DELTA COUNTY

Branch # A4

BENEFIT PLANS SELECTED

CEBT MEDICAL (PPO 5 & PPO 7)

HRP

CEBT DENTAL PLAN C

CEBT VISION PLAN B

CEBT GROUP LIFE

WWW.CEBT.ORG

Plan Arranged By

Willis of Colorado
2000 South Colorado Boulevard, Tower II, Suite 900
Denver, CO 80222

Phone: 303-773-1373
Fax: 303-773-1685
WATS: 800-332-1168

What is CEBT?

Colorado Employers Benefit Trust (CEBT) is a self-funded, governmental multiple employer trust that provides employee benefits for over three hundred (300) public entities, with over 33,000 employees and dependents covered in the state of Colorado. The CEBT plan offers health, dental, vision and life coverage to the participating groups.

Who is Willis Towers Watson?

Willis Towers Watson is the broker / administrator for the CEBT. It provides customer service for plan participants to obtain answers on claims and benefits questions at (800) 332-1168 or (303) 773-1373. Willis Towers Watson has service representatives that make periodic visits to the participating groups to answer questions. In addition, the Trust administrator markets for prospective new members. Finally, Willis Towers Watson handles the eligibility and premium invoice process between the Trust and the participating employers.

What are the Roles of UMR, CVS Caremark, Delta Dental and Vision Service Plan (VSP)?

CEBT has contracted with these managed health care companies to provide claims processing and provider network access:

UMR provides third party claim payment services and access to the RMHP provider networks for CEBT members who have medical coverage.

CVS Caremark provides the pharmacy payment and access to their provider network for CEBT members who have medical coverage using the RMHP provider network.

Delta Dental of Colorado provides third party dental claim payment services and access to their Dental PPO and Premier networks.

Vision Service Plan (VSP) provides the vision payment and access to their provider network for CEBT members who have vision coverage.

Much of your day to day correspondence, such as Explanations of Benefits (EOB) and requests for further information, will come from UMR. Additionally, you will receive ID cards from UMR, CVS Caremark, and Delta Dental, but not from VSP.

CEBT
LIFE BENEFITS

SCHEDULE OF BENEFITS
LIFE INSURANCE, ACCIDENTAL DEATH
AND DISMEMBERMENT (AD&D) INSURANCE

CLASS	AMOUNT OF LIFE INSURANCE*	FULL AMOUNT OF AD&D INSURANCE
All employees	$20,000	$20,000

*Your amount of insurance will be reduced as follows:

Age	65	40%
	70	65%
	75	75%
	80	80%

This is only intended to highlight some of the pertinent provisions of the Group Plan; such Plan will control in all instances.

CEBT
MEDICAL BENEFITS COMPARISON
(EFFECTIVE JULY 1, 2019)

MEDICAL BASE PLAN	PREFERRED PROVIDER ORGANIZATION (PPO)* OPTION 5	PREFERRED PROVIDER ORGANIZATION (PPO)* OPTION 7
Office Visits	PPO $45 co-pay; Non PPO Subject to deductible then 60/40	PPO $55 co-pay; Non PPO subject to deductible then 60/40
Lab Charges	PPO $45 co-pay; Non PPO Subject to deductible then 60/40	PPO $55 co-pay; Non PPO subject to deductible then 60/40
X-Ray Charges	PPO $45 co-pay then 100% in office setting, outpatient subject to deductible 80/20, Non PPO subject to deductible 60/40	PPO $55 co-pay then 100% in office setting, outpatient subject to deductible 80/20, Non PPO subject to deductible 60/40
Prescriptions Retail - for 30 day supply:	Generic $20 Preferred Brand $40 Non-Preferred Brand $60	Generic $20 Preferred Brand $40 Non-Preferred Brand $60
Mail Order - for 90 day supply:	$40 / $80 / $120	$40 / $80 / $120
Deductible	$2,500 individual $7,500 family	$4,000 individual $12,000 family
Co-insurance	Subject to deductible then PPO 80/20, Non PPO 60/40	Subject to deductible then PPO 80/20, Non PPO 60/40
Maximum Out of Pocket	PPO $4,500 ($9,000 family) Non PPO $9,000 ($18,000 family)	PPO $6,000 ($12,000 family) Non PPO $12,000 ($24,000 family)
Hospital Charges	Subject to deductible then PPO 80/20, Non PPO 60/40 Precertification is required for inpatient stays, and for surgeries, whether inpatient or outpatient	Subject to deductible then PPO 80/20, Non PPO 60/40 Precertification is required for inpatient stays, and for surgeries, whether inpatient or outpatient
Emergency Care	Subject to deductible then PPO 80/20, Non PPO 60/40	Subject to deductible then PPO 80/20, Non PPO 60/40
Urgent Care Services	**PPO $50 co-pay; Non PPO subject to deductible then 60/40**	**PPO $50 co-pay; Non PPO subject to deductible then 60/40**
Ambulance	Subject to deductible then PPO 80/20 of "reasonable & customary"	Subject to deductible then PPO 80/20 of "reasonable & customary"
Out Patient Surgery	Subject to deductible then PPO 80/20, Non PPO 60/40	Subject to deductible then PPO 80/20, Non PPO 60/40
Maternity / Prenatal Care	PPO $45 co-pay (applies to the first prenatal care visit) Non PPO subject to deductible then 60/40	PPO $55 co-pay (applies to the first prenatal care visit) Non PPO subject to deductible then 60/40
MRI or CT Scan with or without Contrast	Subject to deductible then PPO 80/20, Non PPO 60/40	Subject to deductible then PPO 80/20, Non PPO 60/40

