2025 Employee Benefits Resources

Northwest Colorado Council of Governments

2025 Employee Benefits Guide NWCCOG

Eligibility for benefits is dependent on status as a full-time, part-time, temporary, etc. employee. Please see the Employee Handbook for details. After the first full calendar month of employment, full-time and part-time employees are eligible to participate in group medical, dental, vision, life, and disability insurance. Sample: if start date is 3/15/2025, benefit eligibility starts 5/1/2025.

Benefits Quick View

Benefit	Description
Health Insurance	Medical and prescription insurance benefits are handled by Anthem as part of NWCCOG's participation with County Technical Services, Inc. (CTSI) through a program known as the County Health Pool (CHP). There are four plan options including medical, dental, vision, and prescription. NWCCOG pays 85% and the employee pays 15% of the premium cost.
Short Term Disability	Employees injured (non-workers' compensation injuries) off the clock and unable to work receive 60% of their weekly income up to $1,400 per week following a 7-day waiting period. Employees can receive this benefit for 12 weeks. NWCCOG pays 100% of this premium
Long Term Disability	Employees injured (non-workers' compensation injuries) off the clock and unable to work receive 2/3 of their normal wage following a 90-day waiting period. NWCCOG pays 100% of this premium.
Life & Accidental Death & Dismemberment Insurance	NWCCOG provides BASIC Life with Accidental Death and Dismemberment (AD&D) Insurance to employees of up to $100,000 or two-times employees' annual salary. 100% of the premium is paid by NWCCOG for employees.

Flexible Spending Account	A pre-tax savings account, administered by BestFlex, for employees to use on unreimbursed medical and childcare expenses.
Health Savings Account	The High Deductible Health Plan (HDHP) is the only medical plan that makes an employee eligible for a Health Savings Account (HSA). HSA funds rollover every year, are not taxed on accounts' growth, not taxed on withdrawals for health expenses, and are available for health expenses only.
Retirement Program - 401(a) account	All employees are required to participate in 401(a) INSTEAD of Social Security. NWCCOG's retirement plans are administered by Colorado Retirement Association (CRA). Employees are immediately vested. NWCCOG Matches up to 6%. CRA also provides free retirement consulting.
Retirement Program - voluntary 457(b) account	The 457(b) deferred compensation plan is a voluntary pre or post tax retirement fund managed by Colorado Retirement Association (CRA).
Anthem Resource Advisor	Free counseling for employees on financial planning, legal services, identity theft recovery and monitoring, online tools to assist with creating a will, parenting, aging, healthy living, household support, referrals for care services, funeral planning
Travel Assistance Services	Travel assistance services to employee and dependents including: emergency medical assistance while traveling, medical expertise and coordination (referrals, monitoring, evacuation, med/eyeglass replacement, benefit coordination), support for family and friends, legal and financial help, and much more.
Employee Assistance Program	Available to employees through Unum, their spouses or domestic partners, dependent children, parents and parents-in-law for free. EAP's help employees with stress, anxiety, depression, relationship issues, family and parenting, anger, grief, addiction, eating disorders, mental illness, finding childcare, accessing legal help, locating elder services, managing financials, and more.
Paid Time Off	Annual Leave accounts for both vacation and sick leave. Full-time employees earn 128 hours.
Holidays	NWCCOG provides 14 paid holidays each year at 8 hours per holiday.
Compensatory Time	Compensatory is elected by employees in lieu of overtime. Employees can accrue 1.5 hours of PTO for every 1 hour worked over 12 hours in one day or 40 hours in one week.
Flexible Scheduling	NWCCOG offers flex time for work-life balance.
FAMLI Leave Program	FAMLI Leave provides up to 16 weeks of paid leave to cover life circumstances to care for: a new child (including fostered and adopted children), themselves if a serious health condition arises, to care for a family member, to make arrangements for military deployment, to address safety for impacts of domestic violence and/or sexual assault. NWCCOG is an opted out Local Government, but has elected to manage FAMLI deductions and premium payments as a benefit to employees.
Professional Development	Through NWCCOG's Paid Professional Development Program, employees may apply to receive funding for job-related professional development including trainings and college courses. Up to $5,250 per employee is also available per year for non-job-related education.

Leave, Holidays & Schedule

Paid Leave:

Annual Leave accounts for both vacation and sick leave. Full-time employees earn 128 hours, or 16 days of annual leave per year through the fourth year of continuous employment. This is accrued at a rate of 5.34 hours per pay period. The amount is pro-rated for part-time employees based on the number of hours worked per week (24 hours/week minimum required). Annual leave increases as years of service increase at the 5-year, 10-year, and 15-year anniversary dates.

Holidays

Each holiday listed is observed. For the exact date see the annual memorandum. New Years Day, Martin Luther King Birthday, Presidents' Day, Memorial Day, Juneteenth, Independence Day, Colorado Day, Labor Day, Frances Xavier Cabrini Day, Veterans' Day, Thanksgiving, Christmas Day, Floating Holiday (1 day).

Full-time employees accrue annual leave based on the following schedule:

Annual Leave Earned Per Year	Length of Service
128 hours @ 5.34 hours per pay period (or 16 8-hour days)	Commencing on the date of employment, continuing to the fifth anniversary of the date of employment
168 hours @ 7 hours per pay period (or 21 8-hour days)	Commencing on the fifth anniversary of the date of employment, continuing to the tenth anniversary of the date of employment
240 hours @ 10 hours per pay period (or 30 8-hour days)	Commencing on the tenth anniversary of the date of employment, continuing through the remainder of employment

Part-time employees may accrue annual leave proportional to the above schedule.
Employees must schedule use of accrued Annual Leave to minimize interruptions to organizational operations and authorization for use of leave from their supervisor through a signed Request for Leave Form. Annual Leave time will not be advanced (from outside of current pay period), prior to it being accrued under any circumstances. Employees must provide their supervisor with as much advance notice as possible when requesting annual leave. NWCCOG does not provide "sick leave" separately from

Leave - Other

See the Employee Handbook for details on: Bereavement Leave, Shared Leave, Military, Voting, etc.

