Employee Benefits

2025

FREMONT COUNTY COLORADO
EST. 1861

Contents

This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

Getting Started

2025 Benefits

January 1, 2025 through December 31, 2025

Medicare Part D Notice

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Important Notices section for more details.

No matter where you are in your career, Fremont County supports you with benefit programs and resources to help you thrive today and prepare for tomorrow.

This guide provides an overview of your healthcare coverage, as well as life, disability, and more benefits.

You'll find tips to help you understand your medical coverage, save time and money on healthcare, reduce taxes, and balance your work and home life. Take a look at what's available to make the most of your benefits package.

Who's eligible for benefits?

Employees

You are eligible if you are a full-time employee working 30 or more hours per week.

Employees with variable hours and seasonal schedules may be considered eligible for benefits. Refer to "Determining Eligibility" later in this guide for details.

Eligible dependents

- Legally married spouse Biological, adopted or stepchildren up to age 26
- Children over age 26 who are disabled and depend on you for support
- Children named in a qualified medical child support order (QMCSO)

For additional coverage information, please refer to the benefit booklets for each benefit.

When you can enroll

New employees can enroll after first of the month following 30 days, but you must enroll within 30 days of becoming eligible. Existing employees can enroll during the annual open enrollment period.

If you miss the enrollment deadline, you'll need to wait until the next open enrollment.

Changing your benefits

Outside of open enrollment, you may be able to enroll or make changes to your benefit elections if you have a big change in your life, including:

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in your or a dependent's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP).

You must submit any changes within 30 days after the event.

Enrolling for benefits

Employee Navigator

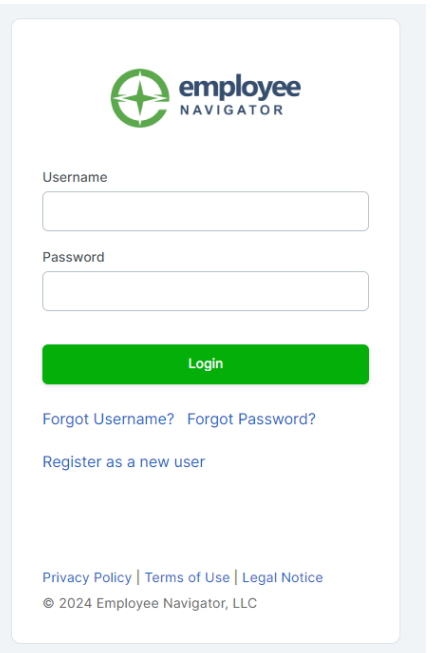
Employee Navigator is an online system that enables you to make all your benefit decisions in one place. If you don't have access to a computer, you can access Employee Navigator from a tablet or smartphone.

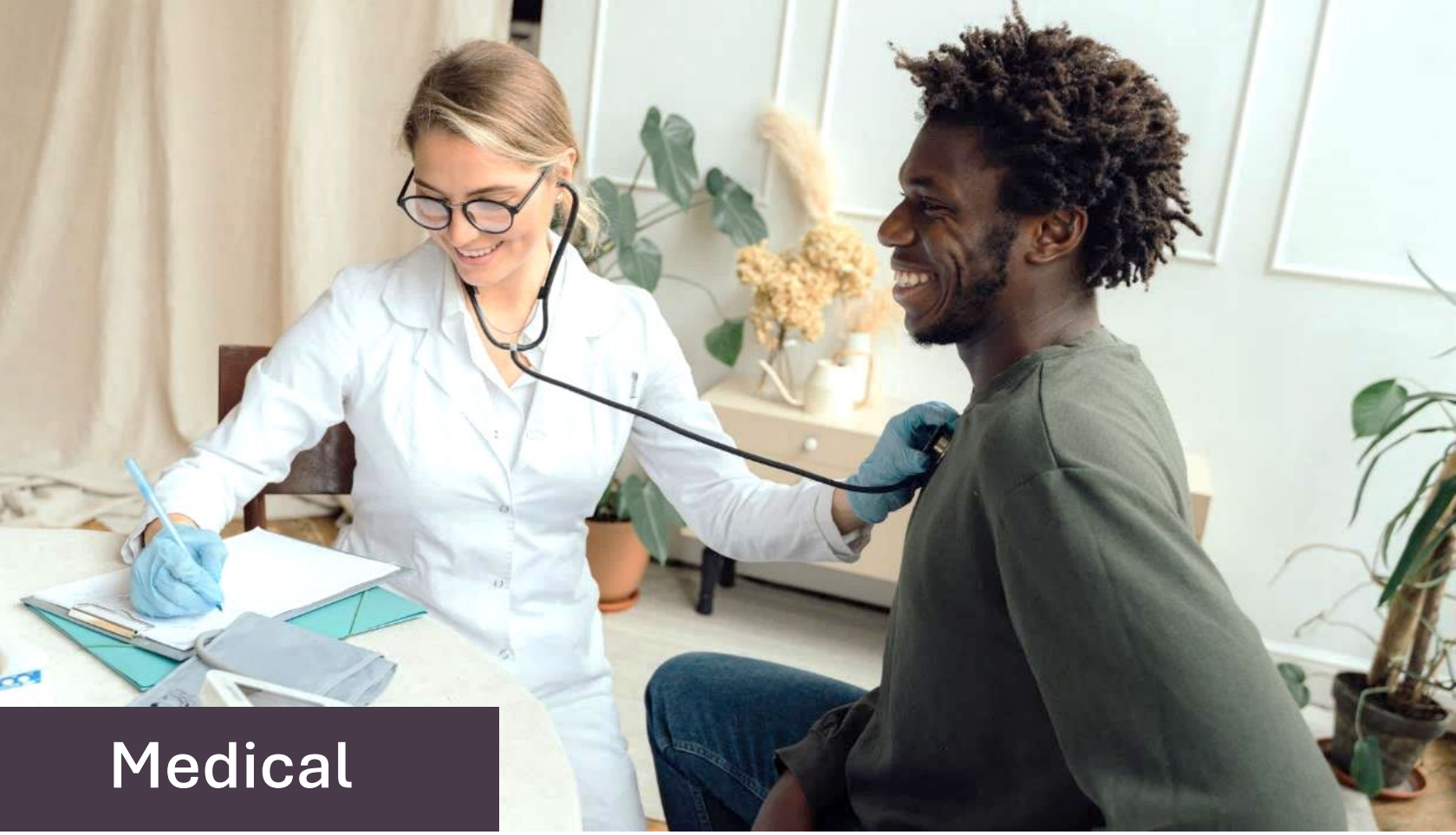
Before you enroll

- Know the date of birth, social security number, and address for each dependent you will cover.
- Review your enrollment materials to understand your benefit options and costs for the coming year.

