Estes Park Medical Center

2017

Employee Benefits Guide

January 1, 2017 - December 31, 2017

This document is an outline of the coverage proposed by the carrier(s). It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Your full Summary Plan Document (SPD) is made available through your Human Resources Department.
The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific coverage issues can be directed to the Benefit Advocates at Arthur J. Gallagher & Co., Austin.GBS.CustomerService@ajg.com.

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**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 pages 36 - 37 for more details.

Customer Service and Contact Information

Arthur J. Gallagher & Co. is here to act as a liaison in your dealings with insurance carriers. If you have questions regarding your coverage or need assistance with claims, let us deal with the insurance company for you. Please contact anyone at Arthur J. Gallagher & Co. with questions regarding your benefits package.

Phone: (512) 499-8005 / (800) 492-8005
Fax: (512) 233-0102
Email: Austin.GBS.CustomerService@ajg.com
Hours of Operation: Monday - Friday
8:00 a.m. - 5:00 p.m. CST

**For information on how to enroll,
please contact your Human Resources Department.**

Benefit	Carrier	Group Number/Network	Customer Service	Website
Medical	UMR/United Healthcare	Group # 76411465 Network: Choice Plus	800-826-9781	www.umr.com
Dental	UMR/United Healthcare	Group # 76411465	800-826-9781	www.umr.com
Vision	EyeMed	Group # 9850249 Network: Select	866-299-1358	www.eyemedvisioncare.com
Group Term Life	Cigna	Group # FLX964803	800-362-4462	www.cigna.com
Voluntary Life	Cigna	Group # FLX964803	800-362-4462	www.cigna.com
Accidental Death & Dismemberment	Cigna	Group # OK 966412	800-362-4462	www.cigna.com
Short-Term Disability	Cigna	Group # VDT961410	800-362-4462	www.cigna.com
Long-Term Disability	Cigna	Group # SGD602416	800-362-4462	www.cigna.com
Health Savings Account (HSA)	The Bank of Colorado	N/A	970-223-8200	www.bankofcolorado.com
Employee Assistance Program (EAP)	Cigna	Username: rewards Password: savings	800-538-3543	www.cigna.behavioral.com/CGI
Flexible Spending Account (FSA)	BMA	N/A	800-934-6302 Option 2	www.bmatpa.com
COBRA Administration	BMA	N/A	800-934-6302 Option 3	www.bmatpa.com
Cancer, Critical Illness, Accident	Allstate	N/A	800-840-6580 extn: 4	michaela_castro@ajg.com
Home & Auto Insurance	Liberty Mutual	N/A	970-290-0871	barney.jones@libertymutual.com
Pet Insurance	Nationwide	N/A	To enroll: 877-738-7874 Customer Service: 800-540-2016	www.petinsurance.com/epmedcenter
SSRP (Retirement)	1st National Bank Wealth Management		866-794-2116	www.firstnationalretirement.com

Eligibility, Enrollment and Useful Benefit Terms

The open enrollment period for eligible employees of Estes Park Medical Center will be in
November 2016.
The new benefit plan will be effective January 1, 2017 - December 31, 2017.

- New employees are effective the first of the month following 30 days of full-time employment.
- You are eligible if you are a full-time employee regularly scheduled to work at least an average of 30 hours a week or a part-time employee regularly scheduled to work 20 hours a week.
- Open enrollment applies to medical, dental, vision and flexible spending account coverage.
- The open enrollment period is the only time employees may enroll in the above listed coverage without the occurrence of a qualifying event (see definition below).

Making Enrollment Changes During the Year:

In most cases, your benefit elections will remain in effect for the entire plan year (January 1st - December 31st). During the annual enrollment period, you have the opportunity to review your benefit elections and make changes for the coming year.

You may only make changes to your elections during the year if you have one of the following status changes:

- Marriage, divorce or legal separation (if your state recognizes legal separation);
- Gain or loss of an eligible dependent for reasons such as birth, adoption, court order, disability, death; reaching the dependent child age limit; or
- Significant changes in employment or employer-sponsored benefit coverage that affect you or your spouse's benefit eligibility.
- Your benefit change must be consistent with your change in family status.

IRS regulations require that for enrollment due to the qualifying events above, change forms must be submitted within 30 days of that qualifying event. Contact your Human Resources office for information on completing these forms.

Co-payment:

Co-payments for office visits and prescription drugs count toward the out-of-pocket maximum.

Calendar Year Deductible and Out-of-Pocket Maximum:

Expenses incurred toward your annual deductible and your out-of-pocket maximum are credited on a calendar year basis. A calendar year is January 1st - December 31st. Your deductible and out-of-pocket maximum will restart January 1st each year, regardless of the expenses you incurred in the prior calendar year or when your annual open enrollment period occurs.

Primary Care Physicians/Specialty Physician Referrals:

You are NOT required to select a Primary Care Physician (PCP) or obtain referrals for specialty physicians. For the best coverage be sure that all providers (doctors, labs, x-rays, etc.) participate in-network.

Dependent Age Limitation:

Your children are eligible for coverage on your medical plan until age 26. Your unmarried dependent children are eligible for coverage on your dental, vision, and voluntary life plan until the age of 26 regardless of student status.

Domestic, In-Network vs. Out-of-Network Benefits:

Domestic benefits consist of using the EPMC Providers. When you use this network, your out of pocket expenses are less than the other two networks.

Estes Park Medical Center's medical plans offer in-network and out-of-network benefit levels. When a doctor or hospital agrees to be in the plan's network, they are contractually bound not to charge over a specific amount for services covered by the plan. When you choose an in-network provider, they will file a claim on your behalf and you are not held responsible for amounts that the provider may charge in excess of their contracted rates. Out-of-network expenses are paid according to 'Usual and Customary' charges, which may leave you with significant out-of-pocket expenses. For the best benefit available under the plan, you should utilize in-network providers when possible. Out-of-network benefit levels can be found on the Summary of Benefits and Coverage.

Medical Plan Comparison Chart

Benefit	HDHP/HSA Plan EPMC	HDHP/HSA Plan In-Network	HDHP/HSA Plan Out-of-Network	PPO Co-pay Plan EPMC	PPO Co-pay Plan In-Network	PPO Co-pay Plan Out-of-Network
Annual Deductible	$2,600 Individual $5,200 Family	$3,500 Individual $7,000 Family	$5,000 Individual $10,000 Family	$750 Individual $1,500 Family	$2,000 Individual $4,000 Family	$4,000 Individual $6,000 Family
Annual Out-of-pocket Maximum Includes deductible, co-insurance and co-pays	$2,600 Individual $5,200 Family	$5,000 Individual $10,000 Family	$10,000 Individual $20,000 Family	$3,500 Individual $7,000 Family	$5,000 Individual $10,000 Family	$10,000 Individual $20,000 Family
Co-insurance In-network benefit	100% after deductible	90% after deductible	60% after deductible	90% after deductible	80% after deductible	60% after deductible
Hospital Services Inpatient	100% after deductible	90% after deductible	60% after deductible	90% after deductible	80% after deductible	60% after deductible
Emergency Room Treatment (Emergency Situation)	100% after deductible			100% after $100 co-pay		
Urgent Care Center Services Additional services/supplies may incur additional fees	N/A	90% after deductible	60% after deductible	N/A	$50 co-pay	60% after deductible
Physician Visits Primary Care Physician Specialist	100% after deductible	90% after deductible	60% after deductible	$20 co-pay $30 co-pay	$40 co-pay $50 co-pay	60% after deductible
Preventive Care (Office Visit) Physician's Services Preventive Testing	100%		60%	100%		60%
Office & Outpatient Surgery	100% after deductible	90% after deductible	60% after deductible	90% deductible waived	80% after deductible	60% after deductible
Lab, X-Ray and Diagnosis Outpatient	100% after deductible	90% after deductible	60% after deductible	100% deductible waived	80% deductible waived	60% after deductible
Lab, X-ray and Major Diagnostics (CT, PET, MRI, MRA and Nuclear Medicine)	100% after deductible	90% after deductible	60% after deductible	90% deductible waived	80% deductible waived	60% after deductible
Prescription Drug Program						
Retail (31 day supply)						
Generic	100% after deductible		60% after deductible	$10 co-pay	$20 co-pay	
Preferred Brand Name	100% after deductible			$20 co-pay	$40 co-pay	
Non-Preferred Brand Name	100% after deductible			$30 co-pay	$60 co-pay	
Specialty	You pay 25% after deductible			25%	25%	
Mail Order (90 day supply)						
Generic	100% after deductible				2.5x co-pay	
Preferred Brand Name	100% after deductible			N/A	2.5x co-pay	
Non-Preferred Brand Name	100% after deductible				2.5x co-pay	
Specialty	You pay 25% after deductible				25%	

Please review your plan document for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

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Health Savings Account (HSA)

Participants in the Estes Park Medical Center High Deductible Health Plan (HDHP) may be eligible to open a Health Savings Account.

