CARE SYNERGY

TEAM MEMBER BENEFITS GUIDE

MAKE THE MOST OF YOUR BENEFITS

2025

Care Synergy Benefits

This Benefits Guide is for general educational purposes and is based on information provided by the employer, summary plan descriptions, and other sources. In case of discrepancy, plan documents will prevail over information presented in this Guide. Please treat this information as confidential and only share it with your dependents. Contact Human Resources with questions.

Eligibility & Enrollment

Welcome to the Care Synergy Benefits Guide

Our benefit plans have been designed to provide you with a package that is both comprehensive and responsive to the needs of all our team members. This booklet is intended to assist in navigating through your benefits choices. The descriptions included in this summary are based on the documents that legally govern how the plans work. In the event of a discrepancy between the descriptions in this summary and the controlling contracts and/or plan documents, the language in the controlling contracts or plan documents will govern. To request a copy of the plan documents, please contact your Human Resources Department.

Our open enrollment period is November 1, 2024 through November 15, 2024.

Open enrollment requires benefit eligible team members to actively log into UKG and either re-enroll in current benefits, enroll in new benefits or decline benefits.

ENROLLMENT REQUIRES A PC OR LAPTOP

Enrollment cannot be completed on mobile device

Who is Eligible for Benefits?

For new hires, your coverage will be effective the first of the month after the date of hire. If you enroll during open enrollment, your coverage is effective January 1 of the following year.

Team members classified as full-time or part-time, regularly scheduled to work at least 20 hours per week, are eligible (along with eligible family members) to participate in the Care Synergy benefit plans.

Eligible family member.

For purposes of these benefits, eligible family members include:

- Your legal spouse.
- Legally-Recognized Domestic Partner (notarized affidavit required).
- Your child(ren), less than 26 years of age. Child(ren) shall include a natural or legally adopted child(ren), stepson or stepdaughter, and/or a child who is less than 26 years of age and has been placed under your legal guardianship.
- Your child who is 26 years of age or over, and who is:
    - Mentally or physically incapable of earning a living;
    - Primarily supported by you.

What's New in 2025?

Virtual Benefit Fair: https://flimp.live/Care-Synergy-2025-Benefits
We will be hosting a *Virtual Benefits Fair* for the 2025 plan year
  - Open Enrollment will occur **November 1st** through **November 15th**!
  - Eligible team members **must** elect and/or decline benefits accordingly.
- Access to a variety of benefit tools to assist you in making the best choices for you and your family
  - PLANselect
  - Access to UKG
  - Access to the Care Synergy Benefits Guide
- Navigate through the booths in the exhibit hall to locate information on all available benefits.

Pharmacy Benefit Manager
- Previously, pharmacy was managed through RxBenefits. This year, we have decided to move the pharmacy back under Cigna aligning the medical and pharmacy coverage.
- This should provide an easier and more streamlined experience for our team members!

CIGNA Medical Plan and Rate Changes:
In response to rising healthcare costs, our medical plan premiums have increased this year. Through strategic adjustments to our plan design, Care Synergy has been able to minimize the impact on our 2025 premiums. The enterprise has consistently worked to insulate our team members from excessive increases over the years. For instance, the employer has taken on most to all the rate increases over the last six years, only increasing the team member cost share two times, this is the second time. Furthermore, our team member rates continue to be lower than the average rate nationwide. Below is an example of how the plans and rates are changing in 2025.

- Medical Plan Design
  - HDHP deductibles and out-of-pocket are increasing:
    - Deductible increased to $3,500 individual/$7,000 individual +1 and maximum out-of-pocket to $4,000 individual/$8,000 individual +1, coinsurance is adjusted to 90% covered/10% team member responsibility.
  - PPO deductibles and out-of-pocket maximum are increasing:
    - Deductible increased to $3,000 individual/$6,000 individual +1 and out-of-pocket maximum increased to $4,500 individual/$9,000 individual +1, urgent care copay is covered as deductible/coinsurance.
- Medical Rates - below is an example of the employee only coverage rate changes:

Plan Name	2024 Per Paycheck Rate	2025 Per Paycheck Rate	Difference
Medical HDHP (FT EE)	$ 43.91	$48.16	$4.25
Medical PPO (FT EE)	$ 85.42	$93.67	$8.25
Medical HDHP (PT EE)	$110.24	$120.90	$10.66
Medical PPO (PT EE)	$151.75	$166.42	$14.67

Rocky Mountain Reserve
- IRS maximum yearly contributions increase for HSA

Additional Resources Available:
- Cigna Pre-Enrollment Benefit Hotline will be made available to all eligible Team Members to assist in answering questions regarding medical and dental plans, locating a doctor, and providing additional Cigna resources.

Keep an eye on Blink and check your email often to stay up to date on benefits and the open enrollment process!

Enrolling in your Benefits

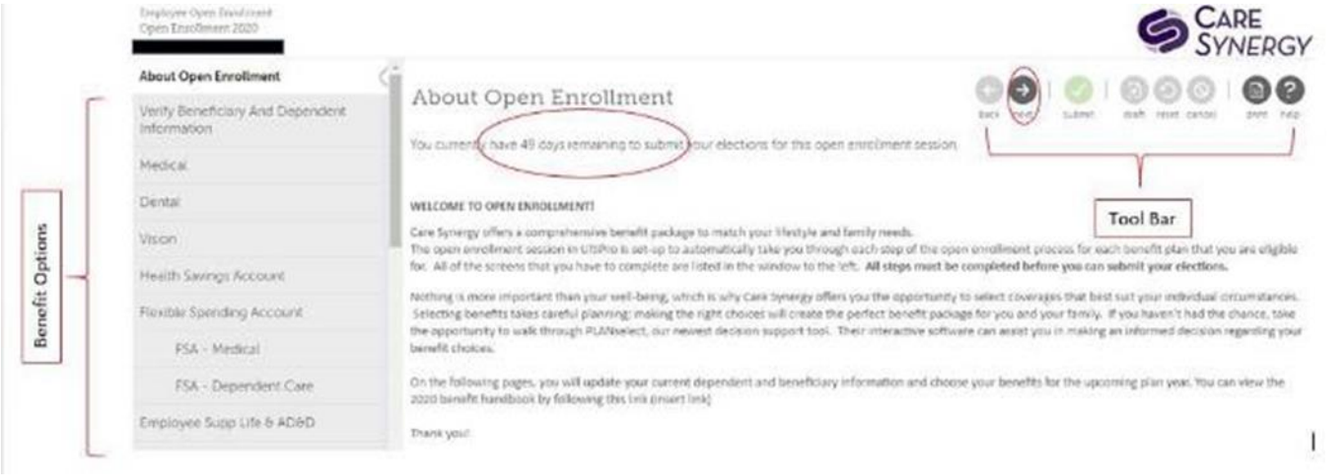
HOW TO ENROLL

Completing your enrollment is easy using UKG! Just log in and get started.

Tip: Take the time to read the messaging that coincides with each benefit offering, as it contains important information regarding your benefit choices.

Access your Open Enrollment session

1. Log in to UKG using Single Sign On
2. Navigate to Myself > Open Enrollment,
3. This will open the About Open Enrollment page
    a) Left Pane: Lists all the Benefits Options
    b) Middle Section: Welcome message including number of days to complete the online open enrollment process
    c) Navigation Toolbar: Command buttons to navigate through the open enrollment process

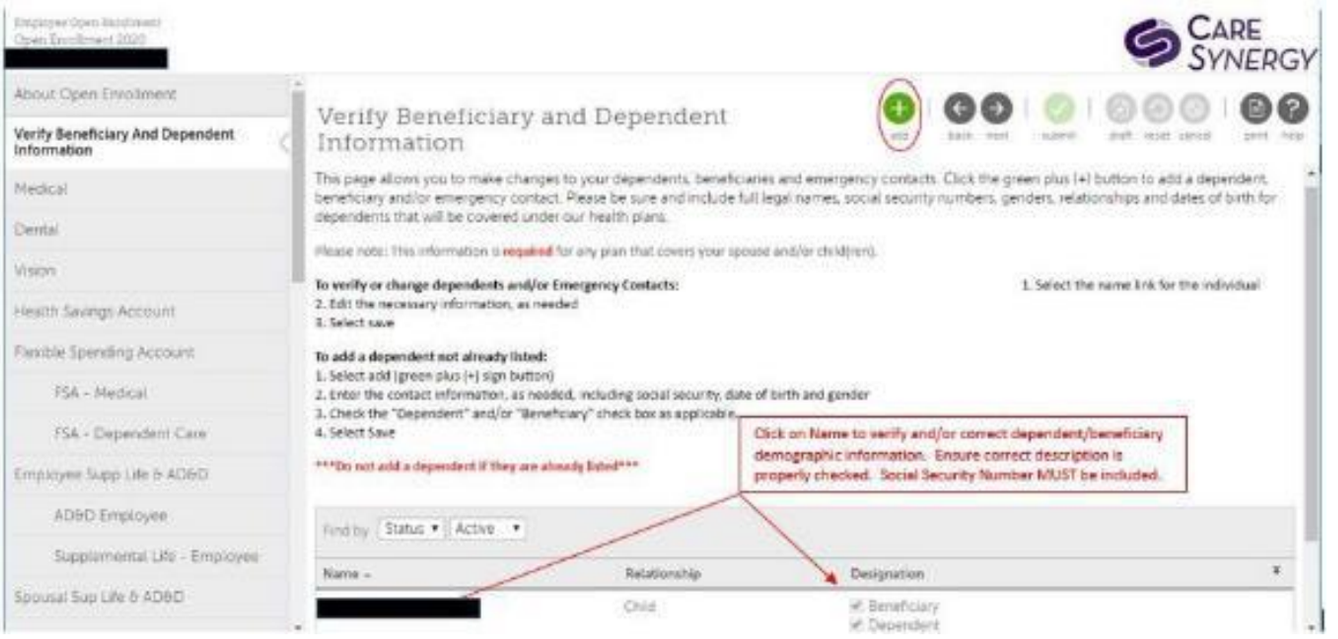


<u>Begin the online enrollment process</u>

4. Click Next button on the Navigation toolbar
5. This will open the Verify Beneficiary and Dependent Information page
    a. Verify and/or correct all dependent and beneficiary information for each qualified dependent that you will be enrolling and each beneficiary that you will be designating by clicking on the person's name
    b. If you need to add a dependent and/or beneficiary, click the Add button and enter the requested information

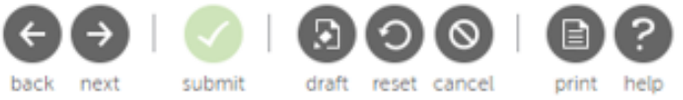
    NOTE: You will need the dependent and/or beneficiary's Full Legal Name, Date of Birth, and Social Security Number

    c. Ensure the correct Designation is checked next to the person's name



6. Click Next to continue through the enrollment process
   a. Simply navigate through each benefit by clicking the Next button in the navigation bar
   b. Once you have enrolled in or declined a benefit coverage, click Next to move to the next benefit option
   c. Repeat the process for each benefit offered

If you make an error or have questions, you can use the buttons in the Navigation Tool Bar.



Each button is designed to assist you in navigating through the open enrollment process. If a button is grayed out, it is not available to you. The appropriate buttons become available as you continue through the enrollment process.

Back – Takes you to the previous screen
Next – Takes you to the next screen
Draft – Saves selection as a draft
Reset – Resets screen to original
Cancel – Takes you out of the enrollment screen
Print – Allows you to print document

The submit button will not be available until you've completed the process. Once you've gone through each enrollment option, the Submit button will turn green, allowing you to confirm your enrollment elections.

7. Review your selections carefully to ensure that everything is correct and accurate, which includes the plans, your covered dependents and your insurance beneficiaries

8. When you are ready to finalize your elections, click the Submit button

9. Review the summary page, confirm your elections and click Submit a second time to authorize your elections

TIP: You can use the Quick Tours and Tips link to the right of your screen to assist you through the process. There is also a "Help" button to answer questions regarding the current screen.

Additional Enrollment Information

If you are enrolling a spouse in the medical plan, be sure to complete the Spousal Surcharge Affidavit section during the UKG enrollment process. If a team member's spouse has other group medical coverage available and chooses not to enroll in that coverage, you will be charged a Spousal Surcharge. You may be required/requested to submit additional documentation.

In addition, team members enrolling in a medical plan who are not able to attest that they are tobacco free or have not completed a Tobacco Cessation Program, will be charged a Tobacco Use Surcharge.

If you have any questions regarding the enrollment process or your benefits in general, ask for assistance by contacting Benefits@caresynergynetwork.org.

Note: You may be eligible for medical coverage if you fall under the ACA hours of service definition. The ACA defines a full-time employee as an employee who is employed and averages at least 30 hours of service per week with that employer. The regulations provide for a monthly equivalency, which states that 130 hours of service in a calendar month is treated as monthly equivalency.

Making changes to your benefits during the year

The only time you may make a change in your coverage during the plan year is when you have a qualified change in your family or employment status, also known as a Qualifying Life Event (QLE). You may change from one coverage type to another upon the occurrence of one of the qualifying events listed below, providing you apply for the change in coverage within 30 days of the qualifying event and provide supporting documentation.

Qualifying Life Event (QLE): A change in your situation, for instance marriage, birth of a child, or losing health coverage, allows eligibility for a special enrollment period to enroll in health insurance outside the annual open enrollment period.

1. Change in marital status
2. Change in number of dependents
3. Change in employment
4. Change in dependent eligibility due to plan requirements (e.g., loss of student status, age limit reached)
5. Change in residence (e.g., team member or dependent moves out of plan service area)
6. Significant cost changes in coverage
7. Significant curtailment of coverage
8. Addition or improvement to benefits package option
9. Change in coverage of spouse or dependent under another employer plan (e.g., spouse's employer had no insurance coverage before but now offers a plan)
10. Loss of certain other health coverage (e.g., plans provided by governmental or educational institutions)
11. Health Insurance Portability and Accountability Act (HIPAA) special enrollment rights
12. Judgements, decrees or orders
13. Entitlement to Medicare or Medicaid
14. Change in hours worked to less than 30 hours per week on average if the team member and covered family members enroll in another plan providing minimum essential coverage
15. Enrollment in the marketplace exchange plan during an exchange special or open enrollment period. Team members and others covered must enroll in the exchange plan by the first day after coverage ends under the employer plan

This qualifying life event list is not all-inclusive, please refer to IRS Section 125 Qualifying Event Checklist. Supporting documentation of a life event will be required. Changes to your benefits must be made within 30 days of the event and must be consistent with your change in status.

Flimp Virtual Benefits Fair

https://flimp.live/Care-Synergy-2025-Benefits

Flimp Benefits Fair is an online resource, along with your benefits guide and other resources, designed to help you make benefit choices that best meet your individual and family needs. Along with informative videos and downloads, you can access PLANselect.

PLANselect: a simple tool to help you select the right health plan and voluntary benefits. This is a major financial decision, so what's the right plan for you and your family?

The tool provides a personalized cost and value analysis with an opportunity for savings, without submitting personal information.

The best plan choice is not necessarily the least expensive or even the richest in coverage. It's the plan that provides the best value – the one that covers anticipated medical services for the lowest cost with the features you need.

Answer a few simple questions and you will see a comprehensive assessment and ranking of options in less than four minutes. It's easy to use and mobile friendly!

PLANselect®

BENEFITS-DECISION SUPPORT

Medical, Dental & Vision

Your Health Benefits – Cigna Medical

	LOCAL PLUS CONSUMER HEALTH PLAN (HDHP) WITH HSA PLAN		LOCAL PLUS PPO PLAN	
PLAN BASICS	**IN-NETWORK**	**NON-NETWORK**	**IN-NETWORK**	**NON-NETWORK**
Deductible Individual/Family	$3,500/$7,000	N/A	$3,000/$6,000	N/A
Calendar Year Deductible	Embedded		Embedded	
Coinsurance Plan/Member	90%/10%	N/A	80%/20%	N/A
Maximum Out-of-Pocket Individual/Family	$4,000/$8,000	N/A	$4,500/$9,000	N/A
Out-of-Pocket Includes	Deductible and Coinsurance		Deductible, Copays and Coinsurance	
NETWORK BENEFITS	YOU PAY		**YOU PAY**	
Office Visit Copay Primary/Specialist	10% after Deductible	N/A	20% Deductible Waived+	N/A
Preventive Care (Including Lab)	$0	N/A	$0	N/A
CIGNA Telehealth++	10% after Deductible	N/A	$15 Copay	N/A
Urgent Care	10% after Deductible	N/A	20% After Deductible	N/A
Emergency Room	10% after Deductible		20% After Deductible	
Diagnostic Lab	10% after Deductible	N/A	20% After Deductible	N/A
Diagnostic X-Ray	10% after Deductible	N/A	20% After Deductible	N/A
Advanced Imaging (MRI, CT, PET)	10% after Deductible	N/A	20% After Deductible	N/A
Inpatient Hospital	10% after Deductible	N/A	20% After Deductible	N/A
Outpatient Facility	10% after Deductible	N/A	20% After Deductible	N/A
Inpatient Mental Health	10% after Deductible	N/A	20% After Deductible	N/A
Outpatient Mental Health	10% after Deductible	N/A	20% Deductible Waived+	N/A
Spinal Manipulation	10% after Deductible 20 visit maximum	N/A	20% After Deductible, 20 visit maximum	N/A
RX COPAYS*				
Tier 1	10% after Deductible		$15	Mail Order $30
Tier 2	10% after Deductible		$50	Mail Order $100
Tier 3	10% after Deductible		$70	Mail Order $140
Specialty Drug	10% after Deductible		20% to $200	N/A

Get the most out of your plan by creating your online profile at mycigna.com or by downloading the app.
More information on how to get started and other great Cigna programs starting on p. 19.