NWCCOG's divisions work differently, and each position has a unique structure and job functions. Your ability to access flex time, remote work, compensatory time, or other schedule and work location options is dependent on a variety of factors. Supervisor approval in advance is required.

FAMLI Leave Program

Colorado voters approved the paid Family and Medical Leave Insurance (FAMLI) program in 2020. FAMLI ensures Colorado workers have access to paid leave in order to take care of themselves or their family during life circumstances that pull them away from their jobs, so workers don't have to

choose between earning a paycheck and taking care of their families. When life happens, FAMLI has you covered.
FAMLI benefits officially became available on January 1, 2024. Covered Colorado workers may receive up to twelve weeks of leave. FAMLI is a complex program where individual benefits are very specific to the employee's individual situation. Please see the Colorado Division of Family and Medical Leave Insurance website.

Compensatory Time, Flexible Scheduling, Exempt Flex Time

Some time and schedule tools such as Compensatory "Comp" Time, Flex Time, and Exempt Time may apply. Connect with Payroll and your manager for details related to your position.

Retirement – Social Security Replacement CRA 401(a)

You may be new to the type of retirement program that NWCCOG provides, and it is important for you understand the unique features and details of the mandatory 401(a) Social Security Replacement Program, managed through the Colorado Retirement Association (CRA).

There are two different parts in the retirement program:

a. **Mandatory** 401(a), ***and***
b. **OPTIONAL** voluntary 457(b).

CRA 401(a) Highlights

Mandatory Participation

All employees are required to participate in the 401(a) INSTEAD of Social Security. You will not be paying the typical employee contribution into Social Security of 6.2% (up to a certain income threshold). You also will not be accruing time and income toward Social Security benefits, so your eligibility will be affected.

Flexible Contribution Range

Employees will a minimum of 3.75% up to 6% of their wages. It is important you understand the 401(a) program contribution option is a one-time only selection within the first three days of your start date. Once you select your contribution percentage it cannot be changed.

Employer Match

Your employer will match your contribution up to 6%, doubling your savings potential.

Immediate Ownership

Enjoy complete ownership of your contributions, including the employer's match, right from the start, without any vesting period. Because there is no vesting period, the funds are entirely yours from the start. In contrast, with Social Security, the benefits received are not based on individual contributions but rather on a formula tied to an individual's work history and earnings.

Individual Retirement Counseling

Schedule a free appointment today with CRA to maximize the value of your retirement options.

Voluntary Retirement Deferred Compensation 457(b) Option

Do you want more options for saving for retirement? In addition to your 401(a) mandatory plan, you may also choose to invest an additional amount of your salary into an OPTIONAL or supplemental retirement plan. The 457(b) deferred compensation plan allows you to defer receiving a portion of their current compensation until retirement or separation from service. The 457(b) plan is voluntary and may provide a tax deferment benefit to you depending on your specific situation. You can choose to start, stop, increase, or decrease contributions at any time but does not include an employer match.

What does Social Security Replacement mean to me and my family?

Contributing to a 401(a)-retirement plan, instead of Social Security, can modify you eligibility for Social Security benefits due to factors such as the ***Windfall Elimination Provision*** (WEP) and the ***Government Pension Offset*** (GPO). Visit My Social Security for help.

Windfall Elimination Provision (WEP) reduces Social Security benefits for individuals who have both a pension from non-Social Security-covered employment (like a 401(a) plan) and qualify for Social Security benefits. WEP Factsheet SSA.gov

Government Pension Offset (GPO) impacts those eligible for a pension from non-Social Security-covered work (e.g., 401(a)) and spousal or survivor benefits. GPO reduces benefits by two-thirds of the government pension. GPO Factsheet SSA.gov

Contributing to a 401(a) plan instead of Social Security may reduce Social Security benefits through WEP and GPO, affecting retirement planning. Consulting with a financial advisor is advisable to make informed retirement income decisions.

Medical & Prescription (Rx) – Health Insurance

Medical and prescription insurance benefits are managed by Anthem through a program known as the County Health Pool (CHP). Choose from four plans: 1) Medical Plan A, 2) Medical PPO B500, 3) Medical PPO B1000, and 4) Medical HDHP 2500.
Need help deciding? Health Insurance Basics from Anthem

NWCCOG 2025 Plans – Rate Split			
Medical A	**NWCCOG Portion (85%)**	**Employee Portion (15%)**	**Premium**
Employee Only	$1,149.20	$202.80	$1,352.00
Employee + 1	$2,153.90	$380.10	$2,534.00
Employee + Family	$2,644.35	$466.65	$3,111.00
Medical B500	**NWCCOG Portion (85%)**	**Employee Portion (15%)**	**Premium**
Employee Only	$1,099.05	$193.95	$1,293.00
Employee + 1	$2062.95	$364.05	$2,427.00
Employee + Family	$2530.45	$446.55	$2,977.00
Medical B1000	**NWCCOG Portion (85%)**	**Employee Portion (15%)**	**Premium**
Employee Only	$1,004.70	$177.30	$1,182.00
Employee + 1	$1884.45	$332.55	$2,217.00
Employee + Family	$2312.85	$408.15	$2,721.00
Medical HDHP 2500	**NWCCOG Portion (85%)**	**Employee Portion (15%)**	**Premium**
Employee Only	$778.60	$137.40	$916.00
Employee + 1	$1,458.60	$257.40	$1,716.00
Employee + Family	$1,794.35	$316.65	$2,111.00

Try Anthem's App Sydney or log on to *www.anthem.com* to manage your medical and prescription coverage.