A Health Savings Account (HSA) is a tax-advantaged personal savings account that works in conjunction with a HDHP. Participants can pay for **qualified** medical expenses with **tax-free** dollars from their HSA. There is no 'use-it-or-lose-it' requirement, the account is **portable** and the balance plus earnings (from interest and/or investments) carries over year after year, all **tax-free**. If HSA monies are used for **non-qualified** medical expenses prior to age 65, a 20% penalty *plus* ordinary income tax must be paid to the IRS.

Eligibility requirements:

In order to open a HSA, you **MUST** meet the following requirements:

- Covered by a HDHP Plan
- **NOT** covered by another health insurance plan that is not a qualified HDHP including:
    - A spouse's medical plan
    - Medicare
    - Tricare
    - Note: Does not apply to specific injury, accident, disability, dental care, vision care and/or long term care insurance plans.
- **NOT** participating in an employer-sponsored Flexible Spending Account (FSA) (unless limited use)
- **NOT** claimed as a dependent on someone else's tax return
- Your spouse must also **NOT** participate in a Healthcare FSA. The Dependent Care FSA will not disqualify you from opening an HSA.

HSAs allow:

- **Tax-free** contributions by employer, employee or others
- **Tax-free** growth of interest or investment earnings
- **Tax-free** distributions of principal and interest to pay for qualified medical expenses
- **Accumulation** of unused funds and **portability** between employers. No "use it or lose it" rules. Portable from employer to employer and across state lines.
- **Flexible use** – You choose whether or when to use the account for health expenses, now or after employment.

In addition to paying for current expenses, funds can be used to pay for:

- COBRA premiums
- Long-term Care premiums
- Out-of-pocket expenses for Medicare
- Medical insurance during unemployment
- Services not covered under a future health plan

If you are covered under the qualified HDHP and meet the eligibility requirements you may open a HSA. HSA plans are intended to be used to pay for healthcare for the individual and his or her covered dependents. Distributions from an HSA to pay for qualified medical expenses are not taxable.

Qualified health care expenses are expenses which are:

- Incurred for the individual, his/her spouse or a tax dependent;
- Eligible as defined in Internal Revenue Code Section 213(d) – generally defined as expenses for the diagnosis, cure, mitigation, treatment or prevention of disease;
- Not reimbursed by insurance or another health plan; and
- Not deducted on the individual's tax return.

Medical expenses that may be reimbursed through a HSA under IRS Code Section 213 include (but are not limited to) the following:

- Deductible payments;
- Coinsurance payments;
- Dental care not provided through another health insurance plan;
- Prescription drugs;
- Emergency ambulance service;
- Chiropractic services;
- Eyeglasses and/or contact lenses;
- Hearing devices;
- Psychiatric care;
- Psychologists' fees;
- Acupuncture
- Over-the-counter-drugs can be reimbursed from the HSA as long as they meet the criteria set out in Internal Revenue Code Section 213(d) and you have a prescription on file for the medication.

For a complete list of eligible expenses please see IRS Publication 502.

Health Savings Account (HSA)

Contributing to your HSA

When you participate in an HSA, you set aside money to pay for eligible out-of-pocket expenses. Money can be contributed to your HSA by you or anyone else. The IRS calendar year maximums for these savings accounts are listed below:

Maximum 2017 (calendar year) Contribution:

- $3,400 for Employee Only
- $6,750 for Employee + Spouse, Employee + Child(ren), Employee + Family
- $1,000 Catch Up Contribution for Employees age 55 and up

A Calendar Year is the 12-month period of January 1st - December 31st.

If you are age 55 or older, you can make an additional contribution amount of $1,000. The HSA cannot receive contributions after the individual has enrolled in Medicare. For the most current HSA contribution information, please go to the U.S. Dept. of Treasury web site at https://www.treasury.gov/resource-center/faqs/taxes/pages/health-savings-accounts.aspx.

Note for Newly Eligible and Partial Year Participants:
If you become newly eligible to contribute to an HSA during the year, you may contribute the maximum contribution for the year (without incurring taxes or a penalty on the amount of the contribution) provided you continue to remain eligible for a 13 month period beginning December 1st of the year in which you become eligible and ending on December 31st of the following year.

If you do not remain eligible for a 13 month period shown above, your excess contributions will be subject to federal income tax and may be subject to the 6% excise tax. Please contact your tax advisor for assistance determining if your partial year contributions will be subject to taxes and penalties.

Using your HSA

With an HSA, your contributions, earnings and eligible withdrawals are all tax-free. As long as your withdrawals are used to pay for qualified health care expenses, you won't pay taxes. Contributions that Estes Park Medical Center makes to your HSA are yours. There are no vesting requirements or forfeiture provisions. Unlike FSAs, HSAs do not have a "use it or lose it" requirement. Your account balance rolls over from year to year and will earn interest tax-free.

Tax filing

You will receive a 1099SA and a 5498SA and be required to file Form 8889 with your annual tax return. Please see your tax advisor if you have any questions.

Employer contributions

Estes Park Medical Center contributes $50 per month to each account.

Opening an HSA

Estes Park Medical Center will offer an employer-sponsored Health Savings Account through Bank of Colorado. The Bank of Colorado account allows you to have HSA contributions deducted from your paycheck on a pre-tax basis. Estes Park Medical Center will pay the $3.00 monthly administration fee on your behalf as long as you are an active employee and enrolled in the High Deductible Health Plan. If you do not wish to open a Estes Park Medical Center Bank of Colorado account, you may contact the financial institution of your choice for HSA options. Fees for other accounts will be the

You are responsible for the eligibility of all items and keeping receipts for tax purposes.

Not all expenses that are qualified health care expenses under the HSA count toward the satisfaction of the calendar year deductible.

Online Services *from UMR*

Accessing online services

1. Visit: **www.umr.com**
2. Select "**Members**"
3. Enter the member ID located on your ID card in the Online Services Access box.

   If you have a flexible spending account (FSA) only, enter your Social Security number.
4. Click "**Go to my online services.**" Our Web site will redirect you to your online services home page.
5. If you have previously registered for online services, enter your username and password in the member login box and click "**Submit**" to login, or

   If you have not yet registered for online services, click the "**Need a Username? Register here.**" link and follow the prompts to complete your registration.

That's all you need to do. You now have access to a variety of services, including everything that follows.

Claim, eligibility and benefit inquiry

You can view your claims (including copies of EOBs), eligibility and benefit information any time of the day or night. In addition, you can view the status of medical deductibles, out-of-pocket and lifetime maximum amounts. You can also access a summary of claim dollars for current year-to-date and prior year claim charges.

Other insurance and accident details

If you have claims pending for updates to other insurance or accident details information, you can make those updates online. Any claims pending will be automatically reprocessed.

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UMR Information

UMR provides a wealth of information and services to help you live a healthier life.

ID card ordering

Order duplicate or replacement ID cards quickly and easily.

Flexible Spending Accounts

If you have a flexible spending account through UMR, you can view account information, access a calculator and many other tools to help you determine potential savings.

Member health information

UMR provides a wealth of information and services to help you live a healthier life. Online tools are available to help you make the best decisions about health conditions and prescriptions. In addition, we provide links to excellent health information sites, articles and a whole lot more.

Provider network links

For your convenience, we've set up a link to your provider network. When you click on the link, the network provider's home page is displayed. You can click the link on the home page to search for in-network physicians or medical facilities.

Forms

Our most widely used forms are available online for easy access.

Questions?

If you have any questions or problems, please contact our technical support team at **1-866-922-8266** or reference our online tutorial guides.