* If your Doctor prescribes a medication where a generic equivalent is available, you may be responsible for the difference in cost if "dispense as written" is not indicated.

\+ The Deductible is only waived for the PPO plan for office visits with a primary care or specialist physician. This does not apply to the HDHP plan and may not apply for all services received during an office visit.

++ Due to the provisions surrounding qualified Consumer Health Plans (HDHP), members are responsible for the full cost of coverage, *including Telehealth services*, prior to meeting the deductible. The typical cost of a telehealth visit is around $55. Keep in mind, this may change at any point during the year based on the provider. Once a member has met the deductible, members will pay 10% of the cost of a telehealth visit until reaching the out-of-pocket-maximum.

Medical Plan Rates

Full Time Team Members (30+ hours per week)

Cigna Consumer Health Plan (HDHP)

MONTHLY	TEAM MEMBER ONLY	TEAM MEMBER + SPOUSE/ DOMESTIC PARTNER	TEAM MEMBER + CHILD(REN)	TEAM MEMBER + FAMILY
Total Cost	$926.35	$1,664.19	$1,571.97	$2,309.82
Care Synergy Contribution	$830.04	$1,298.45	$1,262.17	$1,785.69
Team Member Contribution	**$96.31**	**$365.74**	**$309.80**	**$524.13**

Cigna PPO

MONTHLY	TEAM MEMBER ONLY	TEAM MEMBER + SPOUSE/ DOMESTIC PARTNER	TEAM MEMBER + CHILD(REN)	TEAM MEMBER+ FAMILY
Total Cost	$1,012.60	$1,834.55	$1,730.49	$2,552.35
Care Synergy Contribution	$825.25	$1,288.99	$1,253.35	$1,772.21
Team Member Contribution	**$187.35**	**$545.56**	**$477.14**	**$780.14**

Part Time Team Members (20-29 hours per week)

Cigna Consumer Health Plan (HDHP)

MONTHLY	TEAM MEMBER ONLY	TEAM MEMBER + SPOUSE/DOMESTIC PARTNER	TEAM MEMBER + CHILD(REN)	TEAM MEMBER + FAMILY
Total Cost	$926.35	$1,664.19	$1,571.97	$2,309.82
Care Synergy Contribution	$684.55	$932.71	$952.37	$1,261.57
Team Member Contribution	**$241.80**	**$731.48**	**$619.60**	**$1,048.25**

Cigna PPO Plan

MONTHLY	TEAM MEMBER ONLY	TEAM MEMBER + SPOUSE/DOMESTIC PARTNER	TEAM MEMBER + CHILD(REN)	TEAM MEMBER + FAMILY
Total Cost	$1,012.60	$1,834.55	$1,730.49	$2,552.35
Care Synergy Contribution	$679.76	$923.25	$943.55	$1,248.08
Team Member Contribution	**$332.84**	**$911.30**	**$786.94**	**$1,304.27**

Domestic Partner coverage is subject to imputed income.

Surcharge

If a team member's spouse/legally recognized domestic partner has other group medical coverage available and chooses not to enroll in that coverage, you will be charged a Spousal Surcharge. For 2025, the surcharge amount will be:

	SPOUSAL SURCHARGE
Monthly	$200.00

Team members enrolling in the medical plan who are not eligible to attest that they are tobacco-free or have not completed a Tobacco Cessation Program, will be charged a Tobacco Use Surcharge. For 2025, the surcharge amount will be:

	TOBACCO SURCHARGE
Monthly	$50.00

Which Plan is Right for Me?

When deciding between Medical plans, it's important to keep in mind the potential annual overall costs, including premiums (what you pay to access benefits through the plans), the amount Care Synergy deposits into an HSA (for those members on the HDHP or looking to enroll into it), and the plan Out of Pocket Maximum (the yearly limit before the plan pays 100% of remaining costs). Below is a helpful grid that shows the maximum cost of your healthcare, per plan and per coverage tier.

Annual Maximum Cost of Healthcare	Employee	Employee + Spouse / Domestic Partner	Employee + Child(ren)	Employee + Family
	Full Time			
HDHP W/HSA Annual Premiums PLUS Annual Out of Pocket MINUS Annual CSN HSA Contribution **TOTAL MAX ANNUAL COST**	$1,155.72 + $4,000.00 - **$1,000.00** **$4,155.72**	$4,388.88 + $8,000.00 - **$2,000.00** **$10,388.88**	$3,717.60 + $8,000.00 - **$2,000.00** **$9,717.60**	$6,289.56 + $8,000.00 - **$2,000.00** **$12,289.56**
PPO Annual Premiums PLUS Annual Co-Insurance **TOTAL MAX ANNUAL COST**	$2,248.20 + $4,500.00 **$6,748.20**	$6,546.72 + $9,000.00 **$15,546.72**	$5,725.56 + $9,000.00 **$14,725.56**	$9,361.56 + $9,000.00 **$18,361.56**
	Part-Time			
HDHP W/HSA Annual Premiums PLUS Annual Out of Pocket MINUS Annual CSN HSA Contribution **TOTAL MAX ANNUAL COST**	$2,901.60 + $4,000.00 - **$1,000.00** **$5,901.60**	$8,777.76 + $8,000.00 - **$2,000.00** **$14,777.76**	$7,435.20 + $8,000.00 - **$2,000.00** **$13,435.20**	$12,579.00 + $8,000.00 - **$2,000.00** **$18,579.00**
PPO Annual Premiums PLUS Annual Co-Insurance **TOTAL MAX ANNUAL COST**	$3,994.08 + $4,500.00 **$8,494.08**	$10,935.60 + $9,000.00 **$19,935.60**	$9,443.16 + $9,000.00 **$18,443.16**	$15,651.24 + $9,000.00 **$24,651.24**

Your new pharmacy benefits

Your Cigna Healthcare℠ pharmacy benefits provide you with access to many programs and services that can help you manage your health and prescription medication needs.

1. Refill your prescription(s) before your current plan ends

This will help make sure you have enough medication at home while you're getting started with your new Cigna pharmacy plan.

2. Go online to see how your medication is covered under your new plan

Go to **Cigna.com/druglist** to see your drug list before your new plan starts. You can see what tier your medication is covered on and/or if your medication needs approval before it can be covered.

If your medication needs pre-approval, call your doctor's office.

- Have your new Cigna Healthcare ID card handy when you call. Your doctor's office will need the information listed on the card.
- Let your doctor's office know you now have coverage through Cigna Healthcare. Give them your new insurance information.
- Let them know that your medication needs approval from Cigna Healthcare before it can be covered.
- Ask them to contact Cigna Healthcare as soon as possible to start the coverage review process. They know how the review process works and will take care of everything for you. In case your doctor's office asks, they can download a request form from the Cigna Healthcare provider portal at **cignaforhcp.com**.

Cigna Healthcare will review information your doctor sends us to make sure your medication meets coverage requirements. We'll send you and your doctor a letter with next steps. It can take between 1–5 business days to hear from us. You can always check with your doctor's office to find out if a decision has been made. Once your new plan starts, you can also log in to the **myCigna® App**[1] or **myCigna.com®** to check on your approval.

3. Go online to see if your retail pharmacy is in-network

- **Before your new plan starts**: Go to **CignaHealthcare.com** and click on "Find a Doctor" to see if your pharmacy is in your new network.
- **Once your new plan starts**: Log in to the **myCigna App** or **myCigna.com** and use the Price a Medication tool to see which pharmacies are in your new network – and which ones offer the best price.[2] You can also use home delivery with Express Scripts® Pharmacy to fill your prescriptions.

Prescription Coverage FAQ's – Cigna Member Choice

Your pharmacy coverage will be provided by ***Cigna*** for 2025.

You will be able to manage your medications in the same place that you manage your medical coverage; ***mycigna.com***.

Register today to see what medications your plan covers, compare medication costs, and manage your prescriptions through the ***My Medications page***.

Member Choice - A pharmacy network designed to boost engagement and avoid surprises.

Member Choice Cigna 90 Now puts customers in control of where they fill their 30- and 90-day medications. Members can choose the pharmacy location and pharmacist care team that works best for them. With pharmacists playing an increasingly important role on the care team, there's opportunity to drive better patient adherence, clinical outcomes, satisfaction and overall health care savings.

While the networks are broadly identical, you will be required to select Walgreens or CVS as your anchor pharmacy. The pharmacy not selected will be out-of-network. The selected anchor pharmacy for Care Synergy will be Walgreens. You may update this by calling into Cigna or logging into mycigna.com. You can change your pharmacy anchor once at open enrollment and once per year outside of open enrollment. Relocation and other events will allow for a change to the anchor pharmacy outside of open enrollment and the once per year change allotment.

Option 1	Option 2
Walgreens	**CVS Pharmacy**
30-day supply: 55,000 pharmacies 90-day supply: 30,000 pharmacies	30-day supply: 55,000 pharmacies 90-day supply: 30,000 pharmacies
Voluntary or Exclusive 90-day supply benefit design available at one of the 30,000 pharmacies. **Network excludes CVS**	Voluntary or Exclusive 90-day supply benefit design available at one of the 30,000 pharmacies. **Network excludes Walgreens**

Mail Order through Express Scripts Pharmacy

Make fills easier.

Use home delivery with Express Scripts® Pharmacy.

Home delivery with Express Scripts® Pharmacy is a convenient option when you're taking a medication on a regular basis.[1] It's simple, safe – and saves you trips to the pharmacy.

Make fills easier. Have your medication sent to your home.

With just a few simple clicks of your mobile phone, tablet or computer, your important medications will be on their way to your door (or location of your choice).

- **Easily order, manage, track and pay for your medications** on your phone or online
- Standard shipping at **no extra cost**[2]
- Fill up to a **90-day supply** at one time[3]
- Helpful pharmacists **available 24/7**
- **Automatic refills**[4] or refill reminders so you don't miss a dose
- **Flexible payment options** – split your bill into three smaller equal payments

Three easy ways to get started using Express Scripts® Pharmacy

1. **Log in to the myCigna® App[5] or myCigna.com® to move your prescription electronically.** Click on the Prescriptions tab and select My Medications from the dropdown menu. Then simply click the button next to your medication name to move your prescription(s). Or,
2. **Call your doctor's office.** Ask them to send a 90-day prescription (with refills) electronically to Express Scripts Home Delivery. Or,
3. **Call Express Scripts® Pharmacy at 800.835.3784.** They'll contact your doctor's office to get your prescription. Have your Cigna Healthcare℠ ID card, doctor's contact information and medication name(s) ready when you call.

Got a new prescription?

Ask your doctor to send it to Express Scripts® Pharmacy for you.

1. **Electronically:** For fastest service, have them send it electronically to Express Scripts® Home Delivery, NCPDP 2623735. Or,
2. **By fax:** Have them call **888.327.9791** to get a Fax Order Form.

cigna healthcare

From programs that help improve your health to tools that help manage your health spending, there's so much you can do on myCigna.com or the myCigna® app.

- Find in-network doctors, hospitals and medical services
- Manage and track claims
- See cost estimates for medical procedures
- Compare quality of care information for doctors and hospitals
- Access a variety of health and wellness tools and resources

The myCigna website and app both have an easy, interactive health assessment to help you learn more about your health and what you can do to improve it.

Register today

You can register online or through the app.

1. Go to the **myCigna.com** website or launch the **myCigna app** and select "Register Now"
2. **Enter** your requested information
3. **Confirm** your identity
4. **Create** your security information and provide your primary email address
5. **Review** and submit

Feel better-protected

Cigna is as committed to helping protect your health information as we are to protecting your health and well-being. That's why we take certain steps to enhance the security of your personal health information on the myCigna website and app.

- **Enhanced registration**
- **Two-step authentication**

Together, all the way.®

Cigna®

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Enhanced registration

When you register for the first time on the myCigna website or app, you'll be required to provide a primary email address. Having an email address helps Cigna better protect the information in your myCigna account. We can send automatic alerts when you update your email or password. Your email address also can be used when you need help recovering your myCigna user ID or password.

Two-step authentication

With two-step authentication, you have the option of adding an extra layer of security to your myCigna account to further protect your claim, health and account information.

1. First, you'll be encouraged **to add, update and verify contact information – email addresses and mobile phone numbers.**

2. Once you enable two-step authentication and log in to your myCigna account, you'll be asked **to enter your user ID and password, as well as a six digit code that will be sent to either your email address or mobile phone number**. You'll also be offered to select "Remember this Device." If this choice is selected, you won't be prompted for a code each time you log in to your myCigna account from that device.

Questions?

If you have any questions about your myCigna account or your plan benefits, call the number on the back of your Cigna ID card. Customer service representatives are ready to speak with you 24/7/365.

Now compatible with iPhone® X devices

The Apple® Face ID® feature for iPhone X devices is a new way to unlock and authenticate your myCigna app. It's even more convenient than the Touch ID® tool, and makes authenticating fast and easy. Other iPhone users can still use Touch ID to log in to the app.*

Together, all the way.®

Cigna®

* Please refer to your phone's manufacturer for your phone's specific capabilities. The downloading and use of the myCigna app is subject to the terms and conditions of the app and the online stores from which it is downloaded. Standard mobile phone carrier and data usage charges apply.

Have your ID card handy?

With myCigna, the answer is always "yes."

Big news: You never have to worry about misplacing your ID card. It's always right there on myCigna®, whenever and wherever you need it.*

Accessing your digital ID cards is easy.

- Log in to **myCigna.com** or the **myCigna® App**
- Click or tap "ID Cards"
- View your card(s), as well as any dependents' card(s)**
- Email cards directly to doctors
- Save your digital ID cards in your Apple Wallet

Not registered on myCigna yet?
It's quick and easy.

Visit **myCigna.com®** or scan the QR code to download the **myCigna® App** and register now.

cigna healthcare

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Offered by Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company or their affiliates.

The Cigna Motivate*Me* Program® rewards your healthy actions

Your employer wants to help you get healthy and stay healthy. So when you get involved in wellness goals sponsored by your company, you can earn **up to $125**. And the more you do, the more you earn.

- Health assessment Annual
- preventive exams
- Preventive dental goal
- Coach by phone
- And a variety of other healthy activities

Getting started is easy

Visit **myCigna.com** and select "Wellness" or "View my incentives" to:

- Find detailed instructions on how to get started
- View a list of eligible goals and matching rewards
- Check and track your completed goals and earned rewards.

Reasonable alternatives may be available for certain activities. Please refer to program materials for more information.

The rewards you earn will be automatically applied toward a:

- Debit/gift card

The rest is up to you

For more information or help setting up your account, visit **myCigna.com** or call **800.244.6224**.

*Incentive awards may be subject to tax; you are responsible for any applicable taxes. Please consult with your personal tax advisor for assistance.

Cigna®

If you are eligible for an incentive as part of your Employer wellness program: For all participants - If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Please refer to your Employer's program materials for program and contact information, or contact Cigna at 855.246.1873 and they will work with you and, if you wish, with your doctor.

For participants who may have an impairment - If you are unable to participate in any of the program events, activities or goals because of a disability, you may be entitled to a reasonable accommodation for participation, or an alternative standard for rewards. For worksite accommodations please contact your Employer or HR administrator. For accommodations with online, phone or other Cigna programs, please contact Cigna at 855.246.1873.

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The Cigna Motivate*Me* Program® rewards your healthy actions

Many of you are already completing healthy actions – like completing annual physical, getting a preventive dental exam, even working to lower your stress - and leaving money on the table! All it takes is logging into mycigna.com and clicking the "Wellness" tab. Cigna takes care of the rest – even reviewing submitted claims so you don't have to.