Tax Advantaged Savings Accounts – You could save more on health expenses.

HSA or FSA? What are your options?

Savings accounts may provide tax-related benefits and are often used in conjunction with health insurance so you might wonder, "what is a Flexible Spending Account or what's a Health Savings Account? "How do they work?"

Health Savings Account (HSA):

The ***High Deductible Health Plan (HDHP***) is the only medical plan that makes you eligible for a Health Savings Account (HSA). If you choose the HDHP, you can open or use an existing HSA account through your personal bank (HSA is not provided by BestFlex). Employees are responsible for transferring funds into their own HSA account and then deducting those funds from their yearly taxes to receive the tax benefit. HSA funds roll-over every year, are not taxed on the account's growth, not taxed on withdrawals for health expenses, and are available for health expenses only. Premium costs are not included as a health expense.

Flexible Spending Account (FSA):

FSA Is offered through BestFlex. Flexible Spending Accounts may include certain medical and health related costs but may also include childcare and other expenses

Medical - Anthem & CHP

Anthem is the company that processes our insurance claims and manages our network of doctors/hospitals. County Health Pool (CHP) is our insurance company, but the Anthem network determines which doctors/hospitals to see for the best benefits.

IMPORTANT - In-network coverage only listed below. ***See full benefit summary for out-of-network coverage and important details.***

Medical Plan	PPO A	PPO B500	PPO B1000	HDHP 2500
Medical Coverage				
Deductible Individual/Family	None / None	$500 / $1,000	$1,000 / $2,000	$2,500 / $5,000 (If you select family membership, no individual deductible applies and the family deductible must be met before CHP provides benefits.)
Out of Pocket Maximum (OOP) Individual/Family	$3,500 / $9,000	$3,750 /$9,500	$4,250 / $10,500	$5,000 / $6,850
Out of Pocket Maximum Detail	(Rx deductible, copay and coinsurance do apply to OOP maximum; once OOP maximum has been met, medical, Rx copays and coinsurance do not apply.)	(Medical and Rx copays, deductible and coinsurance do apply to OOP maximum; once OOP maximum has been met, medical Rx and copays, and coinsurance do not apply.)	(Medical and Rx copays, deductible and coinsurance do apply to OOP maximum; once OOP maximum has been met, medical Rx and copays, and coinsurance do not apply.)	(Deductible and coinsurance do apply to OOP maximum; if you select family membership, no individual OOP applies and the family OOP annual maximum must be met which includes family deductible.)
Coinsurance **For covered procedures with various copayments**	80%/20%	80%/20%	80%/20%	80%/20% After deductible is met
Office Visit	**$25 office visit copay** (80%/20% coinsurance for all other services [i.e., lab and X-ray services])	**$25 office visit copay** (80%/20% coinsurance for all other services [i.e., lab and X-ray services])	**$25 office visit copay** (80%/20% coinsurance for all other services [i.e., lab and X-ray services])	80%/20% coinsurance Cor covered procedures after deductible has been met
Lab & X-ray		$200 copay then deductible and 80%/20% coinsurance for high-tech labs and X-rays (MRIs, PET scans, CT scans, etc.)	$200 copay then deductible and 80%/20% coinsurance for high-tech labs and X-rays (MRIs, PET scans, CT scans, etc.)	80%/20% coinsurance for covered procedures after deductible has been met

Disclaimer: Sample illustration of in-network coverage only listed. Please see full benefit summary for out-of-network coverage and other important details. These summary forms are not a contract and is only a summary. The contents of this form are subject to the provisions of the Plan Document and Summary Plan Description which contain all terms, covenants, and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization or use of specified providers or facilities). Consult the actual Plan Document and Summary Plan Description to determine the exact terms and conditions of coverage. The County Health Pool Plan Document may be accessed at www.ctsi.org. You may also contact Anthem Customer Service at 1-866-698-0087.

Prescription

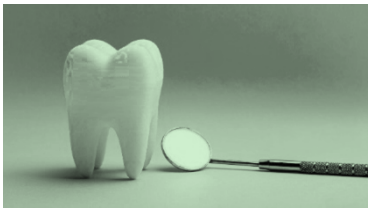
Prescription (Rx) coverage is integrated with the Anthem health insurance plan you select.
Pharmacy services are provided through CarelonRx (formerly IngenioRx). Access info at anthem.com or through Anthem's App (Sydney).

Prescription Coverage	PPO A	PPO B500	PPO B1000	HDHP 2500
Prescription Coverage				
Prescription Coverage (Rx)	$50 deductible (combined retail and mail order)	$75 deductible (combined retail and mail order)	$75 deductible (combined retail and mail order)	Must meet medical deductible before coinsurance is applied to prescription coverage
Prescription Coverage (Rx)	(Rx copays apply to medical OOP max.)	(Rx copays apply to medical OOP max.)	(Rx copays apply to medical OOP max.)	
Rx Retail Prescription Coverage Per prescription at a participating pharmacy up to a 30-day supply.				
Retail Tier I Generic Formulary	$15 or 10% copay, whichever is higher	$10 or 15% copay, whichever is higher	$10 or 20% copay, whichever is higher	80%/20% coinsurance after medical deductible has been met
Retail Tier 2 Brand Formulary	$30 or 20% copay, whichever is higher	$25 or 25% copay, whichever is higher	$25 or 30% copay, whichever is higher	
Retail Tier 3 Non-Formulary	$45 or 40% copay, whichever is higher	$35 or 45% copay, whichever is higher	$35 or 50% copay, whichever is higher	
Rx Mail Order Per Prescription Coverage Per prescription through the mail-order service up to a 90-day supply				
Mail Tier I Generic Formulary	$25 copay	$25 copay	$25 copay	80%/20 % coinsurance after medical deductible has been met
Mail Tier 2 Brand Formulary	$60 copay	$60 copay	$60 copay	
Mail Tier 3 Non-Formulary	$115 copay	$115 copay	$115 copay	