To find out more, take our Web tour on the UMR YouTube channel.

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Your Benefit Plan FAQs...

Q. Who is UMR?

A. UMR is a third-party administrator (TPA) that provides employers and health benefit plan members with services to help them get the most from their benefit plan.

Q. What is a TPA?

A. A TPA is a company that your employer hires to handle the many tasks associated with managing your health benefit plan. For example, UMR handles general enrollment tasks when new plan members sign up to receive health benefits. We also process your health claims, making sure they are handled quickly and accurately. UMR even has medical professionals on staff who can help coordinate your care if you are in the hospital or are dealing with a chronic health condition.

Q. What does it mean to be self-funded?

A. A self-funded benefit plan is financed by your employer, not an insurance carrier. Your employer pays for most of your health plan and claim costs.

Q. What is a PPO?

A. Most TPAs work with a preferred provider organization (PPO). A PPO is a network of health care providers who have agreed to discount (reduce) what they charge for services when treating members of a benefit plan. When you choose to see an in-network PPO health care provider, you will pay less for their services than if you had chosen an out-of-network (non-PPO) health care provider. You have the option to see non-PPO providers, but you will pay more for their services.

Your member ID card contains important information regarding your plan's PPO. Contact your PPO directly or your UMR customer service team to check a health care provider's participation.

Q. What does UMR do for me?

A. We provide you with prompt, personalized service. As a plan member served by us, you have a customer service team of helpful people available to assist you and answer questions about your health benefits. For example, you can ask us about the medical care your plan covers or about a specific health claim. One phone call is all it takes to reach us and speak to someone who can help you get the answers you need.

You may also receive other services, depending on your health plan's features, to help you and your covered family members use the health care system and receive appropriate health care at a reasonable cost.

UMR Information

Q. What can I do to reduce my health care expenses?

A. A lot! First, choose a participating PPO provider whenever possible, so you'll receive the discounts your plan has made available for you. Your benefit plan ID card displays your PPO information. Always show your ID card to your health care provider at each visit.

Learn about the features of your benefit plan, too, so you'll know about money-saving ways to receive your health care, like taking advantage of preventive care services.

Also, read and understand your EOB. It can help you track your health care costs and get a better handle on what you're spending. The "How to Read Your EOB" section in this brochure will help you understand how your health claims are charged, processed and paid.

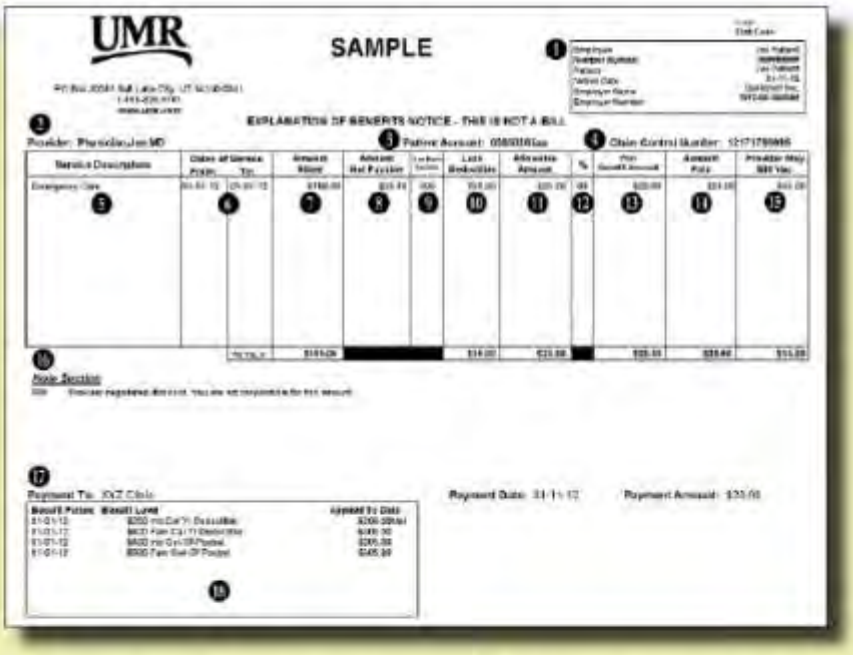
And learn how you and your family can prevent illness and maintain your health. Make health-conscious choices every day. You'll feel better, improve the quality of your life and have more money you can use for other things – not health care!

Q. Will I receive mail from UMR?

A. Members will receive an explanation of benefits (EOB) for most health claims submitted by your health care providers. Your EOB shows you important information, including what your plan pays and what portion of the bill is your responsibility.

You may also receive letters from UMR if we need more information about a health claim in order to process it appropriately. Sometimes, we may send you letters that will require you to follow up with your provider to obtain more information. The requested information is important for timely completion of your claim. Feel free to call us if you have questions or need assistance with our request.

How to Read Your EOB



1. Fields include member information under which the claim was processed.
2. Hospital, physician or other health care provider that performed the services.
3. Account number assigned by the hospital, physician or other health care provider.
4. UMR assigns a unique claim control number to each claim received.
5. Services and/or procedures that were performed by the hospital, physician or other health care provider.
6. Dates(s) services were performed by the hospital, physician or other health care provider.
7. Amount charged for the services by the hospital, physician or other health care provider.
8. Charges not allowed according to the Plan – see comment code.
9. Refers to codes used to explain charges that were not allowed – see Notes Section.
10. Amount applied to the deductible.
11. Charges allowed for payment – this is the difference between the "Amount Billed" and the "Amount Not Payable" and/or "Less Deductible" columns.
12. Percentage at which the Allowable charges are paid.
13. Amount actually payable by the Plan.
14. Amount that UMR paid to the provider.
15. Only amount you are responsible to pay to the hospital, physician or other health care provider, if applicable.
16. Explains codes provided in the "See Notes Section" column. Lists the specific code and its definition.
17. List of individuals or organizations to whom checks were issued.
18. Provides benefit period and benefit levels, amounts applied to individual/family deductibles and out-of-pocket maximums, if applicable.

UMR Information

Use Your Online Benefits Service

Another service UMR provides for you is the online benefits service Web site for fast access to a variety of useful information. These services, and more, are available for you there:

- Ask us a question using the site's "Contact Us" e-mail service
- Check your eligibility information and the status of your claims
- Access information about your benefit plan
- Look up participating PPO providers using the site's "Find a Provider" feature
- Use the site's links to reliable health and medical information

Access your online benefits service from **umr.com**. At the homepage, click Login/Register or Members.

UMR.com

Check the status of a claim, look up providers, access information about your benefit plan and much more!

How to Contact UMR

Go to umr.com

Visit your password-protected online benefit service via the login at umr.com. It's a fast, convenient way to get information and access services and resources provided with your benefit plan.

Call us

Your UMR customer service team is ready to help you Monday through Friday, **8 a.m. – 5 p.m.** in your local time zone.

Use your ID card

You will also find UMR and your PPO contact information on your benefit plan ID card.

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Health information a phone call away

NurseLine SM

Coping with health concerns can be time consuming and complex. It can be hard to know where to find trusted information among so many choices or what to do in a non-emergency situation.

Instead of playing guessing games with health issues, give UMR's NurseLine SM a ring. A simple phone call to NurseLine gets you in touch with a highly trained registered nurse who can answer your medical questions and provide advice — without an appointment.

NurseLine is completely confidential and provides you with the following:

- **24 hour-a-day, 7 day-a-week service**
- **Hearing assistance accommodations**
- **140+ languages including English and Spanish**
- **Audio health library containing over 1,100 topics, such as physical and emotional conditions, procedures, medications, and much more**

What do you do if this happens to you?

It's midnight. Your child has a fever and now you notice a peculiar rash. What should you do?

You wake up with severe stomach cramps. You wonder if you should phone your doctor, go to the emergency room or wait it out.

You're diagnosed with cancer and want to learn more about the disease and possible treatment options.

A family member is scheduled for a surgical procedure. You read the pamphlets from the surgeon's office, but you still have several unanswered questions.