Getting started

- **Log in** to Employee Navigator: www.employeenavigator.com
  Use created login and password: If this is your first time logging in, create an account
  Password: Reset if necessary
- **Add** your personal and dependent information.
- **Select** your benefit plans for the coming year.
- **Review** your choices and costs before finalizing.



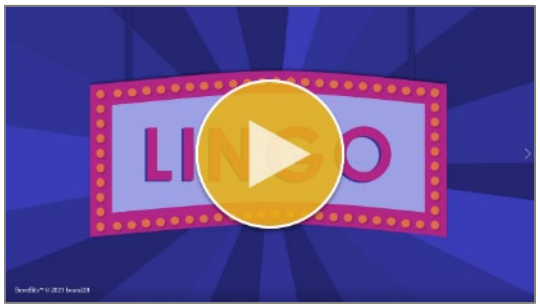


Medical

Words To Know

Can you beat the Health Lingo game? Learn the words that will help you understand how your plan works.

Click to play video



Deductible: The total healthcare costs you pay for with your own money before your plan will start to pay a portion.

Out-of-pocket maximum: Once you've spent this amount on covered medical services, your insurance pays 100% of most eligible expenses for the rest of the plan year.

Coinsurance: After the deductible (if applicable), you and the plan share the cost. For example, if the plan pays 80%, your share of the cost (your coinsurance) is 20%. You are billed for your coinsurance after your visit.

Copay: A set fee (rather than coinsurance) for certain healthcare services—for example, a doctor's office visit. You pay the copay at the time you receive care.

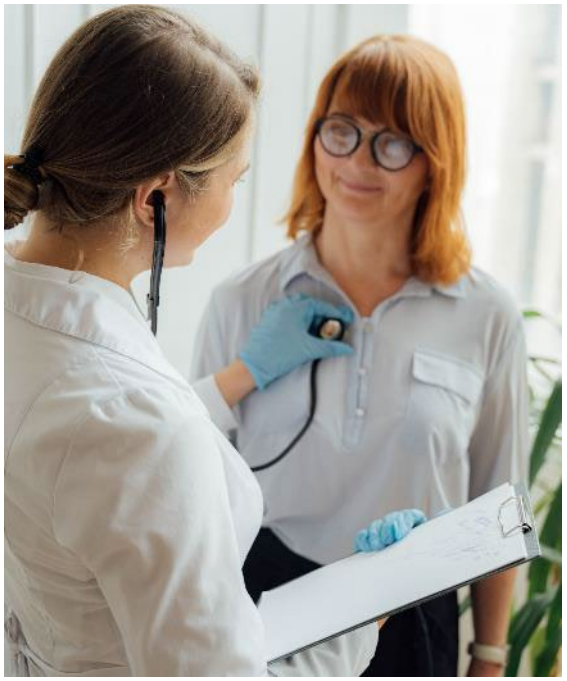
In-network/out-of-network: In-network services will always be the lowest-cost option. Out-of-network services will cost more or may not even be covered. Check your plan's website to find doctors, hospitals, labs, and pharmacies that belong to the network.

Cigna Medical Plans

You always pay the deductible and copayment ($). The coinsurance (%) shows what you pay after the deductible.

	OAP $5,000	OAP $2,500	OAP $1,500	OAP $500
Aggregate Deductible				
Individual:	$5,000	$2,500	$1,500	$500
Family:	$10,000	$5,000	$3,000	$1,000
Out-of-pocket maximum				
Individual:	$5,000	$4,500	$4,000	$2,000
Family:	$10,000	$9,000	$8,000	$4,000
Office visits				
Primary Care:	$55 copay	$45 copay	$40 copay	$30 copay
Specialist:	$55 copay	$45 copay	$40 copay	$30 copay
Urgent Care:	$75 copay	$75 copay	$75 copay	$75 copay
MDLive visit	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Chiropractic	$55 copay	$45 copay	$40 copay	$30 copay
Lab and X-ray	Covered 100% after deductible	Covered 80% after deductible	Covered 80% after deductible	Covered 80% after deductible
Emergency room	Covered 100% after deductible	Covered 80% after deductible	Covered 80% after deductible	Covered 80% after deductible
Hospitalization	Covered 100% after deductible	Covered 80% after deductible	Covered 80% after deductible	Covered 80% after deductible
Outpatient surgery	Covered 100% after deductible	Covered 80% after deductible	Covered 80% after deductible	Covered 80% after deductible
Prescription drugs				
Retail (30 days)				
Tier 1:	$20 copay	$20 copay	$20 copay	$20 copay
Tier 2:	$40 copay	$40 copay	$40 copay	$40 copay
Tier 3:	$60 copay	$60 copay	$60 copay	$60 copay
Mail Order (90 days)				
Tier 1:	$40 copay	$40 copay	$40 copay	$40 copay
Tier 2:	$80 copay	$80 copay	$80 copay	$80 copay
Tier 3:	$120 copay	$120 copay	$120 copay	$120 copay

Cigna Resources



myCigna Mobile App

The myCigna Mobile App helps you personalize, organize and access your important plan information on your phone or tablet. Use the myCigna Mobile App, to log in anytime, anywhere to:

- **Manage** and track claims
- **View**, fax or email ID card information
- **Find** doctors and compare cost and quality ratings
- **Review** your coverage
- **Track** your account balanced and deductibles
- **Compare** prescription drug prices at thousands of pharmacies in our network

Digital ID Cards

Never worry about misplacing your ID card again. It's always right there on myCigna.

- Log in to www.mycigna.com or the myCigna app
- Click or tap "ID Cards"
- View your cards, as well as your dependents' cards
- Email your cards directly to doctors
- Save your digital ID cards in your Apple Wallet

Please note, a physical ID card will not be mailed to your home address upon enrolling. You can print or download ID cards from myCigna.

Finding in-network providers

All four of our medical plans utilize Cigna's Open Access Plus network which offers flexible access to thousands of providers. Once you have created a myCigna account, you can search for providers within the Open Access Plus network. Prior to creating an account, you can research in-network providers by following the below steps:

- Visit www.cigna.com
- Click "Find a Doctor"
- Under How are you Covered? Click "Employer or School"
- Enter your Address, City or Zip and search Doctor by Type, Doctor by Name or Health Facilities and Group Practices
- Search and click "Continue"
- Under Please Select a Plan click "OAP Access Plus, OA Plus, Choice Fund OA Plus"

Pharmacy benefits

Express Scripts: (800) 835-3784

Accredo: (877) 826-7657

Your Prescription Drug List

The Cigna Advantage Prescription Drug List (PDL) is a list of generic and brand-name prescription medications covered by our plans. Covered medications are divided into tiers, or coverage/cost levels. Typically, the higher the tier, the higher the cost of the medication. Log into myCigna to learn more about the medications our plans cover.