Get a personalized health assessment	$25 gift card
Complete my annual physical (preventive exam)	$50 gift card
Get my annual OB/GYN exam (preventive exam)	$50 gift card
Get my mammogram (preventive exam)	$50 gift card
Get my colon cancer screening (preventive exam)	$50 gift card
Talk to a health coaching and make progress to overcome a chronic health problem	$50 gift card
Get help improving lifestyle habits – tobacco	$25 gift card
Get help improving lifestyle habits – weight	$25 gift card
Get help improving lifestyle habits – stress	$25 gift card
Select & add your Cigna care designated provider to your health team	$25 gift card
Receive care from you Cigna designated provider	$25 gift card
Get a preventive dental exam	$25 gift card
Participate in the Cigna Fitness Challenge	$25 gift card

Complete a combination of healthy actions for a max of $125 in gift card rewards!

Telemedicine

Your employees' lives are demanding. It's hard for them to find time to take care of themselves as it is, never mind when they're not feeling well. That's why health plans through Cigna include access to medical and behavioral/mental health virtual care.

Whether they've got meetings all day or they just don't have the time or energy to go anywhere but home after work, employees can:

- Access care from just about anywhere via video or phone.
- Get minor medical virtual care 24/7/365 – even on weekends and holidays.
- Schedule a behavioral/mental health virtual care appointment online in minutes.
- Access board-certified doctors and pediatricians as well as licensed counselors and psychiatrists.
- Have a prescription sent directly to a local pharmacy, if appropriate.

Convenient, not costly.

Medical virtual care for minor conditions costs less than ER or urgent care center visits, and maybe even less than an in-office primary care provider visit.

Together, all the way.®

Cigna.

Minor medical virtual care

Board-certified doctors and pediatricians can diagnose, treat and prescribe most medications for minor medical conditions, such as:

- Acne
- Allergies
- Asthma
- Bronchitis
- Cold and flu
- Constipation
- Diarrhea
- Earaches
- Fever
- Headaches
- Infections
- Insect bites
- Joint aches
- Nausea
- Pink eye
- Rashes
- Respiratory infections
- Shingles
- Sinus infections
- Skin infections
- Sore throats
- Urinary tract infections

MDLIVE providers can also conduct virtual wellness screenings.

Behavioral/Mental health virtual care

Licensed counselors and psychiatrists can diagnose, treat and prescribe most medications for nonemergency behavioral conditions, such as:

- Addictions
- Bipolar disorders
- Child/Adolescent issues
- Depression
- Eating disorders
- Grief/Loss
- Life changes
- Men's issues
- Panic disorders
- Parenting issues
- Postpartum depression
- Relationship and marriage issues
- Stress
- Trauma/PTSD
- Women's issues

Virtual care options

Cigna partners with MDLIVE* for minor medical and behavioral/mental health virtual care.* This can be accessed via **myCigna.com**. Aditionally, Cigna's in-network medical and behavioral providers also provide access to virtual medical and behavioral care, including virtual counseling.

Connect with virtual care your way.

- Contact your in-network provider or counselor
- Talk to an MDLIVE medical provider on demand on **myCigna.com**
- Schedule an appointment with an MDLIVE provider or licensed therapist on **myCigna.com**
- Call MDLIVE 24/7 at 888.726.3171

Encourage your employees to access virtual care whenever and wherever they need it.

Cigna.

Virtual medical care is available from MDLIVE. Behavioral/mental health virtual care is available from MDLIVE.

*Cigna provides access to virtual care through national telehealth providers as part of your plan. Providers are solely responsible for any treatment provided to their patients. Video chat may not be available in all areas or with all providers. This service is separate from your health plan's network and may not be available in all areas or under all plan types. A primary care provider referral is not required for this service.

In general, to be covered by your plan, services must be medically necessary and used for the diagnosis or treatment of a covered condition. Not all prescription drugs are covered. Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. See your plan materials for costs and details of coverage, including other telehealth/telemedicine benefits that may be available under your specific health plan.

Cigna Dental

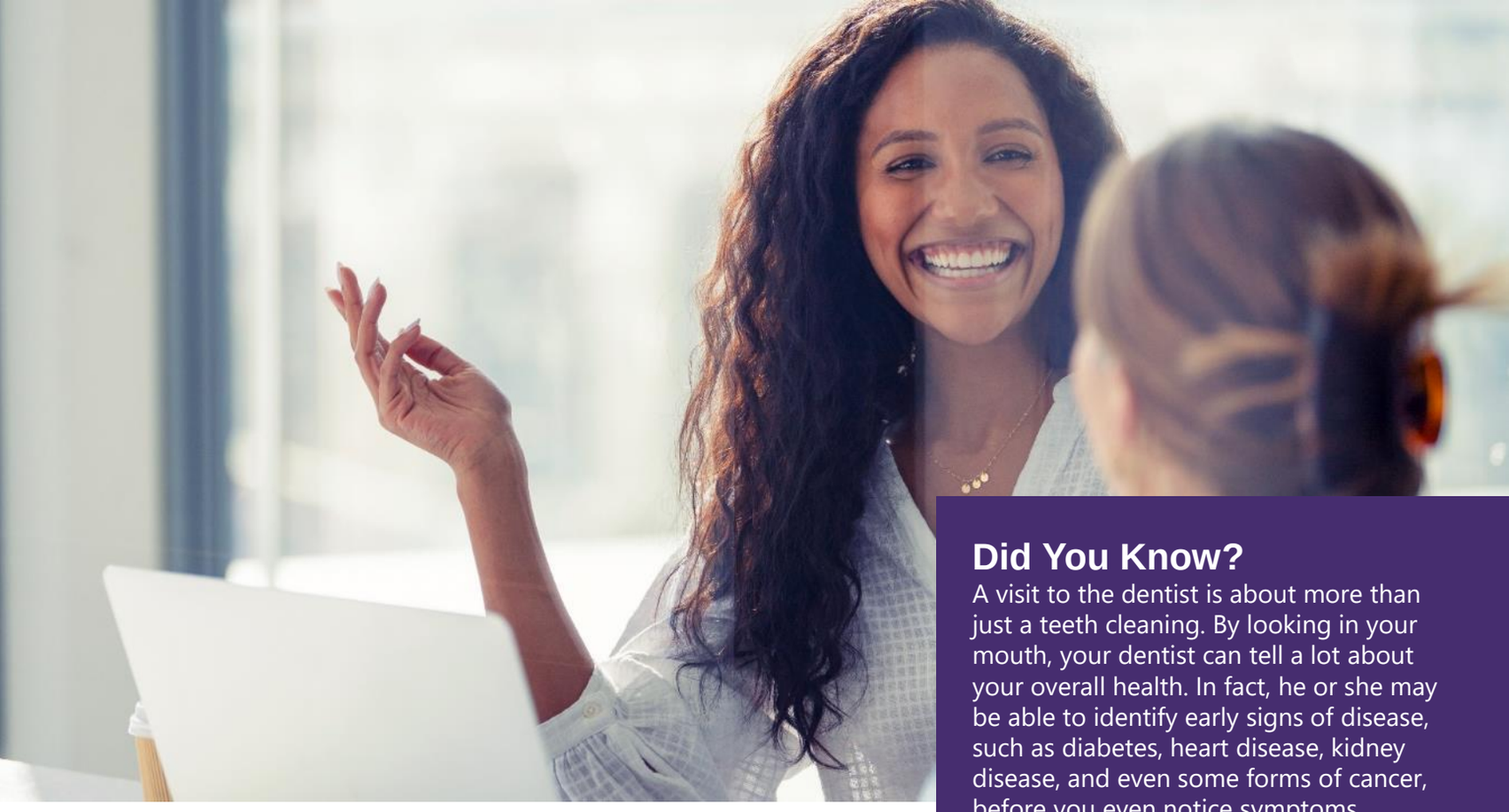
We are pleased to provide you with dental coverage through CIGNA. Below is a summary of the benefit. Refer to the plan description for full plan details.

	PPO PLAN		DHMO PLAN***
	NETWORK	NON-NETWORK	IN-NETWORK ONLY
Basic Information			
Network Provider Required	CIGNA DPPO	All Other Providers	CIGNA DHMO
Deductible (Individual/Family)	$50/$150	$50/$150	N/A
Deductible	Calendar Year	Calendar Year	N/A
Deductible Applies To	Type II & III	Type II & III	N/A
Dental Benefit Year Maximum	$2,000	$2,000	N/A
Preventive Care Applies to Maximum	No	No	N/A
Dependent (Unmarried) Child Age Limit	26	26	N/A
Orthodontia Lifetime Maximum	$1,500	$1,500	N/A
Orthodontia	Child & Adult	Child & Adult	Child & Adult
Type I – Diagnostic & Preventive	100% No Ded.	100% No Ded.	Copay Schedule*
Frequency of Exams/Cleanings	Twice Per Year	Twice Per Year	N/A
Type II – Basic Services	80% after Ded.	80% after Ded.	Copay Schedule*
Type III – Major Services	50% after Ded.	50% after Ded.	Copay Schedule*
Type IV – Orthodontic Services	50%	50%	Copay Schedule*
Periodontic Coverage	Type II	Type II	Copay Schedule*
Endodontic Coverage	Type II	Type II	Copay Schedule*
Implants	Type III	Type III	Copay Schedule*
Reasonable and Customary**	N/A	90%	N/A
Waiting Period (12 months)	50% coverage on Type III and IV	50% coverage on Type III and IV	None
Waiting Period Applies To:	Late Entrants	Late Entrants	N/A
Network Provider Required	CIGNA DPPO	All Other Providers	CIGNA DHMO
Deductible (Individual/Family)	$50/$150	$50/$150	N/A
Deductible	Calendar Year	Calendar Year	N/A
Deductible Applies To	Type II & III	Type II & III	N/A
Dental Benefit Year Maximum	$2,000	$2,000	N/A
Preventive Care Applies to Maximum	No	No	N/A
Dependent (Unmarried) Child Age Limit	26	26	N/A
Orthodontia Lifetime Maximum	$1,500	$1,500	N/A

* See HR for a Copay Schedule of Benefits, or go to MyCigna.com

** Reasonable and customary refers to the average cost of dental services in a given geographic area. If you are seeing an out-of-network provider, Cigna will use the 90th percentile of all provider charges in the geographic area to determine the plan payment amount for your dental services.

*** The DHMO network will differ slightly from the PPO plan. It is recommended that you confirm network status of your dentist before selecting this plan.



Did You Know?

A visit to the dentist is about more than just a teeth cleaning. By looking in your mouth, your dentist can tell a lot about your overall health. In fact, he or she may be able to identify early signs of disease, such as diabetes, heart disease, kidney disease, and even some forms of cancer, before you even notice symptoms.

Cigna Dental Rates

PPO Plan

MONTHLY	EMPLOYEE ONLY	EMPLOYEE + SPOUSE / DOMESTIC PARTNER	EMPLOYEE + CHILD(REN)	EMPLOYEE + FAMILY
Total Cost	$52.87	$104.98	$126.21	$196.51
Care Synergy Contribution	$5.93	$10.81	$15.18	$17.08
Employee Contribution	**$46.94**	**$94.17**	**$111.03**	**$179.43**

DHMO Plan

MONTHLY	EMPLOYEE ONLY	EMPLOYEE + SPOUSE / DOMESTIC PARTNER	EMPLOYEE + CHILD(REN)	EMPLOYEE + FAMILY
Total Cost	$13.99	$25.87	$35.38	$42.50
Care Synergy Contribution	$9.37	$17.32	$23.69	$28.45
Employee Contribution	**$4.62**	**$8.55**	**$11.69**	**$14.05**

Reminder: It is the team member's responsibility to confirm dentist participation in the DHMO plan.

Vision Insurance

VSP

Care Synergy offers a voluntary vision plan through VSP for team members and their family members. You can search for providers by visiting www.vsp.com.

SEE HEALTHY AND LIVE HAPPY WITH HELP FROM CARE SYNERGY AND VSP

Enroll in VSP® Vision Care to get personalized care from a VSP network doctor at low out-of-pocket costs.

VALUE AND SAVINGS YOU LOVE.
Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras for additional savings.

PROVIDER CHOICES YOU WANT.
It's easy to find a nearby in-network doctor. Maximize your coverage with bonus offers and savings that are exclusive to Premier Program locations—including thousands of private practice doctors and over 700 Visionworks retail locations nationwide.

USING YOUR BENEFIT IS EASY!

Create an account on **vsp.com** to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with exclusive member extras. At your appointment, just tell them you have VSP.

QUALITY VISION CARE YOU NEED.
You'll get great care from a VSP network doctor, including a WellVision Exam®—a comprehensive exam designed to detect eye and health conditions.

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
YOUR COVERAGE WITH A VSP PROVIDER			
WELLVISION EXAM	Focuses on your eyes and overall wellness	$10	Every calendar year
PRESCRIPTION GLASSES		$25	See frame and lenses
FRAME	• $150 featured frame brands allowance • $130 frame allowance • 20% savings on the amount over your allowance • $130 Walmart®/Sam's Club® frame allowance • $70 Costco® frame allowance	Included in Prescription Glasses	Every other calendar year
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Included in Prescription Glasses	Every calendar year
LEN ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements	$0 $95 - $105 $150 - $175	Every calendar year
CONTACTS (INSTEAD OF GLASSES)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every calendar year
PRIMARY EYECARE℠	Retinal screening for members with diabetes Additional exams and services for members with diabetes, glaucoma, or age-related macular degeneration. Treatment and diagnoses of eye conditions, including pink eye, vision loss, and cataracts available for all members. Limitations and coordination with your medical coverage may apply. Ask your VSP doctor for details.	$0 $20 per exam	As needed

MONTHLY	EMPLOYEE ONLY	EMPLOYEE + SPOUSE / DOMESTIC PARTNER	EMPLOYEE + CHILD(REN)	EMPLOYEE + FAMILY
Total Cost	$8.62	$13.79	$14.08	$22.70
Employee Cost	**$8.62**	**$13.79**	**$14.08**	**$22.70**

Health Savings Account

Health Savings Account Enrollment Guide

ROCKY MOUNTAIN reserve

What is an HSA?

An HSA is a savings account where tax-free or tax-deductible deposits are made to pay for qualified medical expenses. HSA money can be used to pay for eligible expenses today or can be saved for future expenses. There is no "use-it or lose-it" at the end of the year. An HSA is owned by the participant and they retain ownership even if they change employment.

Know the Rules:

- Participants must have coverage under an HSA-qualified "high deductible health plan" (HDHP) to open and contribute to an HSA. Generally, this is health insurance that does not cover first-dollar medical expenses.
- Contributions to an HSA can be made by the participant, the employer, or both. HSA contributions are limited to a maximum each calendar year.
- HSA contributions may be made pretax through an employer or with post-tax dollars. If made with post-tax dollars individuals may take a deduction on their tax return.
- Once enrolled in Medicare, participants are no longer eligible to contribute to an HSA. However, the funds in the Health Savings Account are still owned by the account holder and can be used to pay for medical expenses tax-free.
- HSAs may be used to pay for eligible medical expenses of the participant, spouse or dependents.
- Only eligible medical expenses can be reimbursed under the plan. Eligible expenses are defined by the IRS. See the next page.
- Ineligible disbursements will be taxed and a penalty may apply.
- The funds in an HSA are always owned by the participant even if they:
  - Change employment
  - Change medical coverage
  - Become unemployed
  - Move to another state.
- Unlike other medical spending accounts, HSA funds remain in the account year to year. There are no "use-it or lose-it" rules for HSAs.
- Participant's contributing to a HSA may not participate in a "general" health (medical) FSA at the same time. They may participate in a "limited" health FSA which can be used to pay for dental and vision expenses only.
- HSA funds may earn interest and can be invested in mutual funds. Earnings in the account are tax-free.
- Eligible individuals who are 55 or older are eligible for an additional $1,000 catch-up contribution. In general, catch-up contributions for a spouse must be made into a separate HSA account opened in the name of the spouse.

An individual can contribute to an HSA if they meet the requirements:

1. Have coverage under an HSA qualified "high deductible health plan" (HDHP).
2. Are not covered by any other health plan including a general health FSA.
3. Are not enrolled in Medicare.
4. Cannot be claimed as a dependent on someone else's tax return.

	Maximum HSA Contribution 2025	Maximum Catch-Up Contribution 2025	Maximum HSA Contribution 2024	Maximum Catch-Up Contribution 2024
Individual	$4,300	$1,000	$4,150	$1,000
Family	$8,550		$8,300	

Use of HSA Funds

Spending HSA Dollars Just Got Easier

The Rocky Mountain Reserve Benefits Card provides instant access to the money in your Health Savings Account by automatically deducting funds from the available balance in your account when you make a purchase.