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Call us today at
1-877-950-5083
PIN 197

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Dental Plan Summary

Benefit	
Type I - Preventive and Diagnostic Services Oral examinations (2 per year), routine cleanings (2 per year), full mouth x-rays (one set every 36 months), bitewing x-rays (2 per year), panoramic x-ray, fluoride (2 per year under age 15), sealants (1/posterior tooth/3years under age 14, space maintainers (limited to non-orthodontic)	100% - no deductible
Type II - Basic Services Fillings, root canal therapy/endodontics, osseous surgery, periodontal scaling and root planning, denture adjustments and repairs, oral surgery, anesthetics, surgical extractions of impacted teeth, repairs to bridges/crowns/inlays	80% after deductible
Type III - Major Services Crowns/dentures/bridges, inlay/onlays, prosthesis over implant	50% after deductible
Orthodontia	Child orthodontia covers children through age 18. Plan pays 50% of the covered orthodontia services, up to the $2,000 lifetime orthodontia maximum.
Annual Deductible	$50 Individual $150 Family
Calendar Year Maximum	$1,500

Vision Plan Summary

Want to learn more?

- For a complete list of providers near you, use our Provider Locator on www.eyemedvisioncare.com and choose the SELECT network or call 1-866-299-1358.
- For Lasik providers, call 1-877-5LASER6.

Additional Discounts and Features:

- 40% off additional eyewear purchases.
- 20% off non-prescription sunglasses.
- 20% off remaining balance beyond plan coverage.
- Laser vision correction - 15% off the retail price or 5% off the promotional price for LASIK or PRK procedures.

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam With Dilation as Necessary	$10 Copay	Up to $30
Contact Lens Fit and Follow-Up *(Contact lens fit and two follow up visits are available once a comprehensive eye exam has been completed)*		
Standard Contact Lens Fit & Follow-Up	Up to $40	N/A
Premium Contact Lens Fit & Follow-Up	10% off retail	N/A
Frames	$0 Copay; $100 allowance; 80% of charge over $100	Up to $50
Standard Plastic Lenses		
Single Vision	$25 Copay	Up to $25
Bifocal	$25 Copay	Up to $40
Trifocal	$25 Copay	Up to $60
Standard Progressive Lens	$90	Up to $40
Premium Progressive	$90, 80% of charge less $120 Allowance	Up to $40
Lenticular	$25 Copay	Up to $60
Lens Options *(paid by the member and added to the base price of the lens)*		
UV Treatment	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Plastic Scratch Coating	$15	N/A
Standard Polycarbonate	$40	N/A
Standard Polycarbonate - Kids under 19	$40	N/A
Standard Anti-Reflective Coating	$45	N/A
Polarized	20% off retail price	N/A
Other Add-Ons and Services	20% off retail price	N/A
Contact Lenses		
Conventional	$0 Copay; $125 allowance; 15% off retail price over $125	Up to $100
Disposable	$0 Copay; $125 allowance; plus balance over $125	Up to $100
Medically Necessary	$0 Copay, Paid in Full	Up to $200
Laser Vision Correction		
Lasik or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	N/A
Frequency		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 12 months	

Cost for glasses with standard progressive lenses

		With EyeMed	Without Vision Coverage**
Step 1:	Get an Eye Exam	$10	$88
Step 2:	Pick a Frame (allowance $100)	$0	$100
	Selected a $170 frame (20% discount)	$56	$70
Step 3:	Pick a Lens	$90	$194
	Upgraded to Std. Polycarbonate	$40	$62
	Added Tint	$15	$25
Step 4:	Total Cost	$211	$539
	See the Savings	$328, or a 61% savings	

Cost for glasses with standard single-vision lenses

		With EyeMed	Without Vision Coverage**
Step 1:	Get an Eye Exam	$10	$88
Step 2:	Pick a Frame (allowance $100)	$0	$100
	Selected a $170 frame (20% discount)	$56	$70
Step 3:	Pick a Lens	$25	$75
	Upgraded to Std. Polycarbonate	$40	$62
	Added Tint	$15	$25
Step 4:	Total Cost	$146	$420
	See the Savings	$274, or a 65% savings	

Cost for disposable contact lenses

		With EyeMed	Without Vision Coverage**
Step 1:	Get an Eye Exam	$10	$88
	Fit and Follow-Up	$40	$74
Step 2:	Purchase Contact Lenses	$200	$200
	Allowance	$125	$0
Step 3:	Total Cost	$125	$362
	See the Savings	$237, or a 65% savings	

**Based on industry averages. Retail prices and costs will vary by market and provider type. Promotions not included.

EyeMed Vision Care Member Website Guide

As an EyeMed member you have 24/7 access to the details of your vision plan benefit. View your benefits, locate a provider, print an ID card or view claim status with the click of a button.

Registration Is Simple

Step 1
Enter **www.EyeMedVisionCare.com/member** in the Web address line on your browser.

Step 2
Click on the **create an online account now** link.

*If at any time you are unable to remember your login information, simply use the **Forgot User ID** and/or **Forgot Password** feature on the Member Web login page to receive a reminder.*

Step 3
Fill out and submit the Member Web registration form.

*Note that you may use your member ID (located on your ID card) **OR** enter the last 4 digits of your social security number.*

Step 4
You will receive an e-mail with a link to verify your registration.

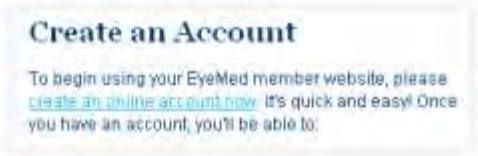
Step 5
After selecting a password on the verification page, you will be automatically logged in and taken to the Member Web home page.

How to Access and Print a Replacement ID Card

The EyeMed Member Web is your easy online portal to do everything you need. These instructions will give you a simple step by step overview on how to register for an account, view your benefits and set your mailing preferences.

Step 1: It's easy to get to EyeMed's Member website. In your navigation bar, type in www.EyeMedVisionCare.com/member and hit enter to be taken to the log-in page.

Step 2: If you don't have an account it's a cinch to create one and take advantage of all that EyeMed Member Web has to offer. Simply click on the "Create an online account now" link located in the first paragraph of the page to be taken to a quick registration process and set-up.



Once you've registered you'll receive a welcoming confirmation email confirming your successful sign-up.

Step 3: To view your explanation of benefits electronically, click on "View Your Benefits" located in the blue bar at the top of the page. Then select Claim Status on the left side of the screen.

To learn more, visit EyeMedVisionCare.com.

LensCrafters Pearle Vision Sears Optical optical Private Practitioners

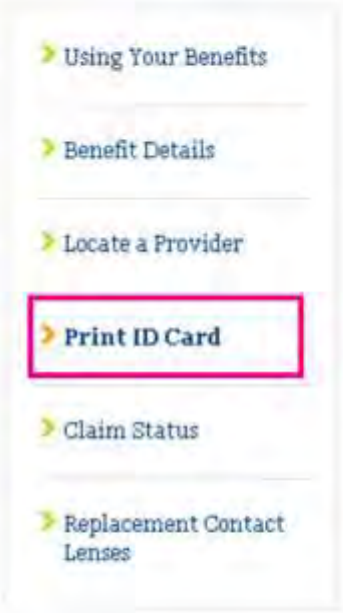
EyeMed Vision Care

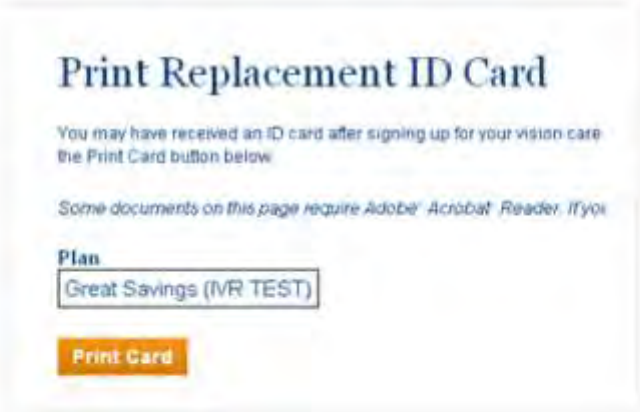
Vision Plan Summary

Need another copy of your ID card? It's easy to print a replacement.

Step 4: If you'd like to get another copy of your ID card, click on the "Print ID Card" link located on the right hand side of the page.

Step 5: Getting your replacement ID card is easy, simply click on the orange "Print Card" button located in the center of the page.