Dental

Dental Single Option	NWCCOG Portion (85%)	Employee Portion (15%)	Premium
Employee Only	$29.03	$5.12	$34.15
Employee + 1	$57.92	$10.23	$68.15
Employee + Family	$75.35	$13.30	$88.65

Dental A	
Administered by CTSI Effective Date 2024 Check for 2025 Updates - See full plan. Illustration Only.	
Covered Benefits	Plan A Coverage Percentage
Annual Calendar Year Deductible (Single/Family)	$50 / Max of 3 x $50
Annual Calendar Year Maximum	$1,500
Diagnostic and Preventive Services (no deductible) • Oral evaluations • X-rays • Cleanings • Space maintainers • Other selected diagnostic and preventive services	100%
General Services (deductible applies)• Emergency palliative treatment• Consultations• Office visits for observation• Other selected general services	80%
Restorative Services (deductible applies) • Amalgam and composite restorations • Pin retention procedures	80%
Endodontic Services (deductible applies) • Root canal therapy • Apexification • Therapeutic pulpotomy • Other selected endodontic services	80%
Oral Surgery Services (deductible applies) • Simple surgical tooth extractions • General anesthesia (surgical procedures) • I.V. sedation (surgical procedures) • Other selected oral surgery services Note: Some surgical procedures (i.e. surgical extraction of impacted wisdom teeth) will be eligible benefits under the medical plan. Consult the Summary Plan Description or contact Customer Service.	80%
Periodontal Services (deductible applies) • Gingivectomy • Crown lengthening • Osseous surgery • Soft tissue grafts• Other selected periodontal services	80%
Prosthodontic Services (deductible applies) • Crowns/onlays/inlays • Partial and full dentures • Other selected prosthodontic services	50%
Orthodontic Services (deductible applies) Eligible dependent children only • Non-surgical dental services related to the supervision, guidance and correction of growing or mature teeth • Examination and records • Tooth guidance • Repositioning (straightening) of the teeth	50% $1,000 Per Individual Per Lifetime Maximum



This is not a contract; it is a partial listing of benefits and services. All covered services are subject to the conditions, exclusions, qualifications, limitations, terms and provisions, of the County Health Pool Plan Document and Summary Plan Description. For a covered dental service, this coverage will pay the applicable percentage (shown in the "Coverage Percentage" column) of the dental maximum allowable for that service (subject to the fee schedule) up to the Annual Maximum. Only those expenses incurred as a result of non-occupational injury or illness will be considered eligible expenses. Please contact Anthem Customer Service at 855-769-1467 to verify your dental coverage. The County Health Pool Dental Plan Document is available at www.ctsi.org

Vision

All vison claims are submitted to VSP by the provider. You need to see a doctor in the VSP Network to obtain the best benefits. You will not be provided with a vision ID card. However, you can print one off their website once you create your own VSP online account.

vsp vision care

Vision Single Option	NWCCOG Portion (85%)	Employee Portion (15%)	Premium
Employee Only	$4.85	$0.85	$5.70
Employee + 1	$9.65	$1.70	$11.35
Employee + Family	$12.54	$2.21	$14.75

Covered Benefits	In-Network
EXAMINATION	$15 Co-pay - A complete exam once every 12 months
EYEGLASS LENSES AND FRAMES	$15 Co-pay - Necessary lenses once every 12 months *Single vision, lined bifocal and trifocal lenses | *Polycarbonate lenses for dependent children |*Standard Progressives covered in full Frame allowance once every 24 months $150 allowance for wide selection of frames ($80 allowance at Costco & Walmart) $170 allowance for featured frame brands 20% savings on the amount over your allowance
CONTACT LENSES	up to $60 Co-Pay * Contact lens exam (fitting and evaluation) Once every 12 months in lieu of eyeglasses *$150 allowance for contacts
COVERED PROVIDERS	Vision Service Plan (VSP) Choice Network Consult www.vsp.com or call Customer Service at 1-800-877-7195
EXTRA DISCOUNTS AND SAVINGS Important! See plan details or vsp.com for details not included here.	**Lens Enhancements | Prescription Eyeglasses and Sunglasses | LightCare** Members without a need for prescription eyewear can use their LightCare Benefit to purchase ready-made non-prescription blue light filtering glasses or ready-made non-prescription sunglasses. When they select this option, both their frame and lens benefits will be exhausted. **Retinal Screening** **Primary Eyecare Plus Program** **Laser Vision Correction Discounts**
Non VSP Provider Coverage	Exam……up to $45 Single Vision Lenses…..up to $30 Lined Bifocal Lenses…..up to $50 Lined Trifocal Lenses....up to $65 Progressive Lenses…....up to $50 Frame ……..up to $70 Contacts…….up to $105

Spending Accounts (Tax Advantaged)

Health Savings Accounts (HSA) and Flexible Savings Accounts (FSA) are different.

FLEXIBLE SPENDING ACCOUNT (FSA)

This benefit allows employees to use pre-tax dollars for unreimbursed medical and childcare expenses. There are limits on the amount employees can contribute, and FSA contributions can be “use it or lose it.”

The BESTflex℠ Plan

Your FSA option is the BestFlex plan from *Employee Benefits Corporation* (EBC). *BestFlex FSA* is an easy way to set aside a portion of earnings, and use it to pay for eligible healthcare, dental, prescription medicine, and daycare expenses.

