86</td>
<td>$693.00</td>
</tr>
<tr>
<td>EPO4 Plan</td>
<td>Individual + Spouse</td>
<td>$1,553.46</td>
<td>$1,523.00</td>
</tr>
<tr>
<td>EPO4 Plan</td>
<td>Individual + Child(ren)</td>
<td>$1,482.06</td>
<td>$1,453.00</td>
</tr>
<tr>
<td>EPO4 Plan</td>
<td>Family</td>
<td>$1,760.52</td>
<td>$1,726.00</td>
</tr>
<tr>
<td>PPO4 Plan</td>
<td>Individual</td>
<td>$778.26</td>
<td>$763.00</td>
</tr>
<tr>
<td>PPO4 Plan</td>
<td>Individual + Spouse</td>
<td>$1,710.54</td>
<td>$1,677.00</td>
</tr>
<tr>
<td>PPO4 Plan</td>
<td>Individual + Child(ren)</td>
<td>$1,634.04</td>
<td>$1,602.00</td>
</tr>
<tr>
<td>PPO4 Plan</td>
<td>Family</td>
<td>$1,945.14</td>
<td>$1,907.00</td>
</tr>
<tr>
<td>PPO2 Plan</td>
<td>Individual</td>
<td>$1,026.12</td>
<td>$1,006.00</td>
</tr>
<tr>
<td>PPO2 Plan</td>
<td>Individual + Spouse</td>
<td>$2,258.28</td>
<td>$2,214.00</td>
</tr>
<tr>
<td>PPO2 Plan</td>
<td>Individual + Child(ren)</td>
<td>$2,156.28</td>
<td>$2,114.00</td>
</tr>
<tr>
<td>PPO2 Plan</td>
<td>Family</td>
<td>$2,571.42</td>
<td>$2,521.00</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](#) 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>Coinurance (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</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>Teladoc</td>
<td>Covered 100%</td>
<td>Covered 100%</td>
<td>Covered 100%</td>
</tr>
<tr>
<td>Telehealth</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</td>
</tr>
<tr>
<td>X-ray</td>
<td>$30 Copay office setting</td>
<td>Outpatient setting Deductible + 20% to COP Max</td>
<td>$40 Copay office setting</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.

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

**Health Coaching**
- Nutrition
- Physical activity
- Tobacco cessation
- Stress management
- Weight loss

**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 HDHP only).

**CEBT Health & Wellness Centers**
- **Weld County: 930 Leta Drive | 719-551-5808**
- **Rifle: 707 Wapiti Avenue, Suite 201-A | 970-440-0085**
- **Glenwood Springs: 1901 Grand Avenue, Suite 200 | 970-440-8087**
- **Gypsum: 35 Lindbergh Drive, Suite 110 | 970-431-2871**
- **Loveland: 2889 N. Garfield Avenue | 970-744-2836**
- **Greeley: 4675 W. 20th Street Road, Unit 8 | 970-373-4625**
- my.marathon-health.com
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. 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 greats out-of-pocket savings if you see a Delta Dental PPO dentist.

Monthly Dental Plan Costs

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 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>RETIREE 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 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>COVERAGE</th>
<th>BENEFIT INFORMATION (subject to Delta Dental guidelines)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DIAGNOSTIC AND PREVENTIVE SERVICES</td>
<td></td>
</tr>
<tr>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>BASIC SERVICES (including occlusal guards)</td>
<td></td>
</tr>
<tr>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>MAJOR SERVICES</td>
<td></td>
</tr>
<tr>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>ORTHODONTICS $2,000 lifetime maximum</td>
<td></td>
</tr>
<tr>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>
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**

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 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>VSP B</th>
<th>RETRIEVE姓</th>
<th>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>
<td>$0.18</td>
</tr>
<tr>
<td>Individual + Spouse</td>
<td>$12.24</td>
<td>$12.00</td>
<td>$0.24</td>
</tr>
<tr>
<td>Individual + Child(ren)</td>
<td>$11.22</td>
<td>$11.00</td>
<td>$0.22</td>
</tr>
<tr>
<td>Family</td>
<td>$20.40</td>
<td>$20.00</td>
<td>$0.40</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.
Annual Notices

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
Annual Notices (continued)

- 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.
Annual Notices (continued)

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.askebsa.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>(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](http://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](http://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 either you or your dependent is disabled (according to the Social Security Administration) within 60 days of your loss of eligibility</td>
<td>29 months</td>
</tr>
</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>30 months</td>
</tr>
<tr>
<td>You become eligible for Medicare after your COBRA election begins</td>
<td>30 months</td>
</tr>
<tr>
<td>You and your spouse divorce</td>
<td>30 months</td>
</tr>
<tr>
<td>He or she is no longer a dependent (because of age or divorce)</td>
<td>30 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><strong>Date:</strong></td>
</tr>
<tr>
<td><strong>Name of Entity/Sender:</strong></td>
</tr>
<tr>
<td><strong>Contact-Position/Office:</strong></td>
</tr>
</tbody>
</table>
| **Address:** | 555 17th Street Ste 2050  
Denver, CO 80202 |
| **Phone Number:** | (303) 773-1373 or (800) 332-1168 |
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
Annual Notices (continued)

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](http://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](http://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
New Health Insurance Marketplace Coverage Options and Your Health Coverage

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) 962-2870</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

LFRAHumanResources@lfra.org

* 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:
  - □ We do not offer coverage. Eligible dependents are:
  - ✗ 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)
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

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:
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.
## 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>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dental</strong></td>
<td></td>
<td></td>
</tr>
<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>Medical</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CEBT</td>
<td>800-332-1168</td>
<td><a href="http://www.cebt.org">www.cebt.org</a></td>
</tr>
<tr>
<td>Healthcare Bluebook</td>
<td>800-341-0504</td>
<td><a href="http://www.healthcarebluebook.com">www.healthcarebluebook.com</a></td>
</tr>
<tr>
<td>Surgery Plus</td>
<td>855-200-6675</td>
<td>cebt.surgeryplus.com</td>
</tr>
<tr>
<td>Teladoc</td>
<td>800-835-2362</td>
<td>member.teladoc.com/cebt</td>
</tr>
<tr>
<td><strong>Prescriptions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CVS Caremark</td>
<td>800-332-1168</td>
<td><a href="http://www.caremark.com">www.caremark.com</a></td>
</tr>
<tr>
<td><strong>Vision</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision B (VSP)</td>
<td>800-332-1168</td>
<td><a href="http://www.vsp.com">www.vsp.com</a></td>
</tr>
<tr>
<td><strong>Wellness Center</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marathon Health – Greeley</td>
<td>970-373-4624</td>
<td>my.marathon-health.com</td>
</tr>
<tr>
<td>Marathon Health – Loveland</td>
<td>970-744-2866</td>
<td>my.marathon-health.com</td>
</tr>
</tbody>
</table>