And that's it! We hope you'll continue to visit EyeMed's Member Web and take advantage of all of the features it has to offer.

On the site it's easy to:

- File a claim
- Locate an in-network provider
- Set your account preferences
- View your Benefits
- Check the status of claims
- Find helpful information about vision wellness

To learn more, visit EyeMedVisionCare.com.

LensCrafters Pearle Vision Sears Optical optical Private Practitioners

EyeMed Vision Care

eyemed

Basic Term Life Insurance and AD&D

Basic Term Life and AD&D Benefits provided by Estes Park Medical Center to all full and part-time employees. This benefit is not portable.

Basic Term Life and AD&D Benefits	
Life Benefit	$30,000
AD&D Benefits	$30,000
Guarantee Issue Amount	$30,000
Employee Age Reduction Schedule	35% at age 65 50% at age 70 65% at age 75

Voluntary Life Insurance Benefits & Rates

All Voluntary Term Life Benefits are portable.

Voluntary Life Benefits	
Employee Life Amount	Lesser of 5 times salary or $300,000 ($25,000 increments)
Employee AD&D Amount	Equal to Life Benefit
Employee Guarantee Issue Amount	$100,000
Spouse Life Amount	50% of employee election up to $150,000 ($5,000 increments)
Spouse AD&D Amount	Equal to Life Benefit
Spouse Guarantee Issue Amount	$30,000
Child Life Amount	$10,000
Child AD&D Amount	Equal to Life Benefit
Age Reduction Schedule	35% at age 65 50% at age 70 65% at age 75
Waiver of Premium	Included
Portability	Included to age 70
Age Rated Premiums	**Employee and Spouse** (rate per $1,000)
Life Rate: < 40	$0.085
40 - 44	$0.195
45 - 49	$0.195
50 - 54	$0.495
55 - 59	$0.495
60 - 64	$0.695
65 - 69	$1.305
70 - 80	$1.965
Child Life Rate (per $10,000)	$1.90
AD&D Rates - add $0.02 for employee and $0.04 for spouse/child	
Employee	$0.02
Spouse/Children	$0.04

For example: A 36-year-old employee wants $30,000 of coverage

$30,000	÷ $1,000 =	30	x	$0.085	=	$2.55	÷ 2 =	$1.28
Elected Benefit Amount				**Rate Above**		**Your Monthly Cost**		**Your Semi Monthly Cost**

Guarantee Issue amounts listed are only available to new hires and their spouses after the initial offering. All other eligible employees and spouses will be required to submit Evidence of Insurability for any new coverage amount or increase in coverage amount.

Short and Long-Term Disability

Voluntary Short-Term Disability Benefits	Tier 1	Tier 2
Weekly Percentage	60%	60%
Weekly Maximum	$1,500	$1,500
Elimination Period Accident/hospitalization Benefit Begins Illness Benefit Begins	 31st day 31st day	 8th day 8th day
Benefit Duration	13 weeks	16 weeks
Pre-Existing Limitation	3 / 12	3 / 12
Composite Rate per $10 of benefit	$0.53	$0.97

Long-Term Disability Benefits are provided by Estes Park Medical Center to all full-time employees only.

Long-Term Disability Benefits	
Monthly Percentage	66.67%
Monthly Maximum	$6,000[1]
Elimination Period	120 days
Benefit Duration	Social Security Normal Retirement Age
Own Occupation Limitation **Mental/Nervous Limitation** **Substance Abuse Limitation**	24 months
Benefits Integration	Full Family Direct
Survivor Benefit	3 months
Rehabilitation	Mandatory
Pre-existing Limitation**	3 / 12[2]

(1) The Monthly Maximum benefit will be offset by any income received from the Social Security Administration or any other supplemental income source. Total monthly income will not exceed 60% of predisability earnings.

(2) The Pre-Existing condition limitation applies to conditions for which you receive medical services within 3 months of the effective date. No benefits are payable for a disability resulting from such a condition unless you have been covered for 12 consecutive months before the disability occurs. Pregnancy is considered a pre-existing condition.

Cigna

Cigna Value Added Services

Park Hospital District dba Estes Park Medical Center

Will Preparation Services	Online interactive tool helps covered employees and their spouses create a will and other legal documents. In addition, employees and their spouses can each create and memorialize their own funeral plan with special arrangements, providing clear guidance to their families when they need it most. The site also provides access to other valuable financial educational materials.[1]
Healthy Rewards®	Offers discounts on a range of health and wellness-related services and products, including discounts on weight management and smoking cessation programs, chiropractic care, anti-cavity products, power toothbrushes, fitness club memberships, hearing and vision care, massage therapy, acupuncture, pharmacy, vitamins, and more.[2]
CIGNA's Identity Theft Program	Provides Identity Theft Resolution Services, which includes access to personal case managers who will work with employees and their covered family members to resolve identity theft issues. Support is available 24 hours a day/7 days a week and the program includes all types of identity theft.[3]
Beneficiary Services	Comprehensive package of financial, bereavement and legal counseling Available for benefit payments >= $5,000
CIGNA Secure Travel®	Travel assistance program Trips more than 100 miles from home Medical evacuation and repatriation with no maximum limits[3]

1 Will Preparation Services are independently administered by ARAG®. Cigna does not provide legal services and makes no representations or warranties as to the quality of the information on the ARAG website or the services of ARAG.
2 Some Healthy Rewards programs are not available in all states. ***A discount program is NOT insurance, and the member must pay the entire discounted charge.***
3 Cigna Secure Travel and Cigna's Identity Theft services are provided under a contract with Europ Assistance USA. Presented here are highlights of these programs. Full terms, conditions and exclusions are contained in the applicable service agreements.

Employee Assistance Program (EAP)

Life.

Just when you think you have it figured out, along comes a challenge. But whether those challenges are big or small, your Life Assistance & Work/Life Support Program is available to help you and your family find a solution and restore your peace of mind.

Call us any time, any day. We're just a phone call away whenever you need us – at no cost to you. An advocate is ready to help assess your needs and develop a solution to help resolve your concerns. He or she can also direct you to an array of resources in your community and online tools.

Visit a specialist. For face-to-face assistance, you have three sessions available to you and your household members. Call us to request a referral.

Reward yourself. Access your Healthy Rewards[®1] amenities program for discounts on a range of health and wellness services and products from participating providers.

Achieve Work/Life Balance. Get extra support for handling life's demands. Call for a referral to a service in your community or advice on topics such as:

- **Legal consultation.** Receive a 30-minute free consultation and up to a 25 percent discount on select fees.
- **Parenting.** Receive guidance on child development, sibling rivalry, separation anxiety and much more.
- **Senior care.** Learn about challenges and solutions associated with caring for an aging loved one.
- **Child care.** Whether you need care all day or just after school, find a place that's right for your family.
- **Pet care.** From grooming to boarding to veterinary services, find what you need to care for your pet.
- **Temporary back-up care.** Don't let an unplanned event get the best of you – find back-up child care.

These are just a few examples of the support available to you. Call to get the assistance you need to help resolve life's challenges.

1.800.538.3543

Log in to www.Cignabehavioral.com/CGI

Click on the Healthy Rewards link to access discount information:

User name: **rewards**
Password: **savings**

Cigna

Flexible Spending Account (FSA)

What is the purpose of the plan?

Estes Park Medical Center has established this plan to help employees save tax dollars and increase their net pay.

What Is an FSA?

An FSA is designed exclusively for employees, and is established by your employer under Section 125, 129, 132f or 105 of the Internal Revenue Code. This plan allows a participating employee to take certain expenses from their paycheck on a pre-tax basis. This means that all amounts deducted from your paycheck and contributed toward your plan will not be subject to Federal Income tax, nor will it be subject to Social Security tax.

What are eligible expenses under the plan?

Premium Payments

Allows you to use pre-tax rather than after-tax dollars to pay for your share of employer sponsored insurance premiums (medical, dental and vision). Premium payment is a simple payroll adjustment which is handled internally by your employer's payroll department. Do not add premium contributions to your medical expense account contributions.