Benefits of Using the Debit Card

1. Easy to use - the Benefits Card is a stored-value card that simplifies the process of paying for qualified expenses.
2. Works at merchants where VISA is accepted.
3. It pays directly at the point of sale - no waiting for reimbursement!
4. The debit card may be used for online expenses including mail-order prescriptions.
5. Keep all receipts in case of a future IRS audit.
6. Rocky Mountain Reserve will never request receipts.

Common Eligible Medical Expenses:

- Acupuncture
- Ambulance
- Bandages
- Birth control pills
- Chiropractor
- Coinsurance, deductibles
- Contact lenses
- Contact lens solutions
- Contraceptive devices
- Crutches, splints, casts
- Dental treatment
- Diabetic supplies
- Diagnostic devices
- Eyeglasses, eye exams,sunglasses (prescription)
- Eye surgery
- Fertility enhancement
- Hearing aids, batteries
- Hospital services
- Immunizations, vaccines, flu shots
- Laboratory fees
- LASIK eye surgery
- Medicines (prescribed)
- Obstetric services
- Optometrist
- Orthodontia
- Prescription drugs
- Pregnancy test kits
- Psychiatric care
- Speech therapy
- Stop smoking programs
- Surgery/operations
- Therapy
- Thermometers
- Vasectomy
- Wheelchair
- X-rays

Health Care Reform:

Over-the-Counter Drugs ***do not*** require a prescription to be eligible for reimbursement under the plan.

- Allergy medications
- Antacids
- Anti-diarrhea medicine
- Cold medicine
- Cough drops and throat lozenges
- Incontinence supplies
- Laxatives
- Nicotine medications, gum, patches
- Pain relievers
- Sinus medications, nasal sprays, nasal strips
- Sleep aids
- Menstrual care products

Potentially Eligible Expenses:

A recommendation from a medical professional is required:

- Massage therapy
- Vitamins
- Herbal supplements
- Natural medicines
- Aromatherapy
- Weight-loss program
- Health club dues

Ineligible Expenses:

- Cosmetic surgery
- Hair transplant/re-growth
- Maternity clothes
- Nutritional supplements
- Personal use items: such as toiletries, tooth brush, facial care, shampoo
- Teeth whitening

For a more detailed list of medical expenses, go to: https://rockymountainreserve.com

Online Access

To Create Your Online Account:

1. Go to https://rockymountainreserve.com
2. Click on "Login/Register" in the top right-hand corner
3. Click on "Employee Registration"
4. Username will be the name you use to log in for the web portal and mobile application.
5. The password must contain at least 3 of these: special character, number, upper or lower case letter
6. For Employee ID Use SS# or other assigned Employee ID.
7. For Registration ID select "Card Number" which is your Benefits MasterCard. If you do not have a card, your Employer will give you an Employer ID.

Mobile Application:

On the mobile application, participants can see their account balance, transactions, and request disbursements.

Search "RMR Benefits" on the app store

IOS Store

Google Play

Flexible Spending Accounts

Flexible Spending Account Enrollment Guide

ROCKY MOUNTAIN reserve

What is an FSA?

A health Flexible Spending Account (FSA) allows individuals to use pre-tax dollars to pay for medical expenses not covered by insurance. A Dependent Care FSA (DCFSA) allows individuals to use pre-tax dollars for daycare or dependent care expenses. The dependent care FSA (DCFSA) cannot be used to pay for medical expenses. Individuals elect to contribute a portion of their paychecks pre-tax to a Health FSA or Dependent Care FSA and then can use those funds for eligible expenses.

Know the Rules:

Health (medical) FSA

The IRS maximum for 2025 is $3,300. Employers may set a lower limit.

Participants may claim and be paid out their entire annual election at any time.

Every expense must be substantiated. Participants must be able to provide receipts, statements or bills for all expenses if substantiation is requested. Documents must include the date, amount and description of the expense or service.

Only eligible expenses can be reimbursed. Medical expenses are defined by IRS rules. Expenses generally include items and services for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body. See IRS Publication 502.

All over-the-counter drugs are eligible along with all menstrual care products.

Only "out-of-pocket" medical expenses are eligible for reimbursement. Medical expenses covered by insurance or any other plan or program are not eligible for reimbursement.

Expenses for personal use or cosmetic surgery are not eligible for reimbursement. See IRS Publication 502.

Medical expenses reimbursed under the health (medical) FSA may not be used to claim a federal income tax deduction.

Health FSA and Dependent Care FSA

- Contributions are subject to the IRS "use-it-or-lose-it" rule. However, for the health FSA, the employer may adopt a provision allowing up to a $660 (2025) carry over of unclaimed monies. Unclaimed monies not carried over are forfeited at the end of the plan year.
- Elections cannot be changed during the plan year, unless the participant has a change of status. IRS Regulations define a change of status.
- Expenses must be incurred by a participant, spouse or eligible dependents during the current plan year and while participating. Expenses are incurred when the medical care is provided and not when the expense is billed, the bill is due or when the bill is paid.
- Every employer sets the deadline when claims and documentation must be submitted after the end of the plan year. It is usually 60 or 90 days after the end of the plan year.

Limited Purpose (dental & vision) FSA

- Employees contributing to a HSA may only participate in a "limited" health FSA not a "general" health FSA. A limited health FSA can only be used to pay for "out of pocket" dental and vision expenses.
- Please note when using the debit card for the Limited Purpose FSA it must be at a dental or vision facility that their MCC code is registered as a dental or vision facility. Otherwise it may pull from your HSA.

Dependent Care FSA

- Participants may only be paid what they have contributed at any point in time.
- Participants must be ready to provide receipts for dependent care expenses.
- Dependent care expenses reimbursed by the dependent care FSA may not be used to claim the day care credit.

Tax Savings Examples:

Dave, a single taxpayer, earns $27,000/year and has eligible medical expenses of $1,200/year.
Dave's annual savings realized by participating in the FSA is **$327**.

Michael and Sharon, working parents, earn a total of $48,000/year. They have $5,000 in child care expenses and $1,000 per year in eligible medical expenses.
Their annual savings realized by participating in the FSA is **$1,637**.

Assumptions are based off of 15% Federal, 4.63% State, and 7.65% FICA tax

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Eligible Expenses

ROCKY MOUNTAIN reserve

Common Eligible Medical Expenses:

- Eyeglasses, eye exams, sunglasses (prescription)
- Over-the-counter drugs
- Menstrual care products
- Eye surgery
- Fertility enhancement
- HMO expenses
- Hearing aids, batteries, and exams
- Hospital services
- Immunizations, vaccines, flu shots
- Laboratory fees
- LASIK eye surgery
- Medicines (prescribed)
- Obstetric services
- Optometrist
- Orthodontia
- Prescription drugs
- Psychiatric care
- Psychologist
- Speech therapy
- Stop smoking programs
- Surgery/operations
- Therapy
- Vasectomy
- Wheelchair
- X-rays

Dual Purpose Expenses That Potentially Qualify:

The expense must be for a specific medical reason and be accompanied by a *prescription*.

- Massage therapy
- Vitamins
- Supplements
- Herbal supplements
- Natural medicines
- Aromatherapy
- Weight-loss program
- Health club dues

Ineligible Expenses:

- Cosmetic surgery
- Long term care
- Hair transplant/re-growth
- Maternity clothes
- Nutritional supplements
- Personal use items: such as toiletries, cotton swabs, toothbrush, toothpaste, facial care, shampoo
- Teeth whitening
- Drunk driving classes

Health Care Reform & Over-the-Counter Items:

Over-the-Counter Medicine and Drugs ***do not*** require a prescription to be eligible for reimbursement under the plan.

- Allergy medications
- Antacids
- Anti-diarrhea medicine
- Bug-bite medication
- Cold medicine
- Cough drops and throat lozenges
- Diaper rash ointments
- Hemorrhoid medication
- Incontinence supplies
- Laxatives
- Muscle/joint pain products/rubs
- Nicotine medications, gum, patches
- Pain relievers
- Sinus medications, nasal sprays, nasal strips
- Sleep aids
- Wart removal medication

These are only examples and this list is not all-inclusive -- it only provides some of the more common expenses.
Additional information is available in IRS Publication 502 and on our website: Rocky Mountain Reserve

Over-The-Counter Items:

- Band-aids/bandages
- Cold/hot packs for injuries
- Condoms
- Contact lens solutions
- Diabetic supplies
- First aid kits
- Medical alert bracelets/necklaces
- Pregnancy test kits
- Thermometers

Dependent Care Eligible Expenses:

- A dependent receiving care must be a child under the age of 13, or a tax dependent unable to provide for their own care, who resides with you. The care must be necessary for you or your spouse to be gainfully employed or to go to school. Care may be provided by anyone other than your spouse or your children under the age of 19. Expenses for schooling, kindergarten, over-night care, and nursing homes are not reimbursable. **See IRS Publication 503**.
- The maximum you can elect, in a calendar year, is equal to the smallest of the following:
  - $5,000 – Married and filing federal taxes jointly or a single parent
  - $2,500 – Married and filing separate federal tax return
- The amount contributed year-to-date, is available for reimbursement.

Access to Your FSA Money

Access with a Debit Card

Pay for Expenses with a Debit Card

- Easy to use- the Benefits Card is a stored-value card that simplifies the process of paying for qualified expenses.
- Restricted by merchant code (MCC) to healthcare-related merchants where MasterCard is accepted.
- It pays directly at the point of sale - No waiting for reimbursement!
- You can use it to pay for online mail-order prescriptions.
- **You must save all receipts and be prepared to provide receipts if they are requested.**

Save All Receipts For Purchases Made With The Benefit Card

Please remember to keep receipts for all purchases made with the Benefit Card. Per IRS regulations, Rocky Mountain Reserve may request itemized receipts to verify the eligibility of purchases made with the card.

- All receipts or other proofs of purchase must include the date of service, name of provider, dollar amount, and a description of the purchased service or product.
- Any receipt that does not contain the detailed information described above is not acceptable. Credit card receipts and canceled checks are not acceptable.
- If the requested receipt is lost or otherwise unavailable, most providers can provide a detailed statement documenting FSA eligible purchases. An Explanation of Benefits (EOB) is sufficient documentation to substantiate a transaction. Additional documentation will be requested UNLESS the transaction matches a co-payment, a previously approved repetitive expense, or was at a merchant that has installed the inventory information approval system referenced above.
- If a receipt is requested, Rocky Mountain Reserve will email a request within hours. Participants can mail, fax, email, upload the receipt online, or take a picture and submit it through the mobile app.

No Receipt Retailers

Some retailers have installed an inventory information approval system for most medical expenses and receipts will not be requested.

Below is a sample of some of the retailers who have installed the inventory information approval system:

1-800 Contacts	Costco	King Soopers	Safeway
Albertsons	CVS	Kroger	Sam's Club
City Market	Drugstore.com	Rite Aid	Target

Submit Claims for Reimbursement

Submit Claims Through a Mobile Application

Take a picture of your receipt and submit it with your reimbursement request through the mobile application. You can also look up your account balance and recent transactions. Claims submitted through the mobile application receive **high priority**. To download the mobile application: **Search for "RMR Benefits"**

Submit Claims Through a Web Portal

Participants may file requests for reimbursement directly to Rocky Mountain Reserve through https://www.rockymountainreserve.com Claims submitted through the web portal receive **high priority.**

Submit Claims Manually

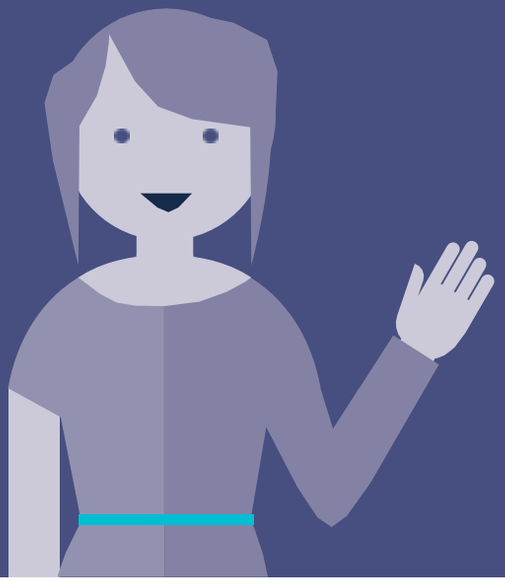
Participants may also file requests for reimbursement directly to RMR through fax, mail, or email.

Fax: 866.557.0109 **E-mail**: claims@rmrbenefits.com **Mail**: PO Box 631458 Littleton, CO 80163

Claims are paid by direct deposit or check

Other Benefits

Retirement Savings with Principal



Welcome!

We're so glad you're here.

There's a retirement plan waiting for you! In just a few steps, you'll be on your way. Here's what to expect.

Get your account set up

Visit **principal.com/Welcome** or use the Principal® app. You can also text **ENROLL** to **78259**.

Sitio web disponible en Español.

Begin by:

- Setting security preferences
- Reading important plan notices

Set your contribution

Contributions are one way to help your savings work hard for you. To learn more, visit principal.com/MatchEnrollmentWebinar.

Check out the plan's investments

Each investment is different, and you can choose based on your goals and how you feel about risk. You can also pick from the plan's investment options later. But by picking it later, you understand that until you make a new investment selection, you're directing contributions to the plan's default.*

For a full listing, refer to the Investment Option Summary.

Principal®

*The plan's participant level default is: American Funds Target Retirement Fund R6 . See Investment Option Summary for important information. If the default is a target date fund series, the applicable target date fund will be based on the plan's normal retirement date.

Keep going!

You've got this, and we've got your back when it comes to educational resources.

To learn more, visit **principal.com/Welcome** or use the Principal mobile app. You can also text **ENROLL** to **78259**.

Sitio web disponible en Español.

See your retirement savings in one place

We'll help you roll eligible outside retirement savings into your retirement account.

Designate a beneficiary

Don't leave the decision up to someone else if something happens to you before retirement. Always designate a beneficiary to ensure the money in your account goes to a loved one.

Keep in touch

Staying in the know when it comes to retirement planning is a pretty good idea. We'll send you educational information about what's important to you.

ELIGIBILITY FOR PARTICIPATION

Eligible Employee-Elective Deferrals

You are an "Eligible Employee" if you are employed by Comfort Bridge dba Care Synergy or any affiliate who has adopted the Plan. However, you are not an "Eligible Employee" if you are a member of any of the following classes of employee:

1. Employees who are non-resident aliens.
2. Employees who are students performing services described in Code section 3121(b)(10).

Eligible Employee-Other Contributions

For purposes of Matching Contributions, the term "Eligible Employee" will have the same meaning as specified above under "Eligible Employee-Elective Deferrals."

Time of Participation-All Contributions

If you are an Eligible Employee, you will become a participant eligible for purposes of Elective Deferrals and Matching Contributions on the first day of your employment coincident with the date you first perform an Hour of Service as an Eligible Employee.

Matching Contributions

- If you make an Elective Deferral, the Company will make a Matching Contribution on your behalf in an amount equal to 50% of your contributions that are not in excess of 8% of your compensation.
- Matching Contributions are allocated to your account at the discretion of the Company. Complicated provisions of the Internal Revenue Code may also further restrict matching contributions for highly compensated employees.

Vesting

Participant Contributions

Vesting = Ownership. You are always vested in what you contribute – your money is yours! When does the company match in your account actually belong to you?

1. At your Date of Hire two-year anniversary you are 50% invested, upon reaching your three-year anniversary, you are 100% vested.
2. If you leave/change jobs/retire and you worked here two years but didn't hit your three-year anniversary, you can take all of what you contributed and HALF of the company match in your account. Once you reach your three-year anniversary your entire account balance is yours.
3. The number of years you work will dictate how much of the company match you get to take with you when you leave: if you work here less than two years, you don't take the match with you; if you work here two years you can take half the match with you; if you work here three years (or more) you can take all the match.

Matching Contributions

Your interest in your Matching Contribution Account will vest based on your Years of Vesting Service (defined below) in accordance with the following schedule:

Years of Vesting	Vesting Percentage
Less than one year	0%
One year but less than two years	0%
Two years but less than three years	50%
Three years but less than four years	100%
Four years but less than five years	100%
Five years but less than six years	100%
Six or more years	100%

Notwithstanding the foregoing, you will become fully (100%) vested upon (1) your attainment of Normal Retirement Age while an employee of the Company, (2) your death while an employee of the Company, or (3) the date you suffer a disability while an employee of the Company.

SunLife Disability Insurance

Care Synergy offers you the opportunity to purchase short- and long-term disability insurance through SunLife. The amount you pay for these plans is deducted from your paycheck on a post-tax basis. This ensures that any benefit payments you receive are not taxed.