MEDICAL BASE PLAN	PREFERRED PROVIDER ORGANIZATION (PPO)* OPTION 5	PREFERRED PROVIDER ORGANIZATION (PPO)* OPTION 7
Pet Scans and SPECT Scans	Subject to deductible then PPO 80/20, Non PPO 60/40	Subject to deductible then PPO 80/20, Non PPO 60/40
Durable Medical Equipment	Subject to deductible then PPO 80/20, Non PPO 60/40	Subject to deductible then PPO 80/20, Non PPO 60/40
Physical, Occupational and Speech Therapy	PPO $45 co-pay; Non PPO Subject to deductible then, 60/40; pre-authorization required, 20 visit limit per injury or sickness	PPO $55 co-pay; Non PPO subject to deductible then 60/40; pre-authorization required, 20 visit limit per injury or sickness
Chiropractor	PPO/Non PPO $45 co-pay, benefits subject to "reasonable & customary" guidelines, 20 visits limit per year	PPO/Non PPO $55 co-pay, benefits subject to "reasonable & customary" guidelines, 20 visits limit per year

****Bold items are effective July 1, 2019**

*Ambulance, chiropractic and out of network charges are all subject to reasonable and customary guidelines (R&C)

ROUTINE SERVICES – will be processed following the Federal Patient Protection and Affordable Care Act.

The Summary of Benefits and Coverage (SBC) is posted on the www.cebt.org website.

PPO NOTE: Combination of PPO and Non PPO out of pocket limit will never exceed the Non PPO out of pocket limit.

Enrollee Restrictions - If you DO NOT enroll your dependents during this initial enrollment period, your dependents may only be able to enroll if there is a HIPAA qualified loss of coverage.

Eligible Dependent - Legal spouse and children under age 26. Step-children, foster children, and legally adopted children are eligible.

Timely Submission of Claims - All claims are required to be submitted within twelve (12) months from the date of service. If claims are not submitted within these guidelines, payment will not be assured.

This comparison of coverages is intended only as a general description for the principle features of the benefit plans. Please refer to the plan document for details. 02/01/2019

CEBT'S HOSPITAL REIMBURSEMENT PLAN

PURPOSE

For CEBT Employer groups who would like to allow employees the option to choose other coverage as their primary health plan (i.e. spouse's medical plan) CEBT offers a Hospital Reimbursement Plan (HRP). This plan design allows employees to file claims under the other plan as primary and CEBT's HRP plan would be considered secondary coverage.

PLAN DESIGN

All eligibility, exclusions and conditions of CEBT's other plans would apply. The Schedule of Benefits states:

> "The plan will pay up to $1,000 per day for otherwise un-reimbursed eligible medical expenses for hospital confinement. This may include expenses for visits to the plan participant from a provider when confined.
>
> The reimbursement will be paid directly to the plan participant. There is a $30,000 maximum hospital benefit per plan year."

02/2019

CEBT's Covered Preventative Services for Children

Eligible charges for the routine items below will be covered at 100% through in and out of network provider.