Medical Expenses (paid by the employee)

An employee's out-of-pocket health care expenses can be paid with before-tax dollars when an employee elects to deposit some of those dollars into their Medical Expense Reimbursement Account. The amount the employee elects to set aside in this account will be held until he or she submits receipts for eligible expenses to be reimbursed. The maximum amount an employee can elect is **$2,550 for the 2017 plan year**. Eligible expenses can include (not limited to*:

- Above Usual & Customary Charges
- Co-insurance
- Dental Expenses
- Hearing Aids
- Psychologist
- Special Tests (allergy, etc.)
- Chiropractor
- Deductibles
- Eyeglasses & Contact Lenses
- Prescribed Birth Control
- Special Medical Equipment

*For a complete list of eligible expenses please visit http://www.irs.gov/publications/p502/

Your FSA Plan includes a Debit Card

Reimbursement Requests

Your annual election is available at any time during the plan year. Claims can be filed at any time during the plan year: as you incur the expenses, monthly, quarterly or even annually. To submit a claim, complete the request for reimbursement form. Attach your receipts and mail or fax the claim directly to BMA.

Mail:

BMA .
PO Box 781761
San Antonio, TX 78278

Fax:

210-697-0360

Website:

www.bmatpa.com

Flexible Spending Account (FSA)

Health Care FSA Carry Over

Up to $500 of unused Health Care FSA dollars for a plan year may be carried over to the following plan year. The amount of the allowed carry over is determined by your employer.

- Funds eligible for carry over from a previous plan year will be available to you after the end of the claims run-out period.
- The maximum carry over amount allowed by your employer, does not affect your ability to elect the maximum annual election allowed each plan year for the Health Care FSA. For example, if you elected $2,500 for the plan year, and had $500 of unused funds carried over from your previous plan year, the carry over balance would be added to your current election giving you a total annual election of $3,000.
- You do not have to re-enroll in the new plan year to have unused Health Care FSA dollars carry over to a new plan year.

If you have elected not to participate in the FSA program because of the "use-it-or-lose-it" rule, it might be time to reconsider your options!

Dependent Care (must be work related)

Another important part of the FSA is the ability to pay for child care or day care services with before-tax dollars. Your savings will amount to 22% to 35% of your actual child care expense, depending on your individual or family tax brackets. The maximum amount an employee can elect is **$5,000 per plan year, per family**. Eligible expenses can include:

Nursery	Baby-Sitting
Private Pre-K	Extended Day Care before & after school

Note: If you are a highly compensated employee, Estes Park Medical Center may be required to discontinue or limit your contributions to the Dependent Care Reimbursement account in order to comply with certain nondiscrimination requirements applicable to the plan under tax law. You will be notified if you are affected by this rule. Please see your Human Resources Department if you have any questions.

Reimbursement Requests

To submit a claim, complete the request for reimbursement form. Attach your receipts and mail or fax the claim directly to BMA.

Mail:

BMA .
PO Box 781761
San Antonio, TX 78278

Fax:

210-697-0360

Website:

www.bmatpa.com

Employees should be aware that if you elect the Dependent Care Reimbursement Account at any time, your election cannot exceed the IRS limitation of $5,000 per calendar year.

You will be required to coordinate your total payroll deductions to accommodate this IRS limitation. In addition, the IRS limits your elections and/or changes to only the open enrollment period unless you have a qualifying event.

IRS rules state that regardless of the number of pay periods left in the calendar year when you are hired, you may not contribute more than $5,000 to the Dependent Care Reimbursement Account. Your employer will consider how many pay periods are left in the year to determine your per-pay period deductions.

Auto and Home Insurance

Join thousands of satisfied customers with Liberty Mutual Insurance.[2]

Discounted Rates—You could save up to $519.52 a year[3] on auto insurance and receive additional discounts on home insurance

Exceptional Service—Whether you're in an accident or just need some advice, know we'll always be on call for you.

Superior Benefits—Enjoy a number of superior benefits, such as 24-Hour Claims Assistance, Accident Forgiveness[4], Roadside Assistance[5] and Better Car Replacement.[6][7]

Liberty Mutual. INSURANCE

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or Sales Assistant Christine Galassini
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Fort Collins, CO, 80525

(C) 970-290-0871
Barney.Jones@LibertyMutual.com

Client # 124172
(O) 970-372-3380 X58369

[1] Discounts and savings are available where state laws and regulations allow, and may vary by state. To the extent permitted by law, applicants are individually underwritten; not all applicants may qualify. [2] Based on Liberty Mutual Insurance Company's 2014 Customer Satisfaction Survey in which more than 61% of policyholders reported their interaction with Liberty Mutual service representatives to be "among the best experienced" and "better than average." [3] Average annual savings based on countrywide survey of new customers from 01/27/14 to 01/16/2015 who reported their prior insurers' premiums when they switched to Liberty Mutual's group auto and home programs. Savings do not apply in MA. [4] For qualifying customers only. Accident Forgiveness is subject to terms and conditions of Liberty Mutual's underwriting guidelines. Not available in CA and may vary by state. [5] With the purchase of optional Towing & Labor coverage. Applies to mechanical breakdowns and disablements only. Towing related to accidents would be covered under your Collision or Other Than Collision coverage. [6] Optional coverage. Applies to a covered total loss. Deductible applies. Does not apply to leased vehicles and motorcycles. Not available in NC.

Coverage provided and underwritten by Liberty Mutual Insurance and its affiliates 175 Berkeley Street, Boston, MA 02116

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Valid through

Liberty Mutual. INSURANCE

Pet Insurance

Choose a pet health plan to fit your needs

From Nationwide®, the #1 choice in America for pet insurance

Prices include 5% discount!**

	Major Medical Plan comprehensive® + Pet Wellness Plan Plus everyday care®	Major Medical Plan comprehensive®	Pet Wellness Plan Plus everyday care®
	Starting at $47/month*	Starting at $29/month*	Starting at $21/month*
Use any vet	✓	✓	✓
Accidents, including poisonings, cuts and broken bones	✓	✓	
Common illnesses, including ear infections, rashes, vomiting and diarrhea	✓	✓	
Serious/chronic illnesses†, including cancer, diabetes and allergies	✓	✓	
Hereditary conditions†	✓	✓	
Procedures/services, including surgeries, Rx meds and hospitalization	✓	✓	
Wellness services, including exams, vaccinations and flea/heartworm preventives	✓		✓
Annual deductible	$250 for medical claims $0 for wellness claims	$250	$0

Sample reimbursement

When Biscuit needed emergency surgery after eating a handful of pebbles, the Major Medical plan reimbursed 100% of her vet bill (less the deductible).

Sample reimbursement for Major Medical Plan with $250 annual deductible. Sample is based on actual claim submitted for claims.

vethelpline® | Members have **free, 24/7 access** to a veterinary professional through **vethelpline** ($170 value) for any pet question. Only from Nationwide.

Enroll now and receive your discount.

www.petinsurance.com/epmedcenter • 877-738-7874

Nationwide® is on your side

How to apply for Nationwide®

Nationwide® provides coverage for veterinary expenses related to accidents and illnesses. Policies are available for dogs, cats, birds, reptiles and other exotic pets.

Optional wellness coverage is also available for dogs and cats, providing reimbursement for the preventive care necessary to keep them healthy year after year.

Choose from two easy ways to sign up:

Call: **(877) 738-7874** .... give the name of your company to receive your group discount.

Visit: www.petinsurance.com/epmedcenter ..... type in the name of your company for your group discount.

During enrollment, you will be asked for the following information:

- Home or primary telephone number
- Name
- Address
- E-mail address
- Name of your pet
- Pet's species (canine, feline, etc.)
- Pet's date of birth
- Pet's sex
- Pet's breed
- Pet's color
- Medical questions about pet's current and past health, medications and date of last veterinary visit
- Preferred animal hospital (note: policyholders are free to use any veterinarian)
- Payment information/plan*

*If payroll plan is available to you: applications approved between the 1st and the 15th of the month become effective on the 1st of the following month. Applications approved from the 16th through the end of the month become effective on the 1st of not the following month, but the month thereafter.

Example: May 1 approval = June 1 effective date
May 16 approval = July 1 effective date

Nationwide is on your side

Estes Park Medical Center Money Purchase Pension Plan

(Social Security Replacement Plan)

Fact Sheet of Plan Provisions F.A.Q.

What is the Money Purchase Pension Plan and how do I Enroll?