HEALTH SAVINGS ACCOUNT HSA

The maximum amount for a Health Savings Account (HSA) from all sources for each tax year is set by the Internal Revenue Service (IRS) ***not*** *by Anthem or NWCCOG. The tax year limit applies to ALL your contributions – even if you were with a different employer/insurance provider if you were covered only by a HDHP all year. Please consult a tax advisor or the IRS annual publication, (sample: 2022 Publication 969).*

HSA is a special account owned by you and used to pay for current/future medical expenses. HSA contributions roll over and are not a use it or lose it. Special considerations may apply to your specific situation, particularly if you or a spouse is covered by other insurance, enrolled in Medicare (part A-D), an eligible dependent or claimed on someone else's tax return, etc. Consult your tax advisor for details.

Note NWCCOG uses BestFlex for FSA but NOT for HSA. If you choose the High Deductible Health Plan (HDHP) insurance option, and want to add an HSA, you will set up your own HSA through a provider you choose.

Life Insurance & AD&D

NWCCOG provides BASIC Life with Accidental Death and Dismemberment (AD&D) Insurance to employees of up to $100,000- or two-times employees' annual salary and 100% of the premium is paid by NWCCOG for employees. Life and AD&D is provided through Anthem Life Insurance Company, in 2024 this will change to Standard Livings Compass Platform. You may elect to add, at your own cost, OPTIONAL Supplemental Life Insurance for yourself or Dependent Life Coverage for eligible dependents.

County Health Pool is pleased to offer the opportunity to purchase additional guaranteed issue life insurance coverage Protect yourself and your family today! Product Highlights: *Payroll Deducted, No Pre-Existing Condition Limitations, Employee Coverage Includes Waiver of Premium and Living Benefits*

Supplemental Life Features

Employee Coverage Available in $10,000 multiples	Minimum benefit: $ 10,000 Maximum benefit: $300,000 (guarantee issue is $100,000 – see below)
Spousal Coverage Available in $10,000 multiples	Minimum benefit: $ 10,000 (guarantee issue is $20,000 – see below) Maximum benefit: $100,000 (not to exceed 50% of employee amount)
Dependent Life Coverage Chosen by your employer	Spouse/child benefit: $5,000/$2,000 or $2,000/$1,000 (guarantee issue) One affordable rate covers your spouse and eligible children
Age Reductions	Age reductions apply beginning at age 65. Spousal benefits terminate at age 65.
Enroll at NEW HIRE ONLY for Guaranteed Issue (available to newly eligible employees/spouses only)	No medical questions on Supplemental Life amounts up to $100,000 if age 70 or younger, $20,000 if over age 70, and $20,000 for your spouse. No medical questions for Dependent Life coverage.

*This benefit description is intended to be a brief outline of benefits available to eligible employees. It does not include all the terms of coverage. The complete terms of coverage are contained in the contract documents (the certificate, policy and/or trust agreement). In the event of a conflict between the contract documents and this description, the contract documents will prevail. Initial rates are based on your age on your effective date of coverage. Rates will change on your birthday, based on these age brackets. **Spousal benefits terminate when spouse reaches age 65. See the full plan details for important detailed information.* Benefits reduce on the first of the month following each of the birthdays listed above. Premiums are based on age and reduced benefit amount. Coverage ends when you retire or terminate coverage with County Health Pool.

Employee/Spouse Rates	
Age	*Rate*
Under 30	*$0.09*
30-34	*$0.09*
35-39	*$0.12*
40-44	*$0.17*
45-49	*$0.27*
50-54	*$0.47*
55-59	*$0.77*
60-64	*$1.03*
65-69	*$1.55*
70-74	*$2.82*
75-79	*$4.26*
80+	*$7.74*

Dependent Life	Option 1	Option 2
Spouse	$2,000	$5,000
Children	$1,000	$2,000
Monthly Rate	$.78 per unit	$.92 per unit

Children are Eligible from age 15 days to 19 years; to age 26 if eligible tax exemption.

Employee Benefit Schedule		
Age	**Benefit Amount**	**Factor**
Under 65	100% of amount selected	1.00
65	65% of the full amount	.65
70	50% of the full amount	.50
75+	35% of the full amount	.35

Employees may have many value added benefits as part of the medical insurance through Anthem Blue Cross and Blue Shield (BCBS) or through Group Term Life and Accidental Death & Dismemberment (AD&D) from AnthemLife. If an employee opts out of the medical and dental insurance plans, it may impact eligibility for additional programs. Check your plan coverage for details.

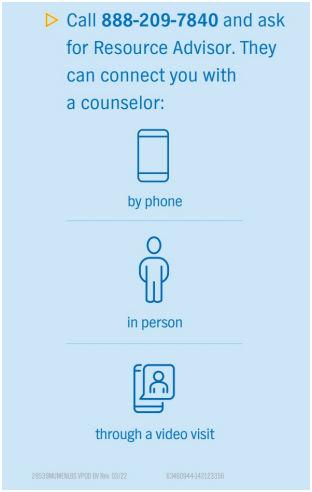
AnthemLife – Value-Added Services

Employees with Life Insurance through AnthemLife, have access to Resource Advisor and Travel Assistance.

Resource Advisor

Resource Advisor
1-888-209-7840

Receive counseling and access to financial and legal tools and services.
Resource Advisor is here to help with life's issues. Resource Advisor, a member assistance program that's included with your life and/or disability benefit, provides resources and services to support you and your household family members when you need it.



When you're feeling stressed, worried or having a tough time, you may want someone to talk to. You and your household family members can call Resource Advisor anytime, 24/7 and talk with a counselor.

By phone: Call 1-888-209-7840.
In-person: Call to set up face-to-face sessions and then schedule with your counselor.
Video Chat: Talk with a counselor from the convenience of your home or wherever you have internet access and privacy using LiveHealth Online. If you choose video visits, Resource Advisor will walk you through the scheduling process with LiveHealth Online and give you a coupon code to access the visits at no extra cost to you.

Resource Advisor offers you and each family member up to three counselor visits for each issue or concern. Counselors can help with: Stress, Anxiety, Illness, Depression, or Family and relationship issues.

Contact Resource Advisor or see full plan documents for details. Limitations and restrictions may apply.