Prescription drug requirements

- **Prior Authorization** – Certain medications need approval from Cigna before our plans will cover them
- **Quantity Limits** – For some medications, our plans only cover up to a certain amount over a certain length of time. For example, 30mg a day for 30 days
- **Step Therapy** – Certain high-cost medications are part of the Step Therapy program. Our plans don't cover Step Therapy medications until you try one or more generic and/or preferred-brand alternative first (unless approval is received from Cigna)

Home delivery

Express Scripts Pharmacy helps make it easy to get your medication. Easily order, manage, track and pay for your medications on your phone or online. Members can fill up to a 90-day supply at one time. You can even set up automatic refills or set up refill reminders so you don't miss a dose.

Vision www.cigna.com/homedelivery

Have a complex medical condition?

If you are using a specialty medication, Accredo, Cigna's specialty pharmacy, can help. Accredo can provide you with the personalized care and support you need to manage your therapy – at no extra cost.

- Personalized care services
- 24/7 access to specialty-trained pharmacists and nurses
- Fast shipping at no extra cost
- Refill certain prescriptions by text
- Manage medications online

Dental

Our Plans

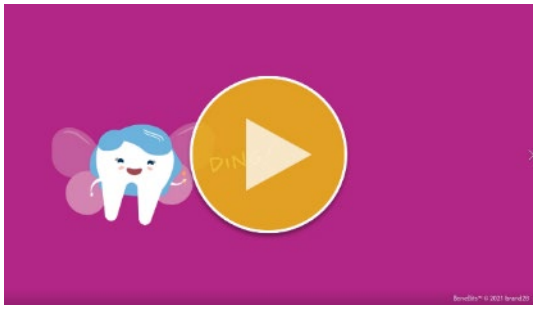
Reliance Standard Dental Plan

Why sign up for dental coverage?

Brushing and flossing are great, but regular exams catch dental issues early. If there's a problem, our dental plan makes it easier and less expensive to get the care you need to maintain your smile.

Find out how it works!

Click to play video



Reliance Standard Dental

You always pay the deductible and copayment ($). The coinsurance (%) shows what the plan pays after the deductible.

	In-Network	Out-of-Network
Annual deductible Individual: Family:	 $50 $150	 $50 $150
Annual plan maximum	$1,500 per person	$1,500 per person
Diagnostic & preventive	100%	100%
Basic services	80%	80%
Major services	50%	50%
Orthodontia	50% (children up to age 19)	50% (children up to age 19)
Orthodontia lifetime maximum	$1,500 per person	$1,500 per person

Network Providers

Reliance Standard has contracted with Ameritas to provide members access to a nationwide dental network. While you can see any provider you'd like, you will save money when seeing a provider in the Ameritas network due to their discounted fees. When seeing an out-of-network provider, you may be balance billed and responsible for charges over Amertias's discounted rates. Visit www.dentalnetworkpartners.ameritas.com to find a provider in the Ameritas network

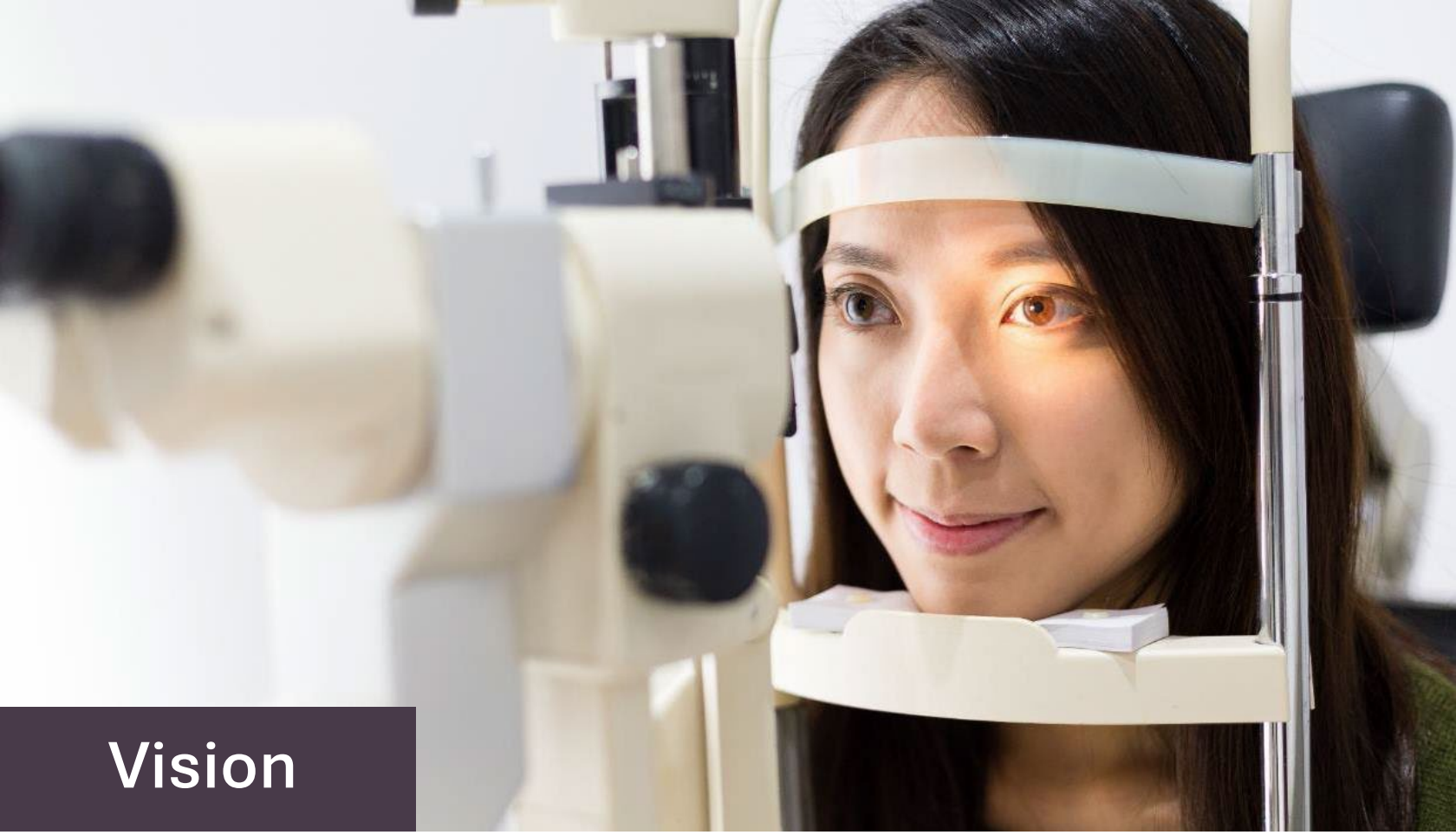
Maximum Rewards

With Maximum Rewards, members can carryover part of their unused annual maximum. Members must submit at least one claim during the benefit year while staying at or under the plan threshold amount. Members can even earn an extra reward called the PPO Bonus by seeing a Network Provider.