The Estes Park Medical Center Money Purchase Pension Plan is a mandatory Social Security replacement plan. Each employee of EPMC does not pay into Social Security during their employment; instead you contribute to the Money Purchase Pension Plan.

The amount you contribute is equal to the Old-Age Survivors and Disability Insurance Tax in effect for the year of compensation, currently 6.20%. Your contribution is then supplemented with a mandatory employer contribution, currently set at 6.25% of your compensation. Contributions and earnings in the plan are tax deferred savings. You will be responsible for paying taxes when you withdraw the money from your account. All employees must participate in the Plan and are immediately enrolled upon hire.

When do I begin contributing?

You begin contributing to the plan on the first pay-period of your employment. EPMC will continue to withhold your contribution as long as you remain an employee of EPMC.

How is my account invested?

Your plan is participant directed and offers investment options that provide a straightforward way to begin saving meaningfully. In your plan enrollment packet you will find a list of investment options to choose from that include Money Market, Bond, Equity and Target Date and Target Risk Funds. You also have access to Morningstar Retirement Manager, a web-based resource you can use to create a personalized investment strategy based on the investment options available in the Plan.

*If you do not make any investment elections for the funds in your account, you will automatically be invested in the Tributary Balanced Fund Class Institutional Plus.

When can I withdraw money from my account?

You may only withdraw from your account balance after you terminate employment, or upon reaching age 62 or older if still employed. The Plan is designed to be retirement savings for use when you retire. Depending on the type of withdrawal you request, certain taxes may apply. If you are under age 59 ½ you may also be subject to an additional 10% penalty. Please see your Summary Plan Description and Special Tax Notice documents for more details.

How are my contributions vested?

You are always 100% vested in the contributions you have made to the plan. Vesting refers to the portion of the Employer Contributions you are entitled to receive. You receive vesting credit for each year you work with EPMC. Below is the vesting schedule for your plan.

Vesting Schedule

Less than one year employment: 25%
One year of employment: 50%
Two years of employment: 75%
Three or more years of employment: 100%

Retirement Plan Information

Estes Park Medical Center Money Purchase Pension Plan

(Social Security Replacement Plan)

What are my distribution options?
Upon termination of employment or reaching age 62 or older, you may request a distribution of your vested account balance. Your distribution options are:

- Lump Sum/ Lump Sum Rollover
- Monthly, quarterly or annual installments
- Partial distributions ($1,000 minimum)

Please see your Summary Plan Description and Special Tax Notice documents for more details.

Who administers the Plan?
First National Bank Wealth Management is the trustee for the plan.

How can I access my account?
You can access your account online by going to the First National Retirement website.
The first time you access the site you will need to:

Visit: www.firstnationalretirement.com
Select: Account Log In
Click: Need to Register?

This website allows you to view your account, update your profile and make changes to how you invest your account balance. Additionally, the website provides you information regarding each of the funds offered in your retirement plan with access to fund fact sheets and prospectuses. The website is also where you can access the Morningstar Retirement Manager and other retirement planning tools. If you do not have access to a computer or feel more comfortable transacting business via the telephone, you can call 866.794.2116. This phone number provides you the same service options that are available on the website.

How is my Social Security Benefit affected?
While employed at EPMC you do not pay into Social Security. Your Social Security benefit (if you earn one) will be calculated using a special reduced formula known as the Windfall Elimination Provision (WEP). WEP is applied because you will be paid a retirement benefit based on service with EPMC, which is not covered by Social Security. The WEP calculation is intricate, but it is capped so most employees will still receive a benefit from Social Security. If you receive a pension from a federal, state or local government based on work where you did not pay Social Security taxes, your Social Security spouse's, or widow's or widower's benefits may be reduced. This is known as Government Pension Offset (GPO).

For more information on Windfall Elimination Provision or Government Pension Offset, please contact Social Security at:
1-800-772-1213 or www.ssa.gov

Note this document is only a summary of your plan provisions. For complete plan details please refer to the Summary Plan Description and Plan Document.

Estes Park Medical Center

Estes Park Medical Center
457(b) Deferred Compensation Plan

Fact Sheet of Plan Provisions F.A.Q.

What is the 457 Deferred Compensation Plan and how do I Enroll?
The Estes Park Medical 457 Deferred Compensation plan is a voluntary tax-deferred employee contribution plan. It is provided to you as an employee of EPMC to allow you to build your retirement savings faster. EPMC does not make any contributions to this plan. As of your hire date you are eligible to enroll in the 457 plan. In order to participate in the 457 plan you will need to complete an enrollment form.

When do I begin contributing and how much can I contribute?
After completing your enrollment form, you may begin contributing to the plan as soon as the first day of the month following your date of hire. The maximum amount that you may contribute to the 457 plan is the lesser of:

Contribution Limits
- $18,000 (for 2017, and as adjusted annually); or
- 100% of your wages

How is my account invested?
Your plan is participant directed and offers investment options that provide a straightforward way to begin saving meaningfully. In your plan enrollment packet you will find a list of investment options to choose from that include Money Market, Bond, Equity and Target Date and Target Risk Funds. You also have access to Morningstar Retirement Manager, a web-based resource you can use to create a personalized investment strategy based on the investment options available in the Plan.

*If you do not make any investment elections for the funds in your account, you will automatically be invested in the Tributary Balanced Fund Class Institutional Plus.

How are my contributions vested?
You are always 100% vested in the contributions you have made to the plan.

When can I withdraw money from my account?
You may only withdraw from your account balance after you terminate employment or for an Unforeseeable Emergency (while employed), as defined under IRS rules. The Plan is designed to be retirement savings for use when you retire. Depending on the type of withdrawal you request, certain taxes may apply. If you are under age 59 ½ you may also be subject to an additional 10% penalty. Please see your Summary Plan Description and Special Tax Notice documents for more details.

What are my distribution options?
Your distribution options are:
- Lump Sum/ Lump Sum Rollover (you may only rollover to another 457 Plan)
- substantially equal monthly, quarterly, semi-annual or annual installment payments over a fixed reasonable period of time (provided that this period does not exceed your life expectancy or the joint life expectancies of you and your beneficiary); or
- an annuity

Retirement Plan Information

Estes Park Medical Center

Estes Park Medical Center
457(b) Deferred Compensation Plan

Who administers the Plan?
First National Bank Wealth Management is the trustee for the plan.

How can I access my account?
You can access your account online by going to the First National Retirement website.
The first time you access the site you will need to:

Visit: www.firstnationalretirement.com
Select: Account Log In
Click: Need to Register?

This website allows you to view your account, update your profile and make changes to how you invest your account balance. Additionally, the website provides you information regarding each of the funds offered in your retirement plan with access to fund fact sheets and prospectuses. The website is also where you can access the Morningstar Retirement Manager and other retirement planning tools. If you do not have access to a computer or feel more comfortable transacting business via the telephone, you can call 866.794.2116. This phone number provides you the same service options that are available on the website.

Note this document is only a summary of your plan provisions. For complete plan details please refer to the Summary Plan Description and Plan Document.

Additional Information

PTO (Paid Time Off)

Employees begin to accrue PTO and ESL from their first day of employment. Accrual amounts are based on an employee's service date and hours worked. PTO accruals will increase after an employee completes one year of continuous service based on the employee's service date.

Options for PTO usage include: vacation, sick, holiday, cash in, and contributing to the Employee Assistance Fund and PTO donations. Once employees reach their PTO maximum, PTO accruals will stop and will not resume until the employee schedules time off, donates hours, or cashes out hours.

The table below shows the annual PTO accrual and maximum accrual schedule for employees eligible to participate in the PTO Program.

Years of Service	Accrual Rate Per Hour	Annual PTO Accrual	Annual 8 Hour Days	Maximum Accrual
Less than 1	.0885	184 hours	23	276 hours
1 but less than 5	.0923	192 hours	24	288 hours
5 but less than 10	.1077	224 hours	28	336 hours
10 but less than 15	.1192	248 hours	31	372 hours
15 or more	.1308	272 hours	34	408 hours

If you are a full-time employee and work 60-79 hours per pay period, you will accrue a percentage of the 80-hour PTO schedule. For example, if you work 64 hours per pay period, you will accrue 80% of the 80-hour PTO schedule (64 hours is 80% of 80 hours).