	Short Term Disability	Long Term Disability
Benefit after your claim is approved	You will receive a check for your benefits on a **weekly** basis. It will replace **60%** of your Total Weekly Earnings, up to **$1,500** each week.	You will receive a check for your benefits on a **monthly** basis. It will replace **60%** of your Total Monthly Earnings, up to **$11,000** each month.
When benefits begin	Benefits begin as soon as **15 days** from the date you are unable to work due to an injury and **15 days** due to an ill- ness.	Benefits begin as soon as **90 days** from the date of your disability.
Benefits may be paid for	Up to **11 weeks**, as long as you are still unable to work due to a covered disability.	Up to your Social Security Normal Retirement Age or longer, depending on your age at disability.
Additional plan info	This plan provides a benefit for covered disabilities resulting from illness or injury that are **not work-related**.	This plan provides a benefit for covered disabilities resulting from illness or injury that occur **on or off** the job.

COMMON CAUSES OF SHORT-TERM DISABILITY

- ☑ Pregnancy
- ☑ Injuries
- ☑ Joint disorders
- ☑ Back disorders
- ☑ Digestive disorders

COMMON CAUSES OF LONG-TERM DISABILITY

- ☑ Musculoskeletal conditions
- ☑ Circulatory condition
- ☑ Cancer
- ☑ Nervous system disorders
- ☑ Injuries

SunLife Disability Premium Rates

Employee - monthly rate for Short-Term Disability. Short-Term Disability coverage is contributory. You are responsible for paying for all or a part of the cost through payroll deduction.
Find your age bracket (as of the effective date of coverage) to see your rate. Follow the example below to figure out your monthly and pay period costs.

Your age	STD Rate*
Under 25	$1.055
25 - 29	$1.203
30 - 34	$0.950
35 - 39	$0.741
40 - 44	$0.637
45 - 49	$0.593
50 - 54	$0.698
55 - 59	$0.889
60 - 64	$1.081
65 - 69	$1.203
70+	$1.203

Employee - monthly rate for Long-Term Disability. Long-Term Disability coverage is contributory. You are responsible for paying for all or a part of the cost through payroll deduction. Find your age bracket (as of the effective date of coverage) to see your rate. Follow the example below to figure out your monthly and pay period costs.

Your age	LTD Rate*
Under 25	$0.210
25 - 29	$0.347
30 - 34	$0.526
35 - 39	$0.878
40 - 44	$1.222
45 - 49	$1.561
50 - 54	$1.691
55 - 59	$1.902
60 - 64	$2.175
65 - 69	$1.876
70+	$1.034

STD Rate calculation table

Example weekly benefit earnings)		Divide by 10		Multiply by rate		Example (60% of monthly cost		
$350	/	10 = 35	x	1.055	=	$36.93		
Your weekly benefit (60% of earnings)		Divide by 10		Multiply by rate		Your monthly cost		
$ _____	/	10 = _____	x	$ _____	=	$ _____		
Your monthly cost		Multiply by 12 months		Annual cost		Divide by your number of pay periods per year (ex: 12,24,26,52,etc.)		Your estimated cost per pay period
$ _____	x	12	=	$ _____	/	_____	=	$ _____

LTD Rate calculation table

Example monthly earnings		Divide by 100		Multiply by rate		Example monthly cost		
$2,500	/	100 = 25	x	0.210	=	$5.25		
Your monthly earnings		Divide by 100		Multiply by rate		Your monthly cost		
$ _____	/	100 = _____	x	$ _____	=	$ _____		
Your monthly cost		Multiply by 12 months		Annual cost		Divide by your number of pay periods per year (ex: 12,24,26,52,etc.)		Your estimated cost per pay period
$ _____	x	12	=	$ _____	/	_____	=	$ _____

*Contact Human Resources to confirm your part of the cost.

Basic Life and Accidental Death and Dismemberment from SunLife

Care Synergy provides you with a Basic Life and Accidental Death & Dismemberment plan at no cost to you. It is important to have up-to-date beneficiary information on file. Please update your beneficiaries in UKG.

PROTECTS YOUR LOVED ONES

Life insurance provides your loved ones with money they can use for household expenses, tuition, mortgage payments and more.

HELPS PAY YOUR FINAL EXPENSES

Your beneficiaries may use this money to pay for your burial or cremation, and pay any outstanding medical bills.

BASIC LIFE	
Life Benefit Amount	1x Annual Earnings Up to $500,000*
AD&D Benefit Amount	Same as Life
Minimum Benefit	$25,000
Rounding Method	To the $1,000
OTHER BENEFIT INFORMATION	
Reduction of Benefits – Level 1	To Age 65: To 65%
Reduction of Benefits – Level 2	At Age 70: To 50%
Reduction of Benefits – Level 3	At Age 75: To 35%

*Even among people who have life insurance, about **1 in 5** say they don't have enough.*

What is my AD&D benefit?
We will pay your beneficiaries an Accidental Death insurance amount that matches your Basic Life insurance amount, if you die from a covered accident. Additional benefits are available for accidental injuries (i.e., dismemberment) such as loss of limbs, fingers or sight. Refer to your Certificate for a full list of covered accidental injuries.

Voluntary Life and AD&D from SunLife

Care Synergy provides you with the option to purchase an additional Life and Accidental Death & Dismemberment plan. This plan allows you to cover your spouse and dependent children.

VOLUNTARY LIFE BENEFITS	
For you	You can choose from **$1,000 to $500,000**—in increments of $1,000 **not to exceed 5 times** your Basic Annual Earnings. No medical questions asked **up to the Guaranteed Issue amount of $180,000**. Benefits are reduced at age 65 and may reduce again in subsequent years as noted in your Certificate.
For your spouse	If you elect coverage for yourself, you can choose from **$1,000 to $500,000**—in increments of $1,000. No medical questions asked **up to the Guaranteed Issue amount of $25,000**. The amount you select for your spouse cannot exceed 100% of your coverage amount. Benefits may reduce as noted in your Certificate.
For your child(ren)	If you elect coverage for yourself, you can choose **$1,000 to $10,000**—in $1,000 increments. No medical questions asked. The amount you select for your child(ren) cannot exceed 100% of your coverage amount. Benefits may reduce as noted in your Certificate.
VOLUNTARY AD&D BENEFITS	
Voluntary Accidental Death & Dismemberment may be purchased separately from Voluntary Life at the same schedule as above. See Voluntary AD&D plan certificate by contacting HR or logging or on the Flimp Virtual Benefits Showcase.	

Do I need to answer any health questions to enroll?

Yes, if you request an amount higher than the Guaranteed Issue amount. To answer health questions, please fill out our Evidence of Insurability application. Health questions must be approved by Sun Life before coverage takes effect. Please see your Certificate for details.

Voluntary Life and AD&D Rates

Monthly Rates (per $1,000 of Volume)		
Life Rate (per $1,000)	Employee/Spouse†[1]	
Age <24	$0.05	
Age 25-29	$0.06	
Age 30-34	$0.08	
Age 35-39	$0.09	
Age 40-44	$0.13	
Age 45-49	$0.25	
Age 50-54	$0.35	
Age 55-59	$0.50	
Age 60-64	$0.66	
Age 65-69	$1.27	
Age 70-74	$4.00	
Age 75+	$4.00	
AD&D Rate (per $1,000)	$0.028	
†[2]**Child Life Rate** †[2]**Child AD&D Rate** **Full child benefit begins at**	$0.20 per $1,000 $0.028 6 months	
Child benefit younger than 6 months	Birth to 14 days	$1,000
	14 days to 6 months	$1,000

† Employee must elect Voluntary coverage in order to extend coverage to spouse or child(ren)

[1] Spouse rate per $1,000 is based upon employee's age

[2] Child age limit is 26 years of age.

Notice regarding SunLife Accident and Hospital Indemnity Coverages

IMPORTANT: This is a fixed indemnity policy,

NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- Visit HealthCare.gov or call 1-800-318-2596 (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

- **For questions or complaints about this policy**, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

SunLife Accident Coverage

HELPS YOUR FINANCES AFTER A MISHAP

When you, your spouse or child has a covered accident, like a fall from a bicycle that requires medical attention, you can receive cash benefits to help cover the unexpected costs.

Accident Insurance can be used however you want, and it pays in addition to any other coverage you may already have. **Benefits are payable directly to you.** And get this – there are no health questions or pre-existing conditions limitations.

While health plans may cover direct costs associated with an accident, you can use accident benefits to help cover related expenses like lost income, childcare, deductibles and co-pays.

What's more, all family members on your plan are eligible for a **wellness-screening benefit**, also paid directly to you once each year per covered person.

DISLOCATIONS	OPEN (SURGERY)	CLOSED (NO SURGERY)
Hip	$6,000	$3,000
Knee, ankle, or bones of the foot	$3,000	$1,000
Elbow, wrist, Shoulder or Lower jaw	$1,000	$500
Finger(s) or toe(s)	$400	$200
FRACTURES	**OPEN (SURGERY)**	**CLOSED (NO SURGERY)**
Bones of the face, Nose or Multiple ribs	$1,500	$750
Leg	$2,500	$1,250
Vertebrae, Sternum or Pelvis	$2,400	$1,200
Lower jaw, Shoulder, Forearm, Hand, Wrist, Foot, Ankle, Kneecap, Elbow or Heel	$900	$450
Collarbone	$900	$350
Rib or Coccyx	$600	$300
Finger or Toe	$300	$150
ADDITIONAL INJURIES		
Eye Injury - surgical repair | object remove		$300 | $300
Paralysis—paraplegia | quadriplegia		$25,000 | $50,000
Coma		$10,000
Concussion		$150
BURNS	**2ND DEGREE**	**3RD DEGREE**
20 square centimeters – 225 square centimeters	$400 - $2,000	$1,000 - $20,000
Skin graft	50% of the applicable Burn Benefit	
LACERATIONS		
No sutures and treated by doctor - Greater than 15 cm with sutures (total of all lacerations)		$35 - $700
WELLNESS – Get $50 each year with your annual preventive care exam ($0 on both plans)		**$50**

LIFE AND DISMEMBERMENT LOSSES*	
Accidental Death	$50,000
Accidental Death Common Carrier (pays an additional benefit if accidental death occurs while traveling as a fare-paying passenger on a public conveyance)	$150,000

Coverage	Cost per month
Employee	$12.38
Employee + Spouse	$20.20
Employee + Child(ren)	$23.34
Employee + Family	$31.16

SunLife Hospital Indemnity Coverage

HELPS PROTECT YOUR FINANCES FROM A HOSPITAL STAY.

If you, your spouse or children suffer an injury or illness that requires hospital admission or overnight stay, Hospital Indemnity coverage from SunLife can help offset those expenses. Just like Accident and Critical Illness, this valuable benefit pays directly to you, to use how you see fit.

Hospital Indemnity Benefits	
Benefits are payable for hospital stays due to:	Sickness Accidents* Routine pregnancy Complications of pregnancy Newborn complications Mental and nervous disorders Substance abuse

First Day Benefits Payable per benefit year	
First day hospital confinement – This benefit pays the first day you stay in a regular hospital bed.	$1,500 per day 1 day
First day ICU confinement – This benefit pays the first day you stay in an ICU bed.	$1,500 per day 1 day

CONFINEMENT BENEFITS Payable per benefit year	
Hospital confinement – This benefit pays for a hospital stay in a standard room. Payable with: • *First day hospital confinement benefit*	$200 per day Up to 30 days
Intensive Care Unit (ICU) confinement – This benefit pays for a hospital ICU stay. Payable with: • *First day hospital confinement benefit*	$200 per day Up to 30 days
Wellness screening benefit – This benefit pays for a covered wellness test or exam even without a hospital stay.	**$50**

Coverage	Monthly Rate
Employee	$25.90
Employee + Spouse	$54.90
Employee + Child(ren)	$42.85
Employee + Family	$71.85

SunLife Critical Illness Coverage

HELPS PROTECT YOUR FINANCES FROM AN ILLNESS.

When you, your spouse or child is diagnosed with a covered condition, you can receive a cash benefit to help pay unexpected costs not covered by your health plan.

HELPS COVER RELATED EXPENSES.

Use your benefit to help with related expenses like lost income, childcare, travel to and from treatment, deductibles and co-pays.

PAYS A CASH BENEFIT DIRECTLY TO YOU.

Critical Illness insurance can be used however you want, and it pays in addition to any other coverage you may already have. Just like Accident, all family members on your plan are eligible for a wellness-screening benefit, also paid directly to you once each year per covered person.

Critical Illness Benefits	
For you	You can choose **$10,000** or **$20,000** of coverage. No medical questions asked.
For your spouse	If you elect coverage for yourself, you can choose **$5,000** or **$10,000** of coverage. No medical questions asked. Not to exceed 50% of your coverage amount.
For your child(ren) – *to age 26*	If you elect coverage for yourself, you can choose **$5,000** or **$10,000** of coverage. No medical questions asked. Not to exceed 50% of your coverage amount.

Covered conditions – *The plan pays 100% of the benefit amount unless stated otherwise*		
Core Conditions	Heart Attack[R] End-Stage Kidney Disease[R] Occupational HIV/Hepatitis B, C or D	Stroke[R] Coronary Artery Bypass Graft[R] (pays 25%) Major Organ Failure[R]
Cancer Conditions	Invasive Cancer[R] Noninvasive Cancer[R] (Pays 25%) Skin Cancer[R] (Pays 5%)	
Other Conditions	Complete Blindness Complete Loss of Hearing Loss of Speech Benign Brain Tumor Coma	Severe Burns Advanced ALS/Lou Gehrig's Disease Advanced Parkinson's Disease (pays 25%) Advanced Alzheimer's Disease (pays 25%)
Wellness Screening Benefit	Payable to any covered person on your plan one time each year, once you provide proof of an eligible health screening.	Employee $50 Spouse $50 Child $50

[R] Recurrence benefit available. See plan certificate for details.

SunLife Critical Illness Rates

Rates are effective as of January 1, 2024.
The chart below shows possible coverage amounts and their **monthly** costs.
Find your age bracket (as of the effective date of coverage) to see the cost for the coverage amount you choose.

Employee Critical Illness - Non-tobacco rates ! Age and monthly cost

Coverage amounts	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$10,000	3.00	3.60	4.50	5.90	7.70	9.80	12.20	16.20	22.40	32.70	51.20	76.00
$20,000	6.00	7.20	9.00	11.80	15.40	19.60	24.40	32.40	44.80	65.40	102.40	152.00

Employee Critical Illness - Tobacco rates ! Age and monthly cost

Coverage amounts	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$10,000	3.00	4.20	5.40	7.60	10.10	14.20	18.20	25.30	35.10	45.60	67.20	93.50
$20,000	6.00	8.40	10.80	15.20	20.20	28.40	36.40	50.60	70.20	91.20	134.40	187.00

Spouse Critical Illness - Non-Tobacco rates ! Age and monthly cost

Coverage amounts	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$5,000	1.50	1.80	2.25	2.95	3.85	4.90	6.10	8.10	11.20	16.35	25.60	38.00
$10,000	3.00	3.60	4.50	5.90	7.70	9.80	12.20	16.20	22.40	32.70	51.20	76.00

Spouse Critical Illness - Tobacco rates ! Age and monthly cost

Coverage amounts	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$5,000	1.50	2.10	2.70	3.80	5.05	7.10	9.10	12.65	17.55	22.80	33.60	46.75
$10,000	3.00	4.20	5.40	7.60	10.10	14.20	18.20	25.30	35.10	45.60	67.20	93.50

Child(ren) Critical Illness

Coverage amounts	Monthly Cost
$5,000	0.50
$10,000	1.00

Long-term Care Insurance - LTC SOLUTIONS, INC.

What is LTC Insurance?

Long-term care insurance is designed to pay for custodial care once you are in need of assistance with two or more Activities of Daily Living or have a cognitive impairment like dementia or Alzheimer's.

Long-term care insurance will pay for care received at home, in a nursing home or assisted living facility.

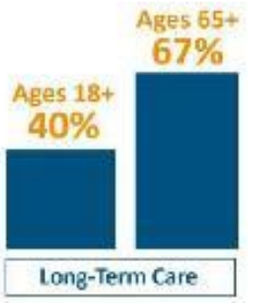
The Cost[1]

Nursing home costs are averaging $105,000 per year. With an average length of stay at 2.4 years, total costs can exceed $278,000.

2020 (CO) Annual Cost / Average Stay

Home Care	*Assisted Living*	*Nursing Home*
x 3 Years	x 2.5-3 Years	x 2.4 Years
$64,000	$54,900	$116,800

The Risk



56% of couples without long-term care insurance spend their income down to the poverty level after one partner has spent 6 months in a nursing home.[3] Compared to using other lines of personal insurance, long-term care is the highest risk.