Benefit Threshold	$750	Dental benefits received for the year cannot exceed this amount
Annual Carryover Amount	$250	Maximum Rewards amount is added to the following year's maximum
Annual PPO Bonus	$150	Additional bonus earned for seeing network providers
Maximum Carryover	$1,500	Maximum possible accumulation for Maximum Rewards and PPO bonus combined

Prevention Plus

Benefits for Diagnostic and Preventive procedures are not deducted from the plan member's annual maximum benefit. This saves the entire $1,500 annual maximum for Basic and Major procedures that are covered by the plan. Diagnostic and Preventive procedures include dental exams, cleanings and fluoride.



Vision

Our Plans

Reliance Standard Vision Plan

Click to play video

Why sign up for vision coverage?

Even if you have 20/20 vision, an annual eye exam checks the health of your eyes and can detect other health issues. If you do need glasses or contacts, vision coverage helps with the cost.

Visit the plan's website for extra savings on services like LASIK and PRK, and rebates on contact lenses.

Reliance Standard Vision Plan

You always pay the copayment ($). The coinsurance (%) shows what you pay.

	In Network	Out of Network
Exam	$10 copay	Reimbursed up to $35
Materials	$25 copay	See schedule below
Frames	$180 allowance	Reimbursed up to $90
Lenses		
Single:	Covered in full after $25 copay	Reimbursed up to $25
Bifocal:	Covered in full after $25 copay	Reimbursed up to $40
Trifocal:	Covered in full after $25 copay	Reimbursed up to $55
Contacts		
Elective:	$180 allowance	Reimbursed up to $144
Medically Necessary:	Covered in full after $25 copay	Reimbursed up to $200
Frequency		
Exam:	Every 12 months	Every 12 months
Frames:	Every 24 months	Every 24 months
Lenses:	Every 12 months	Every 12 months

Network Providers

Reliance Standard has contracted with EyeMed to provide members access to a nationwide vision network. While you can see any provider you'd like, you will save money when seeing a provider in the EyeMed Insight network due to their discounted fees. When seeing an out-of-network provider, you will be reimbursed up to the amounts listed above. Visit www.eyemed.com/en-us to find a provider in the EyeMed Insight network.

Additional Benefits

When seeing an in-network provider, you will receive a 15% discount on the remaining balance of the conventional contact lens allowance, a 20% discount on the remaining balance of the frame allowance and a 20% discount on items not covered by the plan.

Members receive an average discount of 15% off retail price or 5% of promotional prices at US Laser Network participating providers for LASIK or PRK services.

For tinted lens options, members will pay $15 for solid or gradient tint.

Members also receive a 40% discount on a complete paid of glasses once the funded benefit has been exhausted.

Healthcare flexible spending account (FSA)

Click to play video

Are you eligible?

You don't have to enroll in one of our medical plans to participate in the healthcare FSA.

Find out more

- Rocky Mountain Reserve
- Eligible Expenses
- Ineligible Expenses

Do you pay for day care?

Look in the Financial Wellness section for information on tax savings through the Dependent Care FSA.

Set aside healthcare dollars for the year

A healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses you expect to have over the coming year.

How the Rocky Mountain Reserve FSA works

- You estimate what your and your dependents' out-of-pocket costs will be for the coming year. Think about what out-of-pocket costs you expect to have for eligible expenses such as office visits, surgery, dental and vision expenses, prescriptions, and certain drugstore items.
- You can contribute up to $3,200, the annual limit set by the IRS. Contributions are deducted from your pay pre-tax, meaning no federal or state tax on that amount.
- During the year, you can use your FSA debit card to pay for services and products. Withdrawals are tax-free as long as they're for eligible healthcare expenses.

Estimate carefully!

If you don't spend all the money in your account, you can roll over up to $640 to use the following year. Any additional remaining balance will be forfeited.

Potential tax savings

Because FSA contributions are pre-tax, they reduce the total amount of your income the government makes you pay taxes on. Tax savings vary depending on filing status and other variables, but here's an example using single-filer status and marginal federal income tax rates:

$60,000 annual pay, contributing $1,500 to FSA

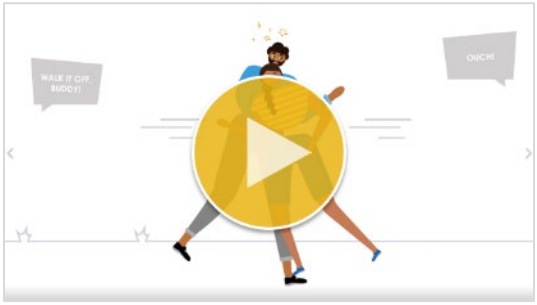
$330	$115	$445
22% income tax savings	7.65% FICA tax savings	Total FSA tax savings

$120,000 annual pay, contributing $3,200 to FSA

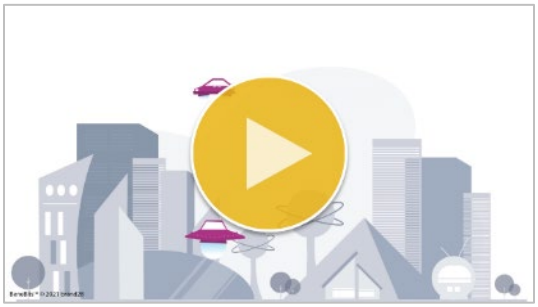
$768	$244	$1,012
24% income tax savings	7.65% FICA tax savings	Total FSA tax savings

Engage

Click to play videos



Urgent Care vs. ER



Virtual Healthcare

Maximize Your Health Benefits

Knowing how to best use your healthcare coverage can help you improve your health and reduce your expenses. In this section you'll find tips on:

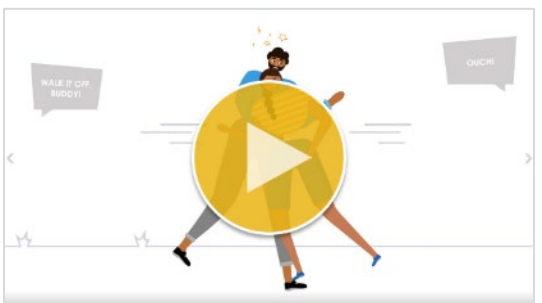
- Finding the right care at the right cost
- Alternatives to hospital care
- Understanding preventive care benefits
- Saving money on prescription drugs

Know where to go

Where you get medical care can significantly affect the cost. Here's a quick guide to help you know where to go based on your condition, budget, and time.