Employees may elect to "cash in" up to 80 PTO hours each year at 100% of the value. The annual cash -in limit increases to 120 hours for employees with ten or more consecutive years of service at EPMC.

ESL (Extended Sick Leave)

All Full-time non-contracted employees earn 1.538 ESL hours per pay period. Part-time employees earn ESL based on the number of hours paid per pay period multiplied by the factor of 0.01923. ESL hours may accumulate up to a maximum of 360 hours. ESL accruals will stop once the bank reaches 360 hours and will not resume until the bank is brought to below the maximum.

Employees who are out of work for their own illness/injury for twenty-four or more consecutive work hours may use ESL. ESL hours may be used for one's own personal illness, maternity, paternity, or adoption.

Payments for the first twenty-four hours absent can be paid out of the employee's PTO bank or the hours can be taken unpaid. Then in the last line of the same paragraph; If the ESL bank is depleted and employee is still out of work, he/she can be paid any accrued PTO hours.

ESL will be paid at the base hourly rate in effect on the date of the absence. Part-time employees' ESL pay will be determined based on the number of hours they would normally be scheduled to work on the day of the absence.

Full-Time Payroll Deductions - Semi-Monthly

UMR - PPO Co-pay Plan Full-Time	Per Paycheck Employee Cost	Monthly Employee Cost	Monthly Employer Cost
Employee Only:	$73.88	$147.76	$837.34
Employee + Spouse:	$227.56	$455.12	$1,613.59
Employee + Child(ren):	$159.09	$318.19	$1,553.50
Employee + Family:	$280.75	$561.50	$2,393.78
UMR - HDHP/HSA Plan Full-Time			
Employee Only:	$33.84	$67.69	$778.39
Employee + Spouse:	$186.56	$373.12	$1,403.61
Employee + Child(ren):	$168.79	$337.58	$1,269.92
Employee + Family:	$253.82	$507.63	$2,030.53
Monthly HSA Employer Contributions			
Employee Only:		$50.00	
Employee + Spouse:		$50.00	
Employee + Child(ren):		$50.00	
Employee + Family:		$50.00	
Dental Plan			
Employee Only:	$5.86	$11.72	$26.08
Employee + Spouse:	$16.90	$33.79	$43.01
Employee + Child(ren):	$24.26	$48.52	$61.75
Employee + Family:	$37.32	$74.64	$74.64
Vision Plan			
Employee Only:	$0.23	$0.46	$4.06
Employee + Spouse:	$2.26	$4.52	$4.07
Employee + Child(ren):	$2.49	$4.98	$4.06
Employee + Family:	$4.61	$9.22	$4.07

You are paid 26 times a year, however, premiums will only be deducted from 24 of your annual paychecks, thus making your premiums Semi-Monthly

Part-Time Payroll Deductions - Semi-Monthly

UMR - PPO Co-pay Plan Part-Time	Per Paycheck Employee Cost	Monthly Employee Cost	Monthly Employer Cost
Employee Only:	$118.21	$236.42	$748.88
Employee + Spouse:	$362.02	$724.05	$1,344.66
Employee + Child(ren):	$262.04	$524.07	$1,347.62
Employee + Family:	$472.85	$945.69	$2,009.60
UMR - HDHP/HSA Plan Part-Time			
Employee Only:	$67.69	$135.37	$710.71
Employee + Spouse:	$230.97	$461.95	$1,314.78
Employee + Child(ren):	$208.97	$417.95	$1,189.55
Employee + Family:	$329.96	$659.92	$1,878.24
Monthly HSA Employer Contributions			
Employee Only:	$50.00		
Employee + Spouse:	$50.00		
Employee + Child(ren):	$50.00		
Employee + Family:	$50.00		
Dental Plan			
Employee Only:	$5.86	$11.72	$26.08
Employee + Spouse:	$16.90	$33.79	$43.01
Employee + Child(ren):	$24.26	$48.52	$61.75
Employee + Family:	$37.32	$74.64	$74.64
Vision Plan			
Employee Only:	$0.23	$0.46	$4.06
Employee + Spouse:	$2.26	$4.52	$4.07
Employee + Child(ren):	$2.49	$4.98	$4.06
Employee + Family:	$4.61	$9.22	$4.07

You are paid 26 times a year, however, premiums will only be deducted from 24 of your annual paychecks, thus making your premiums Semi-Monthly

Important Information

This book highlights some of the main features of your benefit programs, but does not include all plan rules, features, limitations or exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be any inconsistencies between this book and the legal plan documents, the plan documents are the final authority. Estes Park Medical Center reserves the right to change or discontinue its benefit plans at any time.

HIPAA Privacy Notice

HIPAA requires Estes Park Medical Center to notify you that a privacy notice is available upon request. **Please contact Human Resources if you have any questions.**

The Women's Health and Cancer Rights Act

Do 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 all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Contact the Human Resources Department for more information.

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and co-insurance applicable to other medical and surgical benefits provided under the Estes Park Medical Center Health Plan. Please see the Medical Benefit Plan for specific details.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in 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, 2016. Contact your State for more information on eligibility

Alabama - Medicaid Website: www.myalhipp.com Phone: 1-855-692-5447	**Georgia** - Medicaid Website: http://dch.georgia.gov/medicaid Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
Alaska - Medicaid The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email:CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	**Indiana** - Medicaid Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone: 1-800-403-0864
Colorado - Medicaid Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	**Iowa** - Medicaid Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
Florida - Medicaid Website: https://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268	**Kansas** - Medicaid Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512
Kentucky - Medicaid Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	**Louisiana** - Medicaid Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447
Maine - Medicaid Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	**Oregon** - Medicaid Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index.html Phone: 1-800-699-9075
Massachusetts - Medicaid and CHIP Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	**Pennsylvania** - Medicaid Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462
Minnesota - Medicaid Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	**Rhode Island** - Medicaid Website: www.eohhs.ri.gov Phone: 401-462-5300
Missouri - Medicaid Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	**South Carolina** - Medicaid Website: http://www.scdhhs.gov Phone: 1-888-549-0820
Montana - Medicaid Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	**South Dakota** - Medicaid Website: http://dss.sd.gov Phone: 1-888-828-0059
Nebraska - Medicaid Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	**West Virginia** - Medicaid Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-596-5820, HMS Third Party Liability
Nevada - Medicaid Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	**Utah** - Medicaid and CHIP Medicaid Website: http://health.utah.gov/medicaid CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
New Jersey - Medicaid and CHIP Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	**Virginia** - Medicaid and CHIP Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
New Hampshire - Medicaid Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218	**Vermont** - Medicaid Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
New York - Medicaid Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831	**Washington** - Medicaid Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
North Carolina - Medicaid Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100	**Texas** - Medicaid Website: https://gethipptexas.com/ Phone: 1-800-440-0493
North Dakota - Medicaid Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	**Wisconsin** - Medicaid and CHIP Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
Oklahoma - Medicaid and CHIP Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	**Wyoming** - Medicaid Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since **July 31, 2016**, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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

OMB Control Number 1210-0137 (expires 10/31/2017)

Medicare D Notice

Important Notice from Estes Park Medical Center About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Estes Park Medical Center and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **Estes Park Medical Center has determined that the prescription drug coverage offered by the Estes Park Medical Center medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered creditable coverage. Because your existing coverage is creditable coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Estes Park Medical Center coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drug. Please see the Medical Benefit Plan in this book for specific details about the prescription drug coverage.

If you enroll in a Medicare prescription drug plan, you and your eligible dependents will be eligible to receive all of your current health and prescription drug benefits and your coverage will coordinate with Medicare.

If you do decide to join a Medicare drug plan and drop your current Estes Park Medical Center coverage, be aware that you and your dependents may not be able to get this coverage back.

CMS Form 10182-CC

Updated April 1, 2011

Medicare D Notice

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Estes Park Medical Center and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below for further information. **NOTE:** You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Estes Park Medical Center changes. You also may request a copy of this notice at any time.

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this creditable coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	January 2017
Name of Entity/Sender:	Estes Park Medical Center
Contact--Position/Office:	Human Resources Department
Address:	555 Prospect Avenue Estes Park, Colorado 80517
Phone Number:	970-557-4457

CMS Form 10182-CC

Updated April 1, 2011

Notes:

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Estes Park
Medical Center

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