Care Synergy's Plan Highlights

Benefit Features	Available Plan Options
Total Benefit Bank *Nursing Home Facility (100%)* *Assisted Living Facility (100%)* *Professional Home Care (100%)*	$50,000 $200,000 or $300,000
Monthly Access Limit	2% of Total Benefit Bank
Inflation Protection	None, 1% Compound, 3% or 5% compound
Elimination Period	90 days

Care Synergy's LTC Plan

Care Synergy has partnered with LTC Solutions, Inc., an expert in the long-term care insurance marketplace and LifeSecure, a well-established carrier in the industry. Together, we bring you the opportunity to purchase a valuable long- term care insurance plan with discounted group rates.

How Much Does a Plan Cost?

Every benefit dollar makes a difference when you need care. LifeSecure offers many plan choices, allowing you to choose a plan that offers enough coverage to be meaningful to you and your family at an affordable rate.

To give you an idea of pricing, here are some *examples* of monthly premiums for a $100,000 benefit bank, 2% monthly access limit, no inflation plan, no marital discount.

****Actual rates will vary based on state of residence, age of applicant, plan design, and applicable marital discount.****

AGE	MONTHLY PREMIUM
30	$29.25
35	$34.00
40	$40.17
45	$47.42
50	$58.17
55	$73.17
60	$96.83
65	$140.08

How Are Premiums Paid?

Employee and spouse / domestic partner premiums will be payroll deducted.

If you leave Care Synergy, you will have the opportunity to continue your coverage at the same rate.

For More Information

Visit
www.myltcguide.com/caresynergy

Call
(877) 286-2852

Email
LTCiBenefitsTeam@ltc-solutions.com

1 Genworth 2019 Cost of Care Survey. Tenth Edition.
2 Based on an 8-hour day for a homemaker at $19/hour to a home health aide for $21/hour.
3 Health Insurance Association of America
4 Karter, Michael J., Fire Loss in the United States during 2004, National Fire Protection Association.
5 Bureau of the Census Data, 2000 and 2000 data collected from the federal Highway Administration, November 2001
6 US Department of Health and Human Services. "National Clearinghouse for Long Term Care Information." 2011.
7 Long-Term Care. AHRQ Focus on Research. AHRQ Pub No. 02-M028, March 2002. Agency for Healthcare Research & Quality
8 US Department of Health and Human Services. What is Long-Term Care? 2009.
9 Active employees ages 18-69 working at least 20+ hours per week.
10 Active employees ages 18-64 working at least 20+ hours per week. Eligible employees ages 65-69 may apply with full underwriting. Spouses ages 18-49 working 20+ hours per week for their employer may apply with reduced underwriting provided the eligible employee also applies for coverage. Spouses ages 50-69 may apply with full underwriting.

Life Beyond Work

HOW CAN WE HELP YOU TODAY?

The Cigna Employee Assistance Program (EAP) has you covered.

As an employee, you have access to the valuable Cigna Employee Assistance Program (EAP) at no cost to you.

EAP personal advocates will work with you and your household family members to help you resolve issues you may be facing, connect you with the right mental health professionals, direct you to a variety of helpful resources in your community and more.

Take advantage of a wide range of services offered at no cost to you

- **3** face-to-face counseling sessions with a counselor in your area, as well as video-based sessions.
- **Legal assistance:** 30-minute consultation with an attorney, face-to-face or by phone.*
- **Financial:** 30-minute telephone consultation with a qualified specialist on topics such as debt counseling or planning for retirement.
- **Parenting:** Resources and referrals for childcare providers, before and after school programs, camps, adoption organizations, child development, prenatal care and more.
- **Eldercare:** Resources and referrals for home health agencies, assisted living facilities, social and recreational programs and long-distance caregiving.
- **Pet care:** Resources and referrals for pet sitting, obedience training, veterinarians and pet stores.
- **Identity theft:** 60-minute consultation with a fraud resolution specialist.

We're here to listen. Contact us any day, anytime.

Call 877.622.4327
Or log in to myCigna.com.
Employer ID: caresynergy
(Needed for initial registration only)
If already registered on myCigna.com, simply log in and go to the EAP link under the Review My Coverage tab.

Together, all the way.®

Cigna.

*Employment-related legal issues are not covered.

Some work/life services offered under the Cigna Employee Assistance Program may be provided by a Cigna contracted third-party vendor.

Confidential Emotional Support

Our highly trained clinicians will listen to your concerns and help you or your family members with any issues, including:

- Anxiety, depression, stress
- Grief, loss and life adjustments
- Relationship/marital conflicts

Work-Life Solutions

Our specialists provide qualified referrals and resources for just about anything on your to-do list, such as:

- Finding child and elder care
- Hiring movers or home repair contractors
- Planning events, locating pet care

Legal Guidance

Talk to our attorneys for practical assistance with your most pressing legal issues, including:

- Divorce, adoption, family law, wills, trusts and more

Need representation? Get a free 30-minute consultation and a 25% reduction in fees.

Financial Resources

Our financial experts can assist with a wide range of issues.

- Retirement, taxes, mortgages, budgeting and more

For additional guidance, we can refer you to a local financial professional and arrange to reimburse you for the cost of an initial one-hour in-person consult.

Online Support

GuidanceResources® Online is your 24/7 link to vital information, tools and support. Log on for:

- Articles, podcasts, videos, slideshows
- On-demand trainings
- "Ask the Expert" personal responses to your questions

Help for New Parents

ParentGuidance℠ supports you through the process of becoming a biological or adoptive parent, including:

- Preparing for the baby emotionally and financially
- Finding child care
- Planning for back-to-work and other issues

Free Online Will Preparation

EstateGuidance® lets you quickly and easily create a will online.

- Specify your wishes for your property
- Provide funeral and burial instructions
- Choose a guardian for your children

What happens when I call for counseling support?

When you call, you will speak with a GuidanceConsultant℠, a master's- or PhD-level counselor who will collect some general information about you and will talk with you about your needs. The GuidanceConsultant will provide the name of a counselor who can assist you. You will receive counseling through the EAP up to 3 sessions per issue, per person, per calendar year. You can then set up an appointment to speak with the counselor over the phone or schedule a face-to-face visit.

What counseling services does the EAP provide?

The EAP provides free short-term counseling with counselors in your area who can help you with your emotional concerns.

If the counselor determines that your issues can be resolved with short-term counseling, you will receive counseling through the EAP. However, if it is determined that the problem cannot be resolved in short-term counseling in the EAP and you will need longer-term treatment, you will be referred to a specialist early on and your insurance coverage will be activated.

Contact EAPBusiness Class℠ Anytime

No-cost, confidential solutions to life's challenges.

Your ComPsych® GuidanceResources® program EAPBusiness Class offers someone to talk to and resources to consult whenever and wherever you need them.

Call: 877.595.5281
TTY: 800.697.0353

Your toll-free number gives you direct, 24/7 access to a GuidanceConsultant℠, who will answer your questions and, if needed, refer you to a counselor or other resources.

Online: guidanceresources.com
App: GuidanceNow℠
Web ID: EAPBusiness

Log on today to connect directly with a GuidanceConsultant about your issue or to consult articles, podcasts, videos and other helpful tools.

24/7 Support, Resources & Information

GGFL-1597

Contact EAPBusiness Class Anytime

Call: 877.595.5281
TTY: 800.697.0353
Online: guidanceresources.com
App: GuidanceNow℠
Web ID: EAPBusiness

LegalShield™ | IDShield™

Affordable Legal and Identity Theft Protection

LegalShield provides the legal and identity theft protection you and your family need and deserve.

AFFORDABLE LEGAL AND IDENTITY THEFT PROTECTION

LEGALSHIELD

FAMILY PLAN

$23.50

PER MONTH

IDSHIELD

EMPLOYEE PLAN	FAMILY PLAN
$6.95	$12.95
PER MONTH	PER MONTH

LEGALSHIELD & IDSHIELD

EMPLOYEE PLAN	FAMILY PLAN
$30.45	$36.45
PER MONTH	PER MONTH

FOR MORE INFORMATION, VISIT

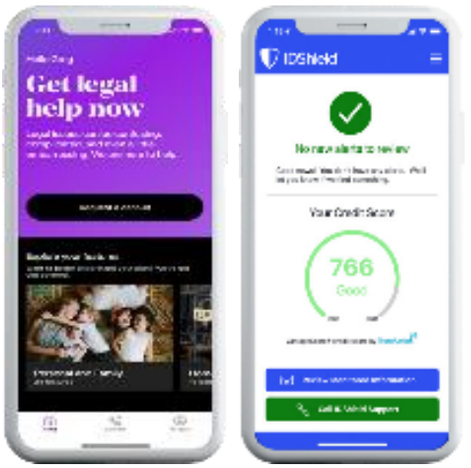
benefits.legalshield.com/caresynergy

LegalShield Coverage Includes:

- Legal Consultation and Advice
- Court Representation
- Dedicated Provider Law Firm
- Legal Document Preparation and Review
- Will Preparation
- Letters and Phone Calls Made on Your Behalf
- Speeding Ticket Assistance
- Divorce
- 24/7 Emergency Legal Access

Identity Theft Services Include:

- Identity Consultation and Advice
- Dedicated Licensed Private Investigators
- Identity, Credit and Financial Account Monitoring
- Child Monitoring
  (Family Plan Only)
- Full-Service Identity Restoration
- Real-Time Alerts
- 24/7 Emergency Access
- Social Media Monitoring and Online Privacy Reputation Management



On-the-go protection!

With the LegalShield and IDShield mobile apps, you have on-the-go access, 24/7!

Download on the App Store

GET IT ON Google Play

Cigna IdentityForce – Only available to those enrolled with Cigna medical

IdentityForce® A TransUnion® Brand OFFERED THROUGH cigna healthcare

Protecting What Matters Most

Identity theft can have serious repercussions. It can hurt your credit score, taint your medical records and drain your college funds and retirement accounts – everything you've worked so hard to build.

IdentityForce, a TransUnion® brand, has been helping people protect their identity and credit for over 40 years, and our Certified Resolution Specialists work diligently to keep you and your family safe.

Two ways to activate your account[1]

1. Visit https://cigna.identityforce.com/starthere
2. Call 833-580-2523

Questions?

Call Member Services at
1-833-580-2523

[1]Available to employees enrolled in a Cigna Healthcare℠ medical plan and their children in household up to age 18.

Offered by Cigna Health and Life Insurance Company

cigna.identityforce.com | 1-833-580-2523 | 1

spot pet insurance

CARE SYNERGY | PIKES PEAK HOSPICE & PALLIATIVE CARE | THE DENVER HOSPICE | Pathways | Colorado Visiting Nurse Association | COLORADO PACE

SCAN TO GET A QUOTE

Fetch Your Quote:

https://spotpet.link/caresynergy

Why Pet Insurance?

1. As a pet parent, you know how expensive vet visits can be.
2. Pet insurance is a financial safety net in case of accidents, injuries, illnesses and chronic conditions.
3. Spot pet insurance plans reimburse up to 90% of eligible vet bills.
4. Spot plans can offer thousands in coverage plan options starting at less than a cup of coffee per day.[1]

Why Spot Pet Insurance?

Top Rated Pet Insurance

Ranked #1 Best Pet Insurance Company of 2023 by US News

Spot plans help you protect your pet in case of accidents, illnesses, and emergencies. With pet insurance plans from Spot, you can get coverage for eligible conditions including surgery, cancer treatment, prescription medications, microchip implantation, X-rays, behavioral issues, dental disease, and more!

Up to 90% Cash Back

Customize the plan that is best for your pet and get cash back on eligible vet bills. Spot plans offer reimbursement rates up to 90% and a range of annual limits to help fit your budget.

20% Member Discount

As a valued employee, you are eligible for a multi-pet discount! (a 10% employee discount on all pets, plus receive an additional 10% with pets 2, 3, 4, etc.)!

24/7 VetAccess™ Helpline

Included in your Spot Pet Insurance plan is immediate access to a 24/7 telehealth helpline to ask veterinary professionals questions about pet health, behavior, and wellness. Get answers and reduce unnecessary vet visits during uncertain times.

How It Works

No Networks!
Visit Any Licensed Vet, Emergency Clinic or Specialist.

Submit Your Claim.
Send it in through our app, online, by mail, or by fax.

Get Reimbursed.
We can send a direct deposit or mail a check.

UKG

Your Payday, Reimagined

UKG Wallet has partnered with your employer to bring you a digital wallet built for every day life.

Decide when and how you get paid

Earned Wage Access (EWA) gets you paid before payday. Work your shift, and we'll make a portion of that money available, giving you more control over when and how you want to use it. The funds you access simply get deducted from your next paycheck. No gimmicks, no hoops–just your money, in your hands.

- Transfer real-time to UKG Visa® Card* (FREE)[1]
- Transfer real-time to non-UKG cards ($2.99)
- Transfer to your bank in 1-3 business days (FREE)
- Pick up cash at Walmart ($2.99)
- Apply towards an Uber ride (FREE)
- Schedule bill payments (FREE)
- Load to Amazon Cash (FREE)

Build better financial habits

Get access to free financial planning tools and exclusive discounts. With UKG Wallet, you can know what's safe to spend and save, bringing you one step closer to reaching your goals.

- Financial Counseling
- Financial Learning
- Saving Tools
- Exclusive discounts

Scan the QR code to download the app![2]

Access these and more in the UKG Wallet App[2]

WWW.UKG.COM

Wellness

Care Synergy cares about you and your continued health. For the January 1, 2025 plan year, Care Synergy will continue to have a $50.00 surcharge for tobacco-users who are enrolled in the Care Synergy Cigna medical plans. You can avoid the surcharge by attesting that you are tobacco- free, or by completing a tobacco cessation program through the Cigna Quit Today Program.

Cigna Quit Today Program

Team members enrolled in the Cigna medical insurance can access the "Cigna Quit Today" program via phone or online. You can access the program online by logging onto MyCigna.com and clicking on the "My Health" tab at the top of the screen. Click on the "Health Dashboard tab, and scroll down to the bottom of the page to Cigna's "Health Programs and Resources" section. Click the Left or Right scroll arrows to get to the "Leave Tobacco Behind for Good" option, then click on the "Quit Today" link.

Additional Smoke-Free Resources

If you are not currently enrolled in the Cigna medical plan, we still want to help you become tobacco free. Below are some free resources to help you reach your goal of becoming tobacco free in 2025!

Smokefree: https://www.smokefree.gov or 1-800-QUIT-NOW

There are text programs, daily challenges, applications with tips and the ability to monitor progress, live chat, and quit plans.

Colorado Quit Line: https://www.coquitline.org or 1-800-784-8669

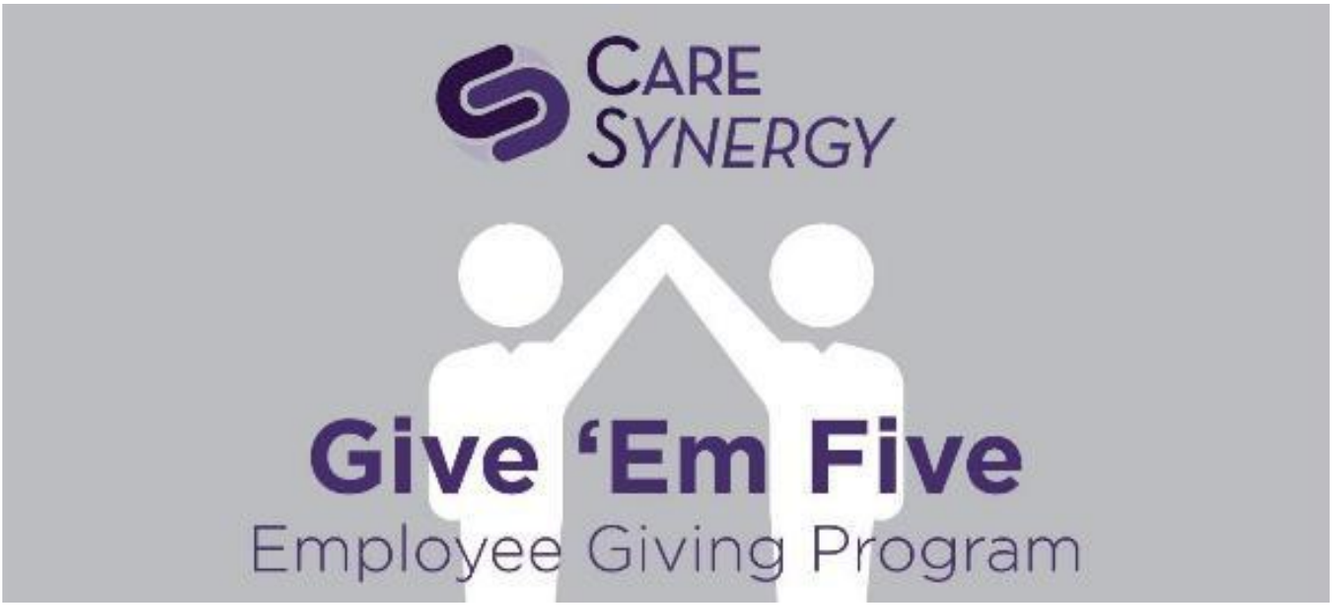
Coaches available 365 days per year online, or via the telephone from 5 a.m. to 11 p.m. The website includes a guide on Preparing to Quit and other resources and tools.