Visit type	Use it for ...
Online visit ($0) Often available 24/7	• non-emergency health issues: – cold, flu, allergies, headache, migraine – rashes, skin conditions – minor injuries – mental health concerns
Office visit ($$) Typically open during regular business hours	• routine medical care and management: – preventive care – illnesses and injuries – existing conditions
Urgent care ($$$) Typically open with extended evening and weekend hours	• urgent but not life-threatening conditions: – sprains or stitches – animal bites – high fever or respiratory infections
Emergency room ($$$) Open 24/7	• life-threatening conditions requiring immediate care: – suspected heart attack or stroke – broken bones – excessive bleeding – severe pain – difficulty breathing

Click to play video



Urgent Care vs. ER

Alternative facilities

If you have time to evaluate your options for non-emergency health treatments, these alternative facilities can provide the same results as a hospital at a fraction of the cost.

Procedure	Alternative	Features	Savings*
Surgery	Ambulatory surgical center	• Specializes in same-day surgeries • Cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery and more • Held to same safety standards as hospitals	Up to 50% vs. a hospital stay
Physical therapy	Outpatient facility	• Most cases are suited for outpatient physical therapy • Same types of treatments and similarly skilled therapists as inpatient facilities	40 to 60% vs. a hospital setting
Sleep study	Home testing	• Diagnoses obstructive sleep apnea • Cost is often covered by insurance if considered medically necessary	Up to $4,500 vs. a lab
Infusion therapy	Home or outpatient infusion	• For drugs that must be delivered by intravenous injections, or epidurals • Delivered by licensed infusion therapy provider • Maintain normal lifestyle and comfort of home or outpatient center	Up to 90% vs. a hospital stay

**Savings estimates are based on in-network facilities and providers*

How to find an alternative treatment facility

Ask your doctor if your treatment must be delivered in the hospital.

You can also search for surgical centers, physical therapy, and similar services on your plan's website, or call member services for assistance. Online tools such as healthcarebluebook.com and healthgrades.com help you compare costs and doctor ratings.

Some alternative facilities include a fee to cover overhead costs. To avoid a surprise on your bill, ask about facility fees before you schedule your appointment.

Preventive care

Typical screenings for adults

- Blood pressure
- Cholesterol
- Diabetes
- Colorectal cancer screening
- Depression
- Mammograms
- OB/GYN screenings
- Prostate cancer screening
- Testicular exam

You take your car in for maintenance; why not do the same for yourself?

Annual preventive checkups can help you and your doctor identify your baseline level of health and detect issues before they become serious.

Health plans are required to cover a set of preventive services at no cost to you, even if you haven't met your deductible. The preventive care services you'll need to stay healthy vary by age, sex, and medical history.

Be aware: Not all exams and tests are considered preventive care

Certain screenings may be considered diagnostic, rather than preventive, based on your current medical condition. You may be responsible for paying all or a share of the cost for those services.

In addition, exams performed by specialists are generally not considered preventive care and may not be covered at 100%.

If you have a question about whether a service will be covered as preventive care, contact your medical plan.

Prescriptions breaking your budget?

Click to play video

The formulary drug tiers determine your cost

$	Generic drugs
$$	Brand-name drugs
$$$	Specialty drugs

Understanding the formulary can save you money

If your doctor prescribes medicine, especially for an ongoing condition, don't forget to check your health plan's drug formulary. It's a powerful tool that can help you make informed decisions about your medication options and identify the lowest cost selection.

What is a formulary?

A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers." These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost you less than "non-preferred" drugs.

Get the most from your coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to be as effective as brand-name drug equivalents.

To find out if a drug is on your plan's formulary, visit the plan's website or call the customer service number on your ID card.

When you need care now

MDLIVE

Talk to a doctor anytime

MDLive gives you 24/7/365 access to U.S. board-certified doctors through the convenience of phone, video or mobile app visits. It's an affordable alternative to costly urgent care and ER visits when you need care now.

24/7/365 Access

- Sign in at www.mycigna.com and click "Talk to a doctor"
- Select the type of care needed and follow the prompts
- Call (88) 726-3171
- Download the myCigna App

Primary Care ($0) – Preventive care, routine care and specialist referrals

- Preventive care checkups/wellness screenings to identify conditions early
- Routine care visits allow you to build a relationship with the same primary care provider (PCP) to help manage conditions
- Prescriptions available through home delivery or at local pharmacies, if appropriate
- Receive orders for biometrics, blood work and screenings at local facilities

Urgent Care ($0) – On-demand care for minor medical conditions

- On-demand 24/7/365, including holidays
- Care for hundreds of minor medical conditions
- A convenient and affordable alternative to urgent care centers and the emergency room
- Prescriptions available, if appropriate

Behavioral Care (Subject to copay) – Therapy and psychiatry from privacy of home

- Access to psychiatrists and therapists
- Schedule an appointment that works for you
- Option to select the same provider for every session
- Care for issues such as anxiety, stress, life changes, grief and depression

Dermatology ($0) – Fast, customized care for skin, hair and nail conditions

- Board-certified dermatologists review pictures and symptoms; prescriptions available, if appropriate
- Care for common skin, hair and nail conditions including acne, eczema, psoriasis, rosacea, suspicious spots and more
- Diagnosis and customized treatment plan, usually within 24 hours

Life & Disability

Name Your Beneficiaries

If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier—receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit, and change your beneficiary as needed if your situation changes.

Is your family protected?

Life and disability insurance can fill financial gaps due to a loss of income. Consider your day-to-day costs and bills during a pregnancy or illness-related disability leave, or how you would manage large expenses (housing, education, loans, credit cards, etc.) after the death of a spouse or partner.

If you need more

In addition to company-provided coverage, we offer voluntary coverage that you can purchase for yourself, your spouse, and your children.

Life insurance

Basic Life

Basic life insurance pays your beneficiary a lump sum if you die. The cost of coverage is paid in full by Fremont County.