Travel Assistance

Extending coverage no matter where life takes you.
If you are 100 miles or more from home – for personal or business travel / 24 hours a day. Travel Assistance.

Find a provider or medical facility

- Set up an emergency transfer if in the hospital, up to $1M, when medically necessary
- Arrange for the return of mortal remains should a member die while traveling
- Send emergency messages, get cash advances, legal help and bail
- Arrange and pay for people you are traveling with, your vehicle, or pet to return home (limits apply)

Easy access to travel tips
Go to anthemlife.com for a complete list of services, limitations, and exclusions that may apply.

Bringing you help – and peace of mind.

Disability Insurance and Added Benefits

SHORT-TERM DISABILITY INSURANCE

Employees injured (non-workers' compensation injuries) off the clock and unable to work receive 60% of their weekly income up to $1,400 per week following a 7-day waiting period. Employees can receive this benefit for 12 weeks. NWCCOG pays 100% of this premium. See full plan for all details.

Short Term Disability Insurance
pays you a weekly benefit if you have a covered disability that keeps you from working.

How does it work?

If a covered illness or injury keeps you from working, this employer-paid Short Term Disability Insurance replaces part of your income while you recover. As long as you remain disabled, you can receive payments for up to 12 weeks.
You're generally considered disabled if you're unable to do important parts of your job — and your income suffers as a result.
This insurance may cover a variety of conditions and injuries. Here are Unum's top reasons for short term disability claims: Normal pregnancy, Injuries, Joint disorders, Back disorders, Digestive disorders.

Why is this coverage so valuable?

Your employer is paying the cost of this coverage. You can use the money however you choose. It can help you pay for your rent or mortgage, groceries, out-of-pocket medical expenses and more.

This is only a partial explanation – See Exclusions and limitations including Definitions for Active Employee, Delayed Effective Date, Disability, Deductible Sources of Income, Exclusions and Limitations, and Termination of Coverage details.

LONG-TERM DISABILITY INSURANCE

Employees injured (non-workers' compensation injuries) off the clock and unable to work receive 2/3 of their normal wage following a 90-day waiting period. NWCCOG pays 100% of this premium.
Includes Work-life balance EAP Access. See full plan for important details.

Long Term Disability Insurance
replaces part of your income if a disability keeps you out of work for a long period of time.

How does it work?
This employer-paid coverage pays a monthly benefit if you have a covered illness or injury and you can't work for a few months — or even longer. You're generally considered disabled if you're unable to do important parts of your job — and your income suffers as a result.
Why is this coverage so valuable?
Your employer is paying the cost of this coverage. You can use the money however you choose. It can help you pay for your rent or mortgage, groceries, out-of-pocket medical expenses and more.
The monthly benefit may be reduced or offset by other sources of income. The IRS may require you to pay taxes on certain benefit payments. See your tax advisor for details.

Added Benefits from Unum Disability Coverage

Work-Life Balance EAP
Get access to professional help for a range of personal and work-related issues, including counselor referrals, financial planning, and legal support.

Worldwide Emergency Travel Assistance
One phone call gets you and your family immediate help anywhere in the world, as long as you're traveling 100 or more miles from home. However, a spouse traveling on business for his or her employer is not covered.

Survivor Benefit
If you die while you've been disabled and receiving benefits for at least 180 days, your family could get a benefit equal to 3 months of your gross disability payment.

Waiver of Premium
If you're disabled and receiving benefit payments, Unum waives your cost until you return to work.

This is only a partial explanation – See Exclusions and limitations including Definitions for Active Employee, Delayed Effective Date, Disability, Deductible Sources of Income, Exclusions and Limitations, and Termination of Coverage details.

EMPLOYEE ASSISTANCE PROGRAM
Available to employees, their spouses or domestic partners, dependent children, parents and parents-in-law for free. EAP's help employees with stress, anxiety, depression, relationship issues, family and parenting problems, anger, grief, addiction, eating disorders mental illness, finding childcare, accessing legal help, locating elder services, managing financials, and more. Our EAP helps over the phone, online, and 3 free in-person counseling sessions along with monthly webinars and educational materials. Note may you have similar benefits from the AnthemLife Resource Advisor which is a different, separate, similar program described above.

Help, when you need it most
With your Employee Assistance Program (EAP) and Work/Life Balance services, confidential assistance is as close as your phone or computer.

Always by your side
Expert support 24/7 Convenient Website
Short-term help Referrals for additional care
Monthly Webinars

Employee Assistance Program – Work Life Balance
Toll-free 24/7 Call 1-800-854-1446 (multi-lingual)
https://www.unum.com/support/employees/life-balance

Who is covered?
Unum's EAP services are available to all eligible employees their spouses or domestic partners, children, parents and parents-in-law.

The EAP from UNUM provides access through HealthAdvocate.

HealthAdvocate offers services that can help with any type of problem you might face. With additional Work/Life specialists, employees can find resources for issues from finding childcare to legal support.