This program was put in place to enhance the health and productivity of our team members. Team members that complete the 6-month program through Cigna or any of the additional free resource providers will receive premium savings on medical insurance for 2025 (if enrolled in the Cigna medical plan).

Cigna MotivateMe Program (see pages 21-22)

MotivateMe is an incentive program available to, Cigna participants, that helps you change unhealthy behaviors and rewards you for it. And that is important, because taking healthy actions will help reduce your risk of illness, disease and costly medical treatment. With MotivateMe, you will work toward achieving real results that mean a real, healthy change for you. Visit mycigna.com and click the "Wellness" tab for more information.

Give ‘Em Five



As Care Synergy and Affiliates team members, not only are we committed to the Mission of each Affiliate, we are also deeply committed to our fellow coworkers.

“Give ‘Em Five” is a program that allows team members to give to other team members in the event they have a personal financial emergency.

Details of the program include:

- Team members may contribute $1, $2, $3, $4, $5 or any other amount per paycheck via payroll deduction to the employee emergency fund.
- It is completely confidential for both the donor and the requestor.
- This fund is to be used when there is a financial need and when other avenues for support have been exhausted.

If you would like to participate in the program, please see Human Resources for a payroll deduction form. Once the form is completed, submit to payroll. This is a voluntary program and your deduction amount can be changed at any time.

Please contact Human Resources to request an Emergency Relief Application.

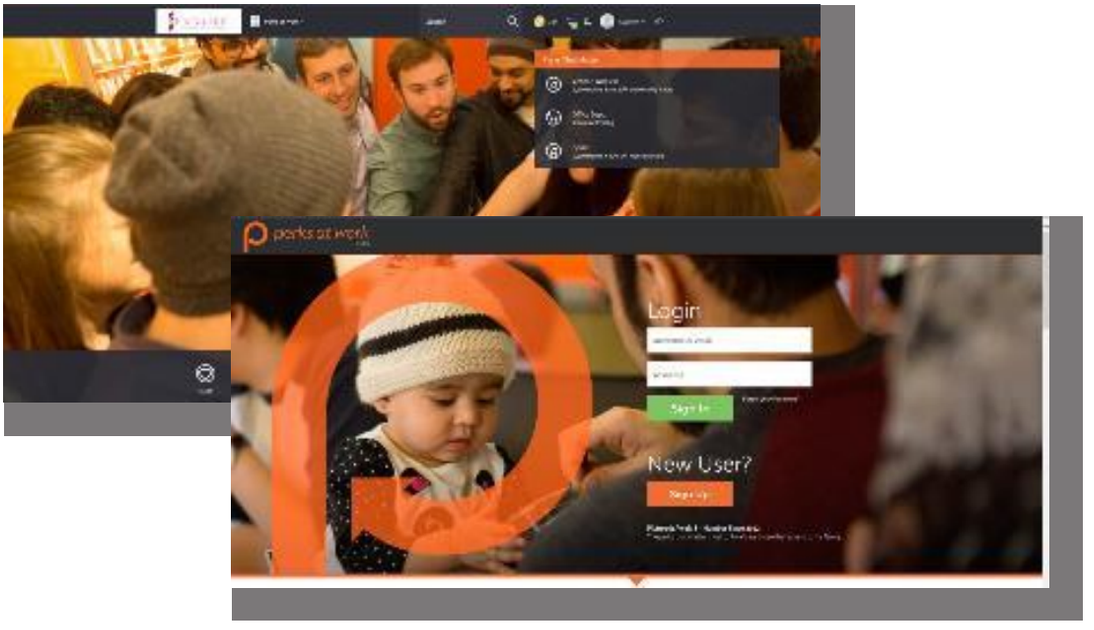
Intalere Marketplace is now Perks at Work

INTALERE℠
ELEVATING THE HEALTH OF HEALTHCARE

One-stop shopping and significant savings for employees on small- (food, utilities, etc.) to large-scale (computers, travel, etc.) purchases.

Intalere is pleased to provide you with Intalere Perks at Work, your one-stop shop for employee pricing. It leverages the purchasing power of all Intalere members and affiliates to help you save money on all of your large purchases (computers, travel, etc) as well as everyday purchases (food, utilities, etc.).

Once you register on Intalere Perks at Work, you will have access to 30,000 merchants and over 25 savings categories. Through Perks at Work, you can receive deep discounts on your favorite fashion brands including Gap, Nordstrom and Lands' End and also save on electronics, computers, vacations and more. You also can access Intalere Exclusives* — exclusive deals with significant savings!



Intalere Perks at Work Benefits

WOWPoints. You will be awarded WOWPoints* in addition to the deep discounts you receive using Intalere Perks at Work! WOWPoints are a virtual currency that you accumulate over time. They never expire and can be used at any time to make purchases directly on the site.

Family Membership. Your account comes with a family membership. Simply logon, click on My Account and choose Family Invitations to add family members to your account.

**Most Intalere Exclusives are not eligible for WOWPoints.*

SL-PERKSWK 040116

Activating your account is easy!

1. Visit Intalere Perks at Work at http://www.perksatwork.com
2. Click on "Sign Up" under the New User section.
3. Complete the short registration process and hit "continue" to submit your information to be verified. If an error appears, you may need to hit "continue" a second time.

   Note: Once you enter your email, the company information should populate automatically; however, you may be required to enter "Intalere" as your company name and "savings12" as your company code.

4. You will then receive a link via email to validate your account; now you have access to Intalere's Perks at Work!
5. Time to start shopping and start saving!

Learn More

Contact us today to learn more about Intalere's Perks at Work:
Intalere Customer Service
877-711-5600
info@intalere.com
www.intalere.com

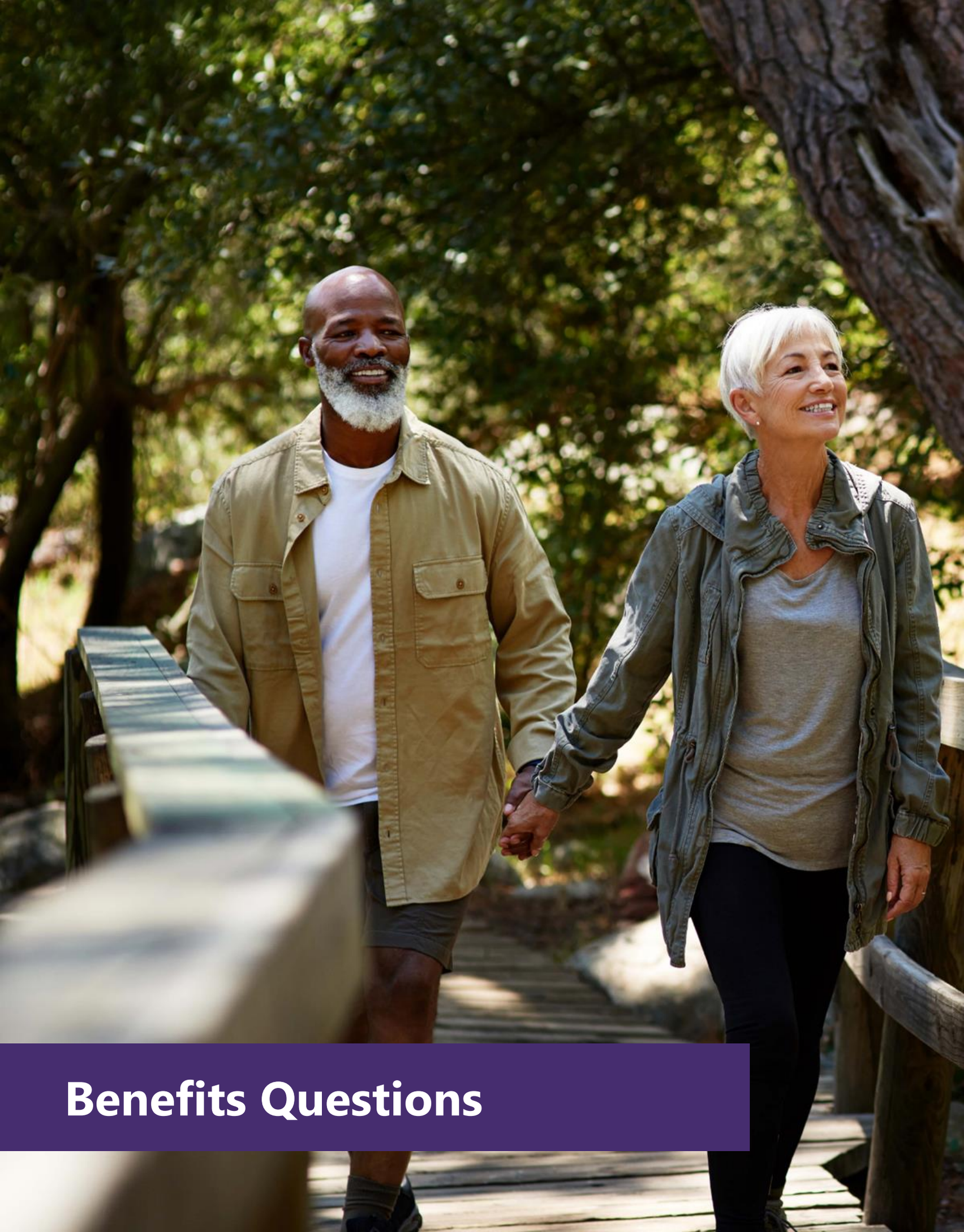
Service Rewards - Nectar

Program Highlights:

- Anniversary Recognition: Receive a message of gratitude each year through Nectar. For milestone anniversaries (1, 3, 5, 10, 15, 20, 25, and 30 years), you'll get a credit of $50 for each year of service.

- Rewards: Accumulate points through recognition and redeem them for fantastic rewards, including company swag and Amazon items with free, expedited shipping.

This program not only acknowledges your service but also offers tangible rewards to show appreciation for your contributions.



Benefits Questions

Additional Information

Resources and Contact Information

Refer to this list when you need to contact one of your benefit vendors. For general information, contact Human Resources at CS-HR or 303-228-5647.

MEDICAL and DENTAL

Provider Name:	CIGNA
Group #:	3339544
Provider Phone Number:	(800) 244-6224
Provider Web Address:	www.mycigna.com

PRESCRIPTION & PHARMACY

Provider Name:	CIGNA
Provider Phone Number:	(800) 244-6224
Provider Web Address:	www.mycigna.com

TELEMEDECINE

Provider Name:	Cigna MDLive
Provider Phone Number:	888-726-3171
Provider Web Address:	www.mycigna.com

VISION

Provider Name:	VSP
Group #:	30093607
Provider Phone Number:	(800) 877-7195
Provider Web Address:	www.vsp.com

FLEXIBLE SPENDING ACCOUNTS/HEALTH SAVINGS ACCOUNTS

Provider Name:	Rocky Mountain Reserve
Provider Phone Number:	(888) 722-1223
Provider Web Address:	www.rockymountainreserve.com

SHORT-TERM/LONG-TERM DISABILITY

Provider Name:	SunLife
Group #:	955915
Provider Phone Number:	800-247-6875 | Telephonic claims: 888-444-0239
Provider Web Address:	www.sunlife.com/account

BASIC & VOLUNTARY LIFE/AD&D ACCIDENT, CRITICAL ILLNESS & HOSPITAL INDEMNITY

Provider Name:	SunLife
Group #:	955915
Provider Phone Number:	800-247-6875
Provider Web Address:	www.sunlife.com/account

VOLUNTARY LONG-TERM CARE

Provider Name:	LTC Solutions, Inc.
Provider Phone Number:	877-286-2852
Provider Email:	LTCiBenefitsTeam@ltc-solutions.com

LEGAL & ID THEFT PROTECTION

Provider Name:	LegalShield
Provider Phone Number:	(800) 654-7757
Provider Web Address:	www.benefits.legalshield.com/caresynergy

EMPLOYEE ASSISTANCE PROGRAMS

Provider Name:	CIGNA
Provider Phone Number:	(800) 926-2273
Provider Web Address:	www.cignabehavioral.com, www.mycigna.com
Provider Name:	GuidanceResources
Provider Phone Number:	877-595-5281
Provider Web Address:	Guidanceresources.com WebID: EAPBusiness

CIGNA WELLNESS

Provider Name:	Cigna MotivateMe
Group #:	3339544
Provider Phone Number:	(800) 244-6224
Provider Web Address:	www.mycigna.com → Incentive Awards Program

DECISION SUPPORT

Provider Name:	PLANselect/BENEFITchoice
Provider Contact:	info@planselect.net
Provider Web Address:	https://myplanselect.com/navigation/care_synergy/2024
Provider Name:	Cigna Pre-enrollment Hotline
Provider Phone Number:	800-564-7642

PERKS AT WORK

Provider Name:	Intalere Perks at Work
Provider Phone Number:	877-711-5600
Provider Web Address:	info@intalere.com www.intalere.com

SERVICE REWARDS

Provider Name:	Nectar
Service Contact:	support@nectarhr.com
Provider Web Address:	https://app.nectarhr.com/login

403(b)

Provider Name:	Principal
Provider Phone Number:	Text 'ENROLL' to 78259
Provider Web Address:	www.principal.com/Welcome

EMPLOYER NOTICES

Table of Contents

NOTICE: CMS Part D Notice of Creditable or Non-Creditable Coverage

When you or a family member becomes eligible for Part D (Medicare's prescription drug benefit), it is important to understand when to enroll in Part D. You can wait as long as you maintain "creditable" coverage (i.e., coverage which on average expects to pay at least as well as Part D expects to pay on average). But if you do not have creditable coverage, you need to enroll in Part D at the earliest opportunity to avoid future penalties.

Below are highlights to note:

- A continuous break in creditable coverage of 63 or more days will trigger a late enrollment penalty payable for life.
- The longer you go without creditable coverage, the higher the penalty. For the rest of your life, you would be charged an additional 1% of Part D base premium for each month you are late.
- When creditable coverage ends, a special enrollment period of two (2) months may be provided to enroll in Part D (but note that this is only available when normal coverage ends, not when retiree or COBRA coverage ends).
- The Part D annual open enrollment occurs each year from October 15th through December 7th for coverage to begin January 1st.

The information below indicates whether prescription drug coverage under our plan is creditable.

Creditable Coverage	Non-Creditable Coverage
PPO **High Deductible Health Plan**	**None (all plans are creditable)**

Anyone needing to learn more about Medicare should contact a Medicare-approved counselor in their state at ***https://www.shiphelp.org***.

REMEMBER: If you have creditable coverage through our plan, keep this Notice as proof. 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 you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	9/17/2024
Name of Entity/Sender:	Comfort Bridge dba Care synergy
Contact – Position/Office:	Human Resources
Address:	8289 E Lowry Blvd
	Denver, CO 80230
Phone Number:	cshr@caresynergynetwork.org

NOTICE: SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance, 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 stopped contributing towards the other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, see the contact information at the end of these notices.

A special enrollment right also arises for employees and their dependents who lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid or who are eligible to receive premium assistance under those programs. The employee or dependent must request enrollment within 60 days of the loss of coverage or the determination of eligibility for premium assistance.

NOTICE: HIPAA NOTICE OF PRIVACY PRACTICE

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. It also describes how your protected health information may be used or disclosed to carry out treatment, payment or healthcare operation or for any purposes that are permitted or required by law.

Your Rights	**You have the right to:** • Get a copy of your health and claims records • Correct your health and claims records • Request confidential communication • Ask us to limit the information we share • Get a list of those with whom we've shared your information • Choose someone to act for you • File a complaint if you believe your privacy rights have been violated
Your Choices	**You have some choices in the way that we use and share information as we:** • Answer coverage questions from your family and friends • Provide disaster relief • Market our services and sell your information
Our Uses and Disclosures	**We may use and share your information as we:** • Help manage the health care treatment you receive • Run our organization • Pay for your health services • Help with public health and safety issues • Do research • Comply with the law • Respond to organ and tissue donation requests and work with a medical examiner or funeral director • Address workers' compensation, law enforcement and other government requests • Respond to lawsuits and legal action

YOUR RIGHTS	When it comes to your health information, you have certain rights. • This section explains your rights and some of our responsibilities to help you.
Get a copy of health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment or our operations. • We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why. • We will include all the disclosures except for those about treatment, payment and health care operations and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 9. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling (877) 696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. • We will not retaliate against you for filing a complaint.