Reliance Standard Life

Benefit Maximum of $30,000 with Guaranteed Issue of $30,000

The benefit amounts above will be reduced if you are age 70 or older. Refer to the plan document for details.

Voluntary Life

You have the option to purchase additional Life coverage for yourself, spouse and child(ren). The is administered by Reliance Standard and premium payments are made through payroll deductions.

Voluntary Life

You have the option to purchase additional Life coverage for yourself, spouse and child(ren). The is administered by Reliance Standard and premium payments are made through payroll deductions.

	Benefit	Guarantee Issue
Employee	$10,000 increments up to $500,000 not to exceed 5x annual earnings	$150,000
Spouse	$10,000 increments up to $500,000 not to exceed 100% of employee amount	$30,000
Child(ren)	$2,000 increments up to $10,000	All amounts

The benefit amounts above will be reduced if you are age 70 or older. Refer to the plan document for details.

Voluntary Group Whole Life

Group Whole Life provides smart, convenient protection that also helps you achieve your financial goals. Mass Mutual Group Whole Life insurance provides coverage at a set premium, builds cash value over time and pays a death benefit making it easier and more affordable than you think. Employees can elect up to $150,000 (Guarantee Issue) worth of coverage if they are actively at work. Your spouse is eligible for $25,000 (if you elect at least $25,000). No health questions required during this open enrollment period!

- Guaranteed Death Benefit, premiums and cash value accumulation
- Dividend Eligible
- Accelerated Death Benefit Options
- Portable, Lifelong coverage

What's guaranteed issue?

If you select coverage above a certain limit (the "guaranteed issue") or after your initial eligibility, you will need to provide additional information about your health status to qualify for the requested amount of coverage.

Disability insurance

Expect the unexpected

Most people underestimate the likelihood of being disabled at some point in their life. Disability insurance replaces part of your pay while you are unable to work so you have a continuing income for living expenses.

Voluntary STD Benefits

Short-term disability (STD) insurance replaces part of your income for limited duration issues such as:

- Pregnancy issues and childbirth recovery
- Prolonged illness or injury
- Surgery and recovery time

STD payments may be reduced if you receive other benefits such as sick pay, workers' compensation, Social Security, or state disability. You pay the cost of this coverage through payroll deductions.

Voluntary Short-term Disability

Weekly benefit amount	60% of weekly earnings, up to a maximum of $1,750
Benefits begin	After 14 days of disability due to accident or sickness
Maximum payment period	13 weeks (including 14 day elimination period)

LTD benefits cushion the financial impact of a disability

Long-term disability (LTD) insurance replaces part of your income for longer term issues such as:

- Debilitating illness (cancer, heart disease, etc.)
- Serious injuries (accident, etc.)
- Heart attack, stroke
- Mental disorders.

If you qualify, LTD benefits begin after short-term disability benefits end. Payments may be reduced by state, federal, or private disability benefits you receive while disabled. Fremont County pays the cost of this coverage.

Things to know about LTD insurance

- It can protect you from having to tap into your retirement savings.
- You can use LTD benefits however you need, for housing, food, medical bills, etc.
- Benefits can last a long time—from weeks to even years—if you remain eligible.

Long-term Disability

Monthly benefit amount	60% of monthly earnings, up to a maximum of $7,500
Benefits begin	After 90 days of disability due to accident or sickness
Maximum payment period	Social Security Normal Retirement Age

Voluntary Plans

Our Plans

Accident

Critical Illness

Hospital Indemnity

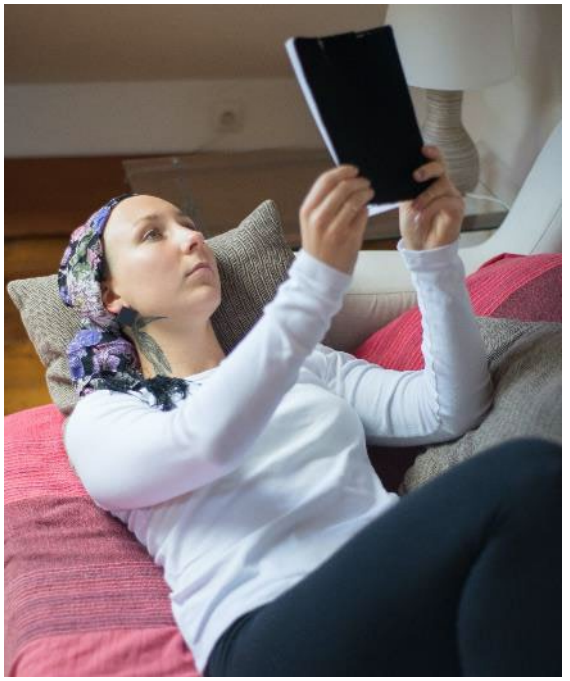
You're unique—and so are your benefit needs

Voluntary benefits are optional coverages that help you customize your benefits package to your individual needs.

You pay the entire cost for these plans, but rates may be more affordable than individual coverage. And you get the added convenience of paying through payroll deduction.

Voluntary benefits are just that: voluntary. You have the freedom and flexibility to choose the benefits that make sense for you and your family. You can also choose not to sign up for voluntary benefits at all—it's up to you.

Voluntary health-related plans



Things to consider

Your medical plan helps cover the cost of illness, but a serious or long-lasting medical crisis often involves additional expenses and may affect your ability to bring home a full paycheck. These plans provide you with resources to help you get by while there are additional strains on your finances.

Accident Insurance

Accident insurance from Reliance Standard helps you pay for unexpected costs that can add up due to common injuries such as fractures, dislocations, burns, emergency room or urgent care visits, as well as physical therapy. If you or a covered family member has an accident, this plan pays a lump-sum, tax-free benefit. The amount of money depends on the type and severity of your injury and can be used any way you choose. You may even be eligible for a $50 benefit if you receive a covered wellness screening such as blood tests, stress tests, or a chest X-ray.

Critical Illness Insurance

Critical illness insurance from Reliance Standard can help fill a financial gap if you experience a serious illness such as cancer, heart attack or stroke. Upon diagnosis of a covered illness, a lump-sum, tax-free benefit is immediately paid to you. Use it to help cover medical costs, transportation, childcare, lost income, or any other need following a critical illness. You choose a benefit amount that fits your paycheck and can cover yourself and your family members if needed. You may even be eligible for a $100 benefit if you receive a covered wellness screening such as blood tests, stress tests, or a chest X-ray.