General Screening Guidelines for Children	
Alcohol & Drug Use – assessments for adolescents	**Autism –** screening for children at 18 and 24 months
Behavioral – assessments for children of all ages	**Blood Pressure Screening**
Cervical Dysplasia Screening – screening for sexually active females	**Congenital Hypothyroidism –** screening for newborns
Developmental – screening	**Dyslipidemia Screening –** for children at higher risk of lipid disorders
Fluoride Chemoprevention Supplements	**Gonorrhea Prevention Medication-** for the eyes of all newborns
Hearing Screening – newborns	**Height, Weight & Body Mass Index (BMI) measurements** – for children
Hematocrit or Hemoglobin Screening	**Hemoglobinpathies or Sickle Cell Screening –** for newborns
Hepatitis B Screening	**HIV Screening** - for adolescents at high risk
Hypothyroidism Screening – for newborns	**Immunization Vaccines –** see section below: "General Immunization/Vaccine for Children"
Iron Supplements	**Lead Screening**
Medical History	**Obesity Screening and Counseling**
Oral Health – risk assessment	**Phenylketonuria (PKU) Screening**
Sexually Transmitted Infection (STI) – prevention counseling	**Tuberculin Testing**
Routine Vision Exam	
General Immunization / Vaccine for Children	
Diphtheria, Tetanus, Pertussis	**Haemophilus Influenza Type B**
Hepatitis A & B	**Human Papillomavirus (HPV) –** thru age 26
Inactivated Poliovirus	**Influenza – flu shots**
Measles	**Meningococcal**
Pneumococcal (pneumonia)	**Rotavirus**
Varicella (chicken pox)	

CEBT's Covered Preventative Services for Adult Men and/or Women

Eligible charges for the routine items below will be covered at 100% through in and out of network provider.

General Screening Guidelines for Women & Men	
Alcohol Misuse – screening & counseling	**Aspirin** – ages 55 – 79 – RX Plan
Blood Pressure	**Tobacco Screening**
Cholesterol Screening	**Colonoscopy** – over age 50
Depression Screening	**Cologuard**
Diabetes (Type 2) Screening	**Diabetes Test**
Hepatitis B & C Screening	**Diet Counseling**
Immunization Vaccines – see section below: "General Immunization/Vaccine for Women & Men"	**HIV Screening** – annually
Obesity Screening & Counseling	**Lung Cancer Screening** - high risk
Sexually Transmitted Infection (STI) – prevention counseling- provided annually	**Routine Vision Exam**
Syphilis Screening	**Generic Statins** – age 40 – 75; with one or more CVD risk factors and have been calculated 10 years risk of cardiovascular event 10% or greater
General Screening Guidelines for Women	
Anemia Screening – for pregnant women	**Bacteruria Screening** – for pregnant women
Breast Cancer Chemoprevention Counseling	**Breastfeeding** - comprehensive support and counseling
BRCA Testing & Counseling	**Rental or Purchase of a breast pump** – limited to one per pregnancy
Chlamydia Infection Screening	**Cervical Cancer Screening**
Domestic and Interpersonal Violence – screening and counseling- annually	**Clinical Breast Exam**
Folic Acid Supplements – RX Plan	**Expanded Tobacco** – intervention and counseling for pregnant tobacco users
Gonorrhea Screening	**Gestational Diabetes Screening**

Osteoporosis Screening – over age 60	**Routine Mammogram –** a baseline age 35-39, One every calendar year age 40-49, no frequency limitations for age 50 and older.
Oral contraceptives and sterilization procedures	
Rh Incompatibility Screening	**Urinary Tract or Other Infection Screening**
HPV DNA testing Cov. 30 years and older	**Well-woman Visits**
General Screening Guidelines for Men	
Abdominal Aortic Aneurysm One Screening – aged 65 - 79	**Digital Rectal Exam (DRE)**
	Prostate Specific Antigen (PSA)
General Immunization / Vaccine for Women & Men	
Hepatitis A & B	**Human Papillomavirus (HPV) –** thru age 26
Influenza – flu shots	**Measles**
Meningococcal	**Mumps**
Pneumococcal (pneumonia)	**Rubella**
Zoster (shingles) – age 60 and over	**Shingrix (shingles) –** age 50 and over

DELTA DENTAL

DELTA DENTAL PPO PLUS PREMIER
CEBT - PLAN C
(EFFECTIVE JULY 1, 2019)

CEBT BENEFIT BY TRUST

MAXIMUM BENEFIT Calendar Year Maximum	$1,500 per member, per calendar year
CALENDAR YEAR DEDUCTIBLE Applies to Basic and Major Services	Individual Deductible - $50.00 Combination of in and out-of-network Family Deductible - $150.00 Combination of in and out-of-network