EAP: Life & Work Resources
brought to you by HealthAdvocate

Licensed professional counseling

A Licensed Professional Counselor* can help you with:

- Stress, depression, anxiety
- Relationship issues, divorce
- Anger, grief and loss
- Job stress, work conflicts
- Family and parenting problems
- Addiction, eating disorders, mental illness

Local resources and support

Work/Life Specialists find support services and local resources to help with:

- Child and elder care
- Legal concerns**
- Financial issues
- Time management
- Relocation issues
- Identity Theft

Benefits Contacts

Retirement	Colorado Retirement Association Est. 1968	Klint Armitstead, Client Service Manager	720.493.6504 karmitstead@cra-online.org	https://www.cra-online.org/ 800.352.0313
Medical* & Prescription	Anthem	Member Services: 1-866-698-0087 Provider Services: 1-877-833-5742	www.anthem.com	Coverage While Traveling: 1-800-810-2583 Pre-Authorization: 1-800-832-7850 Pharmacist: 1-800-824-0898 Specialty: 1-800-870-6419
Vision - VSP	vsp vision care	1-800-877-7195	www.vsp.com	No Vision ID Card Register Online
Dental	Anthem	1-800-627-0004	www.anthem.com	No network you can go anywhere for dental
Life	Anthem			Group Life & AD&D Insurance: C23247
Disability Insurance	unum	1-877-225-2712		LTD -Policy #: 933977/Division: 011 Short-Term:
Flexible Savings (FSA)	The BESTflex Plan Employee Benefits Corporation	Melissa Braun Client Service Consultant	800-346-2126 Ebcflex.com	Direct: 608-829-8388
County Health Pool/CTSI Benefits	CTSI	Betty Apt, CTSI Benefits Administrator	303-861-0507 x133 bapt@ctsi.org	Contact if you are not able to work directly with Anthem

Resources

Important Notices and Information
Please also see the Employee Resources on the Shared Drive or your NEOGOV employee portal Benefits or Resources page, or the paper binder marked Employee Resources in each office.

Notices

SPECIAL ENROLLMENT PERIOD

IF YOU HAVE A NEW DEPENDENT AS A RESULT OF MARRIAGE, BIRTH, ADOPTION, OR PLACEMENT FOR ADOPTION YOU MUST ENROLL THE NEW DEPENDENT(S) WITHIN 31 DAYS. (FOR A QUALIFYING EVENT DEFINED AS A LOSS OF MEDICAID, SCHIP COVERAGE OR ELIGIBILITY FOR STATE PREMIUM ASSISTANCE, THE DEPENDENT MUST BE ENROLLED WITHIN 60 DAYS.)
LATE ENROLLEES — IF YOU DECLINE TO ENROLL YOURSELF OR YOUR DEPENDENTS (INCLUDING YOUR SPOUSE) UNDER CHP'S PLANS WHEN YOU ARE FIRST ELIGIBLE, YOU ARE CONSIDERED TO BE A LATE ENROLLEE UNLESS YOU WERE COVERED UNDER ANOTHER PLAN AND LOSE THAT COVERAGE, IN WHICH CASE YOU MAY BE ELIGIBLE FOR A SPECIAL ENROLLMENT. YOU MAY IN THE FUTURE BE ABLE TO ENROLL YOURSELF OR YOUR DEPENDENTS IN THIS PLAN EFFECTIVE JANUARY I OF A RE-ENROLLMENT YEAR (OPEN ENROLLMENT), PROVIDED THAT YOU REQUEST ENROLLMENT PRIOR TO JANUARY I OF THE YEAR THAT YOU DESIRE COVERAGE.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 NOTICE

Under federal law, group health plans, insurers, and HMOs that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery, effective for the first plan year beginning on or after October 21, 1998. In the case of a participant or beneficiary who is receiving benefits under the plan in connection with a mastectomy and who elects breast reconstruction, federal law requires coverage in a manner determined in consultation with the attending physician and the patient for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

This coverage is subject to a plan's annual deductibles and coinsurance provisions. These provisions are generally described in the Plan Document and Summary Plan Description (SPD). If you have any questions about whether your plan covers mastectomies or reconstructive surgery, please contact your Plan Administrator for the County Health Pool (1-866-698-0087).

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

MODEL 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 toward your or your dependents' other coverage). However, you must request enrollment within [insert "30 days" or any longer period that applies under the plan] 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 [insert "30 days" or any longer period that applies under the plan] after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact [insert the name, title, telephone number, and any additional contact information of the appropriate plan representative].

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

Form Approved
0MB No. 1210-0149
(expires 12-31-2026

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

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 is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%1 of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.·12

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution –as well as your employee contribution to employment-based coverage– is generally

excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within Go days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage.

Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting- medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact: Moira Vander Meer, Office Manager, 970-468-0295 x101

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] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023. An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

PART B: Information About Health Coverage Offered by Your Employer

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.

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

3. Employer Name: Northwest Colorado Council of Governments 4. Employer Identification Number:84-0639906

5. PO Box 2308 6. 970-468-0295

7. Silverthorne 8. Colorado 9. 80435

10. Moira Vander Meer 11. 970-468-0295 12. office@nwccog.org

- As your employer, we offer a health plan to:
  - X All employees. Eligible employees who work more than 24 hours a week
  - Some employees. Eligible employees are:
- With respect to dependents:
  - X We do offer coverage. Eligible dependents of employees who work more than 24 hours a week
  - 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

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• 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)

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

Notice

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 one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. Contact your State for more information on eligibility –

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+) FLORIDA – Medicaid Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442

YOUR STATEMENT OF RIGHTS UNDER FEDERAL LAW *VERY IMPORTANT NOTICE*

Continuation Coverage Rights Under COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** *When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.*

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?
COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
- *Your hours of employment are reduced, or*
- *Your employment ends for any reason other than your gross misconduct.*

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
- *Your spouse dies;*
- *Your spouse's hours of employment are reduced;*
- *Your spouse's employment ends for any reason other than his or her gross misconduct;*
- *Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or*
- *You become divorced or legally separated from your spouse.*

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:
- *The parent-employee dies;*
- *The parent-employee's hours of employment are reduced;*
- *The parent-employee's employment ends for any reason other than his or her gross misconduct;*
- *The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);*
- *The parents become divorced or legally separated; or*
- *The child stops being eligible for coverage under the Plan as a "dependent child."*

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator (County Health Pool CTSI) has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- *The end of employment or reduction of hours of employment;*
- *Death of the employee;*
- *Commencement of a proceeding in bankruptcy with respect to the employer; or*
- *The employee's becoming entitled to Medicare benefits (under Pan A, Part B, or both).*

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days of the date of the event or the date on which coverage would end under the plan because of the qualifying event. You must provide this notice to: CTSI/CHP 800 Grant St., Ste 400, Denver, CO 80203. The county and or entity has responsibility to notify CHP/CTSI, of the employee's death, termination of employment or reduction in hours, or Medicare entitlement.