Hospital Indemnity Insurance

Hospital indemnity insurance from Reliance Standard can enhance your current medical coverage. The plan pays a lump sum, tax-free benefit when you or an enrolled dependent is admitted or confined to the hospital for covered accidents and illnesses. You can use the money you receive under the plan however you see fit, for paying medical bills, childcare, or for regular living expenses like groceries—you decide. You may even be eligible for a $75 benefit if you receive a covered wellness screening such as blood tests, stress tests, or a chest X-ray.

Financial Wellness

Plans To Help You Save

Dependent Care Flexible Spending Account (DCFSA)

Is it time for a financial wellness checkup?

Are you worried about money—making your paycheck last? Paying down debt? Making a big purchase like a car or home? What about retirement?

Ignoring your financial health can take a toll on your quality of life today and in the future. And worrying about money can make you stressed, even to the point of physical illness.

We offer benefits and resources to help you make the most of your money.

Paying for daycare? Make it tax-free!

Click to play video

Every opportunity to save

The biggest deduction from your paycheck is likely federal income tax. Why not take a bite out of taxes while paying for necessary expenses with tax-free dollars?

Dependent Care FSA—up to $5,000 per year tax-free

A dependent care Flexible Spending Account (FSA) can help families save potentially hundreds of dollars per year on day care. This program is administered by Rocky Mountain Reserve

Here's how the DCFSA Plan works

You set aside money from your paycheck, before taxes, to pay for work-related day care expenses. Eligible expenses include not only childcare, but also before- and after-school care programs, preschool, and summer day camp for children younger than 13.

The account can also be used for day care for a spouse or other adult dependent who lives with you and is physically or mentally incapable of self-care.

You can set aside up to $5,000 per household per year. You can pay your dependent care provider directly from your FSA account, or you can submit claims to get reimbursed for eligible dependent care expenses you pay out of pocket.

Estimate carefully!

You can’t change your FSA election amount mid-year unless you experience a qualifying event. Money contributed to a dependent care FSA must be used for expenses incurred during the same plan year. Unspent funds will be forfeited.

Wellbeing & Balance

“The key to keeping your balance is knowing when you've lost it. ”

A Happier, Healthier You

Creating a healthy balance between work and play is a major factor in leading a happy and productive lifestyle, but it’s not always easy.

We offer programs to help you:

- Manage stress, substance use disorder, mental health and family issues.

Taking care of yourself helps you be more effective in all areas of your life. Be sure to take advantage of these programs to stay at your best.

Employee assistance program (EAP)

Contact the EAP

Phone: (800) 847-7240

Website: www.my-life-resource.com

Help for you and your household

There are times when everyone needs a little help or advice, or assistance with a serious concern. The EAP through Health Management Systems of America can help you handle a wide variety of personal issues, such as emotional health, substance use disorder, parenting and childcare needs, financial coaching, legal consultation, and elder care resources.

Best of all, contacting the EAP is completely confidential and free for any member of your immediate household.

No-cost EAP resources

The EAP is available around the clock to ensure you get access to the resources you need:

- Unlimited phone access 24/7
- In-person or video counseling for short-term issues; up to 3 sessions per issue, per year
- Unlimited web access to helpful articles, resources, and self-assessment tools.

Counseling

- Relationship challenges
- Emotional distress
- Job stress
- Communication issues
- Interpersonal conflict
- Alcohol or drug use
- Loss and grief

Elder care

- Help finding care resources for elderly or disabled relatives

Legal

- Local attorney referrals
- Family law (marital, child custody, adoption)
- Estate planning
- Landlord/tenant
- Immigration
- Personal Injury
- Consumer protection
- Real estate
- Bankruptcy

Parenting & childcare

- Quality referrals
- Family day care centers
- Infant centers and preschools
- Before- and after-school care
- 24-hour care

Financial

- Money/debt management
- Identity theft resolution
- Tax issues

Online resources

- Self-help tools to enhance resilience and well-being
- Information and links to various services and topics

Important Plan Information

In this section, you'll find important plan information, including:

- Your medical, dental and vision benefit costs for 2025
- Contact information for our benefit carriers and vendors
- A Benefits Glossary to help you understand important insurance terms.

Your 24-pay period benefit costs

The total amount that you pay for your benefits coverage depends on the plans you choose, how many dependents you cover, and for medical coverage, how much you earn. Your healthcare costs are deducted from your pay on a pre-tax basis—before federal, state, and social security taxes are calculated—reducing your taxable income.

Medical	OAP $5,000	OAP $2,500	OAP $1,500	OAP $500
Employee Only	$18.82	$43.90	$69.37	$95.49
Employee + Spouse	$124.27	$193.24	$254.35	$ 315.10
Employee + Children	$107.27	$166.83	$219.63	$272.13
Employee + Family	$146.81	$228.32	$300.54	$ 372.25

	Dental	Vision
Employee Only	$16.50	$4.50
Employee + Spouse	$34.00	$6.25
Employee + Children	$47.00	$5.75
Employee + Family	$63.50	$10.75

Voluntary life insurance costs

If you elect voluntary coverage, your monthly premium rate is calculated based on your age and the amount of coverage. Use the tables below to estimate the premium amount that will be deducted from your paycheck.

Voluntary life insurance (monthly rate per $1,000 of coverage)

Age	Employee/Spouse Rate
18-24	$0.075
25-29	$0.075
30-34	$0.075
35-39	$0.105
40-44	$0.170
45-49	$0.255
50-54	$0.425
55-59	$0.645
60-64	$0.920
65-69	$1.360
70-74	$2.950
75-79	$6.580
80+	$15.49

Child life insurance

Coverage amount	Rate per $10,000 of coverage	Cost per paycheck
$10,000	$1.80	$0.90

Premium includes all eligible children. *Eligible children include dependent children under age 26 as long as you apply for and are approved for coverage for yourself.*

Calculate your life insurance cost

1. Desired coverage ($10,000 increments)

You:	Spouse:

2. Divide step 1 by $1,000 =

You:	Spouse:

3. Multiply step 2 by rate from table at left =

You:	Spouse:

4. Multiply step 4 by 12 and divide by 24 =

You:	Spouse:

5. Add you + spouse from step 4 =

Cost per paycheck:

Plan contacts and resources

Helpful Resources

Enrollment website
Employee Navigator
employeenavigator.com/

Medical, Dental, and Vision Plans

Cigna Medical
Policy No. 655950
mycigna.com
Member services
(800) 244-6224

Reliance Standard Dental & Vision
Policy No. 422302
reliancematrix.com
(800) 351-7500

Life, Disability & Voluntary Benefits

Reliance Standard
reliancematrix.com
(800) 351-7500

Employee Assistance Program (EAP)

Health Management Systems of America
my-life-resource.com
(800) 847-7240

Flexible Spending Account (FSA)

Rocky Mountain Reserve
rockymountainreserve.com
(888) 722-1223

For all service related questions, contact:

Choice Insurance Services
Brad Gauthreaux
(303) 500-7987
Brad@choiceinsservices.com

Glossary

Accumulation Period
The period of time during which you can incur eligible expenses toward your deductible, out-of-pocket maximum, and visit limitations. The accumulation period for your deductible and OOP maximum may differ from the period for visit limitations.