PPO Dentist	PREMIER Dentist	NON-PAR Dentist	COVERED SERVICES	BENEFIT INFORMATION (subject to Delta Dental guidelines)
DIAGNOSTIC AND PREVENTIVE SERVICES				
100%	100%	100%	Oral Exams and Cleanings	Twice each in a calendar year. Two additional cleanings may be covered for those with a documented EBD condition.
			Sealants	Once per tooth in a 36-month period for unrestored permanent molars, through age 15
			Bitewing X-Rays	Once in a calendar year
			Full Mouth X-Rays	Once in a 5-year period
			Fluoride	Twice in a calendar year, through age 15
			Space Maintainers	One per quadrant, per lifetime to maintain space for eruption of permanent posterior teeth, through age 13
BASIC SERVICES				
80%	80%	80%	Fillings	Once per tooth in a 12-month period; composite (white) fillings
			Simple Extractions	
			Oral Surgery	
			Endodontics / Periodontics	
			Occlusal Guards	Limited to once per five calendar year period. Occlusal adjustments, limited to once per 24 months
MAJOR SERVICES				
50%	50%	50%	Crowns	Once per tooth in 5-year period. Not a benefit under age 12.
			Implants	Once per tooth in a 5-year period. Not a benefit under age 16.
			Dentures, Bridges	Once in a 5-year period, only when existing prosthesis cannot be made serviceable. Fixed bridges or removable partials are not a benefit under age 16.
ORTHODONTICS - Not covered				

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

PPO Dentist - Payment is based on the PPO dentist's allowable fee, or the actual fee charged, whichever is less.
Premier Dentist - Payment is based on the Premier Maximum Plan Allowance (MPA), or the fee actually charged, whichever is less.
Non-Participating Dentist - Payment is based on the non-participating Maximum Plan Allowance. Members are responsible for the difference between the non-participating MPA and the full fee charged by the dentist. You will receive the best benefit by choosing a PPO dentist.

An employer must have at least 25% of the eligible employees enrolled in the plan in order to have the coverage offered.
Members may add coverage once a year at Open Enrollment. Coverage may only be dropped by an employee or dependent with proof of qualifying event.

This is a brief description of services covered under your dental plan. Please refer to the Employee Benefit Booklet for full plan details. If differences exist between this summary and the Employee Benefit Booklet, the Employee Benefit Booklet will govern. 02/01/2019

CEBT
PLAN B VISION SERVICE PLAN (VSP)
(EFFECTIVE JULY 1, 2019)

MEMBER DOCTOR BENEFITS	12/12/24 UP TO	
Exam Co-pay	$ 15.00	Once every 12 months
Material Co-pay	$ 15.00	Once every 12 months
Corrective Contact Lenses Allowance	$160.00	Once every 12 months
Frame Allowance (retail)	$160.00	Once every 24 months

When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again for 12 months.

NON-MEMBER DOCTOR BENEFITS	
Exam	$ 35.00
Single Lens	$ 25.00
Bifocal Lens	$ 40.00
Trifocal Lens	$ 55.00
Elective Contact Lenses	$110.00
Frame	$ 45.00

EXCLUSIONS: Benefits covered under Worker's Compensation Act, surgery or medical treatment of eyes, replacement of lost, stolen or broken lenses and/or frames, services and supplies for which you or your dependent are not required to pay, services and supplies not listed.

An employer must have at least 25% of the eligible employees enrolled in the plan in order to offer coverage.

ENROLLMENT RESTRICTIONS: If any employee or dependent drops coverage, he or she must have proof of a qualifying event in order to do so outside open enrollment. The employee or dependent will need to wait until the next open enrollment period to re-enroll or have proof of a qualifying event.

This is only intended to highlight some of the pertinent provisions of the Group Plan; such Plan will control in all instances. 02/01/2019

CEBT General Notice Of COBRA Continuation Coverage Rights

** Continuation Coverage Rights Under COBRA**

Introduction

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

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

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

What is COBRA continuation coverage?

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

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer;]; or
- The employee's becoming entitled to Medicare benefits (under 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: your Human Resource or Payroll department.

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 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, 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.

If you have questions

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

Keep your Plan informed of address changes

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

CEBT Plan Administrator
Termination notices should be sent by the CEBT participating employer group

Willis of Colorado
2000 S. Colorado Blvd., Tower II, Suite 900
Denver, CO 80222
303-773-1373 or 800-332-1168

CEBT COBRA Administrator
The Plan Administrator will notify the COBRA Administrator of any qualified events submitted by the employer. Below is the contact information for the Qualified Beneficiary's use.

24HourFlex Payments
PO Box 2440
Omaha, NE 68103-2440

24HourFlex (all other correspondence)
PO Box 3789
Littleton, CO 80161

24HourFlex Member Services
(800) 651-4855
7:00 am to 6:00 pm MST, Monday through Friday