YOUR CHOICES	**For certain health information, you can tell us your choices about what to share.** • If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in payment for your care • Share information in a disaster relief situation *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases, we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information

OUR USES AND DISCLOSURES	**How do we typically use or share your health information.** • We typically use or share your health information in the following ways.	
Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you.	***Example:*** *A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
Run our organization	• We can use and disclose your information to run our organization and contact you when necessary. • **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans.	***Example:*** *We use health information about you to develop better services for you.*
Pay for your health services	• We can use and disclose your health information as we pay for your health services.	***Example:*** *We share information about you with your dental plan to coordinate payment for your dental work.*
Administer your Plan	• We may disclose your health information to your health plan sponsor for plan administration.	***Example:*** *Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: *Your Rights Under HIPAA | HHS.gov*.

Help with public health and safety issues	We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect or domestic partner violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research
Comply with the law	• We will share information about you if State or Federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with Federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • We can share health information with a coroner, medical examiner or funeral director when an individual dies.
Address workers' compensation, law enforcement and other government requests	We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: *Your Rights Under HIPAA | HHS.gov*.

NOTICE: CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

Introduction

If 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 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; or
- The employee's becoming entitled to Medicare benefits (under Part 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 after the qualifying event occurs. You must provide this notice to the contact person shown at the end of these notices.

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 (for fully insured plans issued in California, coverage generally last for 36 months). 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 11 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.

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 18 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, 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 *www.healthcare.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 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 information at the end of these notices. 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.

NOTICE: WOMEN’S HEALTH AND CANCER RIGHTS ACT (WHCRA)

Did you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema)? For more information, see the contact information at the end of these notices.

NOTICE: 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 **(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 **(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 July 31, 2024. Contact your State for more information on eligibility.

ALABAMA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
Website: *http://myalhipp.com/* **Phone:** (855) 692-5447	**Health First Colorado Website:** *https://healthfirstcolorado.com/* **Health First Colorado Member Contact Center:** (800) 221-3943 / State Relay 711 **CHP+:** *https://hcpf.colorado.gov/child-health-plan-plus* **CHP+ Customer Service:** (800) 359-1991 / State Relay 711 **Health Insurance Buy-In Program (HIBI):** *https://www.mycohibi.com/* **HIBI Customer Service:** (855) 692-6442
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program **Website**: *http://myakhipp.com/* **Phone:** (866) 251-4861 **Email:** *CustomerService@MyAKHIPP.com* **Medicaid Eligibility:** **Website:** *https://health.alaska.gov/dpa/Pages/default.aspx*	**Website:** *https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html* **Phone:** (877) 357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: *http://myarhipp.com/* **Phone:** (855) MyARHIPP (855-692-7447)	**GA HIPP Website:** *https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp* **Phone:** (678) 564-1162, Press 1 **GA CHIPRA Website:** *https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization- act-2009-chipra* **Phone:** (678) 564-1162, Press 2

CALIFORNIA – Medicaid	INDIANA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program *http://dhcs.ca.gov/hipp* **Phone:** (916) 445-8322 **Fax:** (916) 440-5676 **Email:** *hipp@dhcs.ca.gov*	**Healthy Insurance Premium Payment Program** **All other Medicaid** **Website:** *https://www.in.gov/medicaid/* *http://www.in.gov/fssa/dfr/* **Family and Social Services Administration** **Phone:** (800) 403-0864 **Member Services Phone:** (800) 457-4584
IOWA – Medicaid and CHIP (Hawki)	**MASSACHUSETTS – Medicaid and CHIP**
Medicaid Website: *Iowa Medicaid | Health & Human Services* **Phone:** (800) 338-8366 **Hawki Website:** *Hawki - Healthy and Well Kids in Iowa | Health & Human Services* **Phone:** (800) 257-8563 **HIPP Website:** *Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)* **Phone:** (888) 346-9562	**Website:** *https://www.mass.gov/masshealth/pa* **Phone:** (800) 862-4840 **TTY:** 711 **Email:** *masspremassistance@accenture.com*
KANSAS – Medicaid	**MINNESOTA – Medicaid**
Website: *https://www.kancare.ks.gov/* **Phone:** (800) 792-4884 **HIPP Phone:** (800) 967-4660	**Website:** *https://mn.gov/dhs/health-care-coverage/* **Phone:** (800) 657-3739
KENTUCKY – Medicaid	**MISSOURI – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: *https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx* **Phone:** (855) 459-6328 **Email:** *KIHIPP.PROGRAM@ky.gov* **KCHIP Website:** *https://kynect.ky.gov* **Phone:** (877) 524-4718 **Kentucky Medicaid Website:** *https://chfs.ky.gov/agencies/dms*	**Website:** *http://www.dss.mo.gov/mhd/participants/pages/hipp.htm* **Phone:** (573) 751-2005
LOUISIANA – Medicaid	**MONTANA – Medicaid**
Website: *www.medicaid.la.gov* or *www.ldh.la.gov/lahipp* **Medicaid Hotline:** (888) 342-6207 **LAHIPP Phone:** (855) 618-5488	**Website:** *http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP* **Phone:** (800) 694-3084 **Email:** *HHSHIPPProgram@mt.gov*
MAINE – Medicaid	**NEBRASKA – Medicaid**
Enrollment Website: *https://www.mymaineconnection.gov/benefits/s/?language=en_US* **Phone:** (800) 442-6003 **TTY:** Maine Relay 711 **Private Health Insurance Premium Webpage:** *https://www.maine.gov/dhhs/ofi/applications-forms* **Phone:** (800) 977-6740 **TTY:** Maine Relay 711	**Website**: *http://www.ACCESSNebraska.ne.gov* **Phone:** (855) 632-7633 **Lincoln:** (402) 473-7000 **Omaha:** (402) 595-1178
NEVADA – Medicaid	**OREGON – Medicaid**
Website: *https://dhcfp.nv.gov/* **Phone:** (800) 992-0900	**Website:** *http://healthcare.oregon.gov/Pages/index.aspx* **Phone:** (800) 699-9075
NEW HAMPSHIRE – Medicaid	**PENNSYLVANIA – Medicaid**
Website: *https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program* **Phone:** (603) 271-5218 **Toll free number for the HIPP program:** (800) 852-3345 Ext. 5218 **Email:** *DHHS.ThirdPartyLiabi@dhhs.nh.gov*	**Website:** *https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html* **Phone:** (800) 692-7462 **CHIP Website:** *Children's Health Insurance Program (CHIP) (pa.gov)* **Phone:** (800) 986-KIDS (5437)

NEW JERSEY – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ **Medicaid Phone:** (800) 356-1561 **CHIP Premium Assistance Phone:** (609) 631-2392 **CHIP Website:** http://www.njfamilycare.org/index.html **CHIP Phone:** (800) 701-0710 (TTY: 711)	**Website**: http://www.eohhs.ri.gov/ **Phone:** (855) 697-4347 or (401) 462-0311 (Direct Rite Share Line)
NEW YORK – Medicaid	**SOUTH CAROLINA – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ **Phone:** (800) 541-2831	**Website:** https://www.scdhhs.gov **Phone:** (888) 549-0820
NORTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://medicaid.ncdhhs.gov/ **Phone:** (919) 855-4100	**Website:** http://dss.sd.gov **Phone:** (888) 828-0059
NORTH DAKOTA – Medicaid	**TEXAS – Medicaid**
Website: https://www.hhs.nd.gov/healthcare **Phone:** (844) 854-4825	**Website:** Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services **Phone:** (800) 440-0493
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org **Phone:** (888) 365-3742	**Utah's Premium Partnership for Health Insurance (UPP)** **Medicaid Website:** https://medicaid.utah.gov/upp/ **Email:** upp@utah.gov **Phone:** (888) 222-2542 **Adult Expansion Website:** https://medicaid.utah.gov/expansion/ **Utah Medicaid Buyout Program Website:** https://medicaid.utah.gov/buyout-program/ **CHIP Website:** http://health.utah.gov/chip
VERMONT– Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access **Phone:** (800) 250-8427	**Website:** https://dhhr.wv.gov/bms/ http://mywvhipp.com/ **Medicaid Phone:** (304) 558-1700 **CHIP Toll-Free Phone:** (855) MyWVHIPP (699-8447)
VIRGINIA – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs **Medicaid & CHIP Phone:** (800) 432-5924	**Website:** https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm **Phone:** (800) 362-3002
WASHINGTON – Medicaid	**WYOMING – Medicaid**
Website: https://www.hca.wa.gov/ **Phone:** (800) 562-3022	**Website:** https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ **Phone:** (800) 251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on *Special Enrollment Rights*, contact either:

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

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

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request and posted electronically.

For more information, contact:

NAME:	Comfort Bridge dba Care Synergy
TITLE:	Human Resources
ADDRESS:	8289 E Lowry Blvd
	Denver, CO 80230
PHONE NUMBER:	(303) 228-5647
OTHER CONTACT INFORMATION:	cshr@caresynergynetwork.org

Effective Date of this Notice: January 1, 2025

Definitions

Definitions

Benefits can be confusing, but you don't need to be a benefits specialist to understand what is available to you. We've made these definitions available so you can make the most educated and best decision for yourself and your family.

Premium:

The amount you pay out of your paycheck to be covered by the plan.

Deductible:

Most general: The amount you must pay each plan year before the plan begins paying toward covered services.

For most PPOs: The amount you must pay each plan year before the plan begins paying toward certain covered services such as emergency room visits and hospitalizations.

For HDHP: The amount you must pay each plan year before the plan begins paying toward any covered services (except preventive care, which is paid 100% by the plan).

- **Embedded deductible:** If your spouse and/or children are covered by the plan, the individual deductible applies to each covered family member (capped at family amount).
- **Non-embedded deductible:** If your spouse and/or children are covered by the plan, the individual deductible does not apply. The full family deductible must be paid before the plan begins to pay for covered services for any individual (even if that individual has met the individual deductible).
- For the HDHP plan, if you elect dependent coverage, the full family deductible must be satisfied before the plan begins to cover eligible expenses for any individual covered on the plan.

Out-of-pocket maximum:

- The most you will be required to pay out of your pocket for covered health care services in any one year. The out-of-pocket maximum does not include premium payments taken from your paycheck.
- **Embedded out-of-pocket maximum:** If your spouse and/or children are covered by the plan, the individual out-of-pocket maximum applies to each covered family member (capped at family amount).
- **Non-embedded out-of-pocket maximum:** If your spouse and/or children are covered by the plan, the individual out-of-pocket maximum does not apply. Once the family out-of-pocket maximum has been paid, the plan will pay 100% of all covered health care services for all family members for the remainder of the year.

Plan deductibles and out-of-pocket maximums reset on January 1st each year.

Definitions (Continued)

Copayment or Copay

A set dollar amount you pay for certain health care services such as an office visit. Copays are usually paid at the time of the office visit (e.g., a set dollar amount that PPO and HMO plan members pay for an office visit).

Coinsurance

A set percentage of the total cost for a covered health care service that you pay after you have paid your deductible.

In-Network Providers

In-network providers have contracted with Cigna and have agreed to provide a discount to Cigna plan members. You will pay less out of your pocket when you choose a Cigna network provider.

Out-of-Network Providers

Out of-network providers, facilities, and pharmacies can charge you the full price for services, which is typically much higher than the in-network discounted rate. You will pay more out of your pocket when you choose an out-of-network provider.

Preventive Care

Health care services that help keep you healthy by preventing diseases and other health conditions. The Cigna medical plans pay 100% of the cost of preventive care when it is provided by a Cigna provider. Some preventive care services that may be covered include: exams, screenings, and vaccinations. Please be aware that you may be billed for non-preventive care services that you receive at a preventive care exam. Learn more about preventive care at www.mycigna.com.

STATE SPECIFIC INFORMATION:

Social determinants of health

Many employees are looking for free state resources and may be hesitant to reach out to their employer for help due to the negative stigma attached. Consider including these resources to help bridge that gap for employees.

Need Additional Resources?

Check out these free state resources available to all Team Members!

COLORADO

EDUCATION & EMPLOYMENT

Colorado Department of Education: Offers resources related to education and workforce development. They provide information on schools, colleges, and universities in Colorado, as well as resources for continuing education, adult education, and vocational training. (*https://www.cde.state.co.us/*)

Colorado Division of Vocational Rehabilitation (DVR): Assists individuals with disabilities in obtaining and maintaining employment. They offer vocational counseling, training, and job placement services. DVR can provide assistance with accommodations, accessibility, and job retention support. (*https://dvr.colorado.gov/*)

Colorado Department of Human Services: Oversees several programs that can help with socioeconomic factors. For example, the Office of Early Childhood offers resources for childcare and early education. The Division of Employment and Benefits provides information on public assistance programs like food assistance, Medicaid, and cash assistance. (*https://cdhs.colorado.gov/*)

HEALTH & WELL-BEING

Colorado Department of Public Health and Environment (CDPHE): Responsible for promoting and protecting the health and well-being of Colorado residents. They provide information on healthy eating, physical activity, tobacco cessation, and substance abuse prevention. (*https://cdphe.colorado.gov/*)

Colorado Physical Activity and Nutrition Program (C-PAN): An initiative by the CDPHE that focuses on promoting physical activity and healthy eating. They offer resources, educational materials, and programs to encourage individuals and communities to engage in regular exercise and adopt healthy eating habits. (*https://cdphe.colorado.gov/health/prevention-and-wellness/healthy-eating-and-active-living*)

Colorado QuitLine: Free, confidential service that helps individuals quit tobacco and nicotine use. They offer coaching, support, and resources to develop a personalized quitting plan. They provide telephone counseling, online support, and information on nicotine replacement therapies. (*https://www.coquitline.org/en-US/*)

Colorado Substance Abuse Trend and Response Task Force: They provide resources, information, and support related to substance abuse prevention, treatment, and recovery. Their website offers resources for individuals seeking help with substance abuse issues. (*https://coag.gov/task-force/*)

Colorado 2-1-1: A free and confidential service that connects individuals to a wide range of health and human services. They can provide information on local resources for diet and exercise programs, substance abuse treatment centers, mental health services, and more. You can contact them by dialing 2-1-1 or visiting their website. (*https://www.211colorado.org/*)

Additional Resources (Continued)

COLORADO (Continued)

HEALTHCARE RESOURCES

Colorado PEAK (Program Eligibility and Application Kit): An online portal that allows individuals to determine their eligibility and apply for various state assistance programs, including Medicaid and the Children's Health Insurance Program (CHIP). Through PEAK, you can access information on healthcare coverage options and apply for enrollment.
(*https://peak--coloradopeak.force.com/peak/s/peak-landing-page?language=en_US*)

Connect for Health Colorado: State health insurance marketplace providing a platform for individuals and families to compare and purchase health insurance plans, including private plans and coverage options through Medicaid and CHIP. The marketplace also offers assistance in finding financial aid or subsidies to help make insurance more affordable. (*https://connectforhealthco.com/*)

Colorado Medicaid: Provides healthcare coverage for low-income individuals and families. Employees who meet the income and eligibility criteria can apply for Medicaid to access comprehensive healthcare services, including doctor visits, hospital care, prescriptions, and preventive care. (*https://www.healthfirstcolorado.com/*)

Colorado Indigent Care Program (CICP): A discounted healthcare program that provides reduced-cost medical services to low-income individuals and families who do not qualify for Medicaid. It helps eligible individuals access medical care from participating providers at a reduced fee. (*https://hcpf.colorado.gov/colorado-indigent-care-program*)

HOUSING & MOBILITY

Colorado Housing Connects: A resource that helps individuals find affordable housing options in the state. They provide information and assistance on rental housing, homeownership programs, and resources for individuals facing housing challenges. They can connect you with affordable housing resources and programs in your area. (*https://coloradohousingconnects.org/*)

Colorado Division of Housing: Administers various housing programs and initiatives in the state. They offer resources and support for affordable housing development, rental assistance programs, and homelessness prevention efforts. The DOH website provides information on housing programs and resources available in different communities across Colorado. (*https://cdola.colorado.gov/housing*)

Colorado Housing and Finance Authority (CHFA): Provides financing options and resources for affordable homeownership and rental housing in Colorado. They offer programs such as down payment assistance, low-interest mortgages, and rental assistance for low-income individuals and families. (*https://www.chfainfo.com/*)

Aging and Disability Resources for Colorado (ADRC): Offers information and resources for older adults, individuals with disabilities, and their caregivers. They can provide assistance in finding accessible housing options, home modifications, transportation services, and other resources to support independent living and mobility. (*https://cdhs.colorado.gov/our-services/older-adult-services/state-unit-on-aging/aging-and-disability-resources-for-Colorado*)

Notes