Aggregate Deductible
A type of family deductible in which a family must meet the entire family deductible before the plan covers eligible expenses for any individual.

Aggregate Out-of-Pocket Max
A type of family out-of-pocket maximum in which a family must meet the entire family out-of-pocket maximum before the plan pays 100% of eligible expenses for any individual.

Allowed Amount
The maximum amount your insurance plan will pay for an eligible expense. In-network providers cannot bill you for more than the allowed amount.

Ambulatory Surgery Center
A healthcare facility that specializes in same-day surgical procedures.

Annual Limit
The maximum dollar amount or number of visits your plan will cover for a specific service during a plan year. If you reach an annual limit, you must pay all associated costs for that service for the rest of the plan year.

Balance Billing
Balance billing is when an out-of-network provider bills you for more than your plan's allowed amount. For example, if the provider charges $100 but the plan's allowed amount is only $70, an out-of-network provider can bill you for the $30 difference. Balance billing may not be allowed for all services; consult your insurance plan documents for details.

Beneficiary
The people or entities you select to receive a benefit if you die. You must name beneficiaries for life, AD&D, and retirement plans to ensure the money is distributed according to your wishes.

Brand-Name Drug
A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine. Your coinsurance for brand-name drugs may be higher if there is a generic equivalent available.

COBRA
The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law allows you to temporarily keep your health insurance after your employment ends, based on certain qualifying events. If you elect COBRA coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim
A request for payment that you or your provider submits to your insurance plan after you receive services.

Coinsurance
The percentage of the allowed amount you must pay for an eligible expense. Coinsurance will always add up to 100%. For example, if the plan pays 70% of the allowed amount, your coinsurance is 30%. If your plan has a deductible, you pay 100% of most costs until you have paid the deductible amount.

Copayment (Copay)
A flat fee you pay for some services, such as a doctor's office visit. You pay the copayment at the time you receive care. In most cases, copays do not count toward your deductible.

Deductible
The dollar amount you must pay for eligible expenses before your insurance starts covering a portion. The deductible does not apply to preventive care or certain other services.

Dental Basic Services
Services such as fillings, routine extractions, and some oral surgery procedures.

Dental Diagnostic & Preventive
Generally includes routine cleanings, oral exams, X-rays, and fluoride treatments. Most plans limit preventive exams and cleanings to twice a year.

Dental Major Services
Complex or restorative dental work such as crowns, bridges, dentures, inlays, and onlays.

Eligible Expense
Also referred to as a covered service, this is a service or product for which your insurance plan will pay a portion of the allowed amount. Your plan will not cover any portion of the cost if the expense is not eligible, and the amount you pay will not count toward your deductible.

Embedded Deductible
A type of family deductible in which the plan covers eligible expenses for each person as soon as they reach their individual deductible.

Embedded Out-of-Pocket Max
A type of family out-of-pocket maximum in which the plan pays 100% of eligible expenses for a person as soon as they reach their individual out-of-pocket maximum.

Glossary

Excluded Service
A service for which your insurance will not pay any portion of the cost. These services may also be referred to as "ineligible," "not covered," or "not allowed."

Formulary
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a preferred drug list.

Generic Drug
A drug that has the same active ingredients as a brand-name drug but is sold under a different name. For example, atorvastatin is the generic name for medicines with the same formula as the brand-name drug Lipitor.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

In Network
Also known as participating providers, in-network providers have a contract with your insurance plan. They are usually the lowest-cost option because they have agreed not to charge you more than the allowed amount, and your insurance will cover a bigger portion of eligible expenses than with out-of-network providers.

Mail Order
A medical or prescription drug plan feature allowing a 90-day supply of medicines you take routinely to be delivered by mail.

Out of Network
Also known as nonparticipating providers, out-of-network providers do not have a contract with your insurance plan. They are typically a higher-cost option because they can charge you more than your plan's allowed amount, and your insurance will cover a smaller portion of eligible expenses than with in-network providers. Some plans do not cover out-of-network services at all.

Out-of-Pocket Costs
Healthcare expenses you are responsible for paying, whether from your bank account, credit card, or from a health savings account such as an HSA, FSA or HRA. These costs include any deductibles, copays, and coinsurance you pay for eligible expenses, along with the cost of any services your insurance does not cover.

Out-of-Pocket Maximum
The maximum amount of money you will have to spend on eligible expenses during a plan year. Once you spend this amount, your plan covers 100% of eligible expenses for the rest of the plan year.

Outpatient Care
Care from a hospital or clinic that doesn't require you to stay overnight.

Participating Pharmacy
Also known as an in-network pharmacy, a participating pharmacy has a contract with your medical or prescription drug plan. You will typically pay lower prescription costs at a participating pharmacy.

Plan Year
A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug
A list of prescription drugs your insurance will cover at the highest benefit level. The list, also known as a "formulary," is based on an evaluation of effectiveness and cost. Your coinsurance may be higher for drugs that are not on this list, or your insurance may not cover them at all.

Preventive Care
Routine healthcare services that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems.

Primary Care Provider (PCP)
Your main doctor. Some insurance plans require you to name a PCP, who will direct or approve all of your healthcare and referrals.

Provider
A doctor, dentist, physician's assistant, nurse, hospital, lab, or other healthcare professional or facility that provides healthcare services.

Telehealth/Telemedicine
A virtual visit with a provider using video chat on a computer, tablet or smartphone.

Usual, Customary, and Reasonable (UCR)
The cost of a medical service in a geographic area based on what providers in the area usually charge for the same or a similar medical service. Your plan may use the UCR amount as the allowed amount.

Urgent Care
Care for an illness, injury, or condition that needs attention right away but is not severe enough to require the emergency room. Treatment at an urgent care center generally costs less than an emergency room visit.

Vaccinations
Also known as "immunizations," vaccinations are biological preparations that help prevent or reduce the severity of specific diseases.

Voluntary Benefit
An optional benefit offered by your employer for which you pay the entire premium, usually through payroll deduction.


FREMONT COUNTY COLORADO
EST. 1861