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 1 1 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. Notify and provide this information in writing to CTSI/CHP 800 Grant St., Ste 400, Denver, CO 80203.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 1 8 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under

Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children 's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at wwwehealthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of
The month after your employment ends; or
The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.
If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information
visit https://www.medicare.gov/medicare-and-you*.*

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa*. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit* www.HealthCare.gov*.*

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information
If you have any questions or require additional information about the plan and continuation of coverage, please contact the plan administrator: County Technical Services, Inc. / County Health Pool, 800 Grant Street, Suite 400, Denver, CO 80203, Telephone: 303-861-0507.

CONSOLIDATED APPROPRIATIONS ACT OF 2021 NOTICE
CONSOLIDATED APPROPRIATIONS ACT OF 2021 (CAA)

The Consolidated Appropriations Act of 2021 (CAA) is a federal law that includes the No Surprises Billing Act as well the Provider transparency requirements that are described below.

Surprise Billing Claims
Surprise Billing Claims are claims that are subject to the No Surprises Billing Act requirements:
• Emergency Services provided by Out-of-Network Providers,
• Covered Services provided by an Out-of-Network Provider at an In-Network Facility, and
• Out-of-Network Air Ambulance Services. No Surprise Billing Act Requirements
Emergency

Services As required by the CAA, Emergency Services are covered under your Plan:
• Without the need for Precertification
• Whether the Provider is In-Network or Out-of-Network
If the Emergency Services you received are provided by an Out-of-Network Provider, Covered Services will be processed at the In-Network benefit level.

Note that if you receive Emergency Services from an Out-of-Network Provider, your Out-of-Pocket costs will be limited to amounts that would apply if the Covered Services had been furnished by an In-Network Provider. However, Out-of-Network cost-shares (i.e., Copayments, Deductibles and/or Coinsurance) will apply to your claim if the treating Out-of-Network Provider determines you are stable, meaning you have been provided necessary Emergency Care such that your condition will not materially worsen and the Out-of-Network Provider determines: (i) that you are able to travel to an In-Network Facility by non-emergency transport; (ii) the Out-of-Network Provider complies with the notice and consent requirement; and (iii) you are in condition to receive the information and provide informed consent. If you continue to receive services from the Out-of-Network Provider after you are stabilized, you will be responsible for the Out-of-Network cost-shares, and the Out-of-Network Provider will also be able to charge you any difference between the Maximum Allowable Amount and the Out-of-Network Provider's billed charges. This notice and consent exception does not apply if the Covered Services furnished by an Out-of-Network Provider result from unforeseen and urgent medical needs arising at the time of service.

Out-of-Network Services Provided an In-Network Facility
When you receive Covered Services from an Out-of-Network Provider at an In-Network Facility, your claims will be paid at the Out-of-Network benefit level if the Out-of-Network Provider gives you proper notice of its charges, and you give written consent to such charges. This means you will be responsible for Out-of-Network cost-shares for those services and the Out-of-Network Provider can also charge you any difference between the Maximum Allowable Amount and the Out-of-Network Provider's billed charges. This requirement does not apply to Ancillary Services. Ancillary Services are one of the following services: (a) Emergency Services; (b) anesthesiology; (c) pathology; (d) radiology; (e) neonatology; (f) diagnostic services; (g) assistant surgeons; (h) Hospitalists;

(i) Intensivists; and (j) any services set out by the U.S. Department of Health & Human Services. In addition, we will not apply this notice and consent process to you if we do not have an In-Network Provider in your area who can perform the services you require.

Out-of-Network Providers satisfy the notice and consent requirement as follows:
• By obtaining your written consent not later than 72 hours prior to the delivery of services, or
• If the notice and consent is given on the date of the service, if you make an appointment within 72 hours of the services being delivered.

How Cost-Shares are Calculated
Your cost shares for Emergency Services or for Covered Services received by an Out-of-Network Provider at an In-Network Facility, will be calculated using the median Plan In-Network contract rate that we pay In-Network Providers for the geographic area where the Covered Service is provided. Any Out-of-Pocket cost shares you pay to an Out-of-Network Provider for either Emergency Services or for Covered Services provided by an Out-of-Network Provider at an In-Network Facility will be applied to your In-Network Out-of-Pocket Limit.

Appeals
If you receive Emergency Services from an Out-of-Network Provider or Covered Services from an Out-of-Network Provider at an In-Network Facility and believe those services are covered by the No Surprise Billing Act, you have the right to appeal that claim. If your appeal of a Surprise Billing Claim is denied, then you have a right to appeal the adverse decision to an Independent Review Organization as set out in the “Appeals and Complaints” section of this Benefit Book.

Transparency Requirements
We provide the following information on our website (i.e., www.anthem.com).
• Protections with respect to Surprise Billing Claims by Providers.
• Estimates on what Out-of-Network Providers may charge for a particular service.
• Information on contacting state and federal agencies in case you believe a Provider has violated the No Surprise Billing Act’s requirements.

Upon request, we will provide you with a paper copy of the type of information you request from the above list.
We, either through our price comparison tool on anthem.com or through Member Services at the phone number on the back of your ID card, will allow you to get:

• Cost sharing information that you would be responsible for, for a service from a specific In-Network Provider.
• A list of all In-Network Providers.
• Cost sharing information on an Out-of-Network Provider’s services based on our reasonable estimate based on what we would pay an Out-of-Network Provider for the service.

In addition, we will provide access through our website to the following information:
• In-Network negotiated rates,
• Historical Out-of-Network rates, and
• Drug pricing information.