



Goodwill of Colorado

Employee Benefit Guide

Effective January 1, 2024- December 31, 2024

**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 page 45 for more details.**

Throughout this guide, look for this logo to see ways that your employer and the

C3 Captive

(Collaborative • Concierge • Care)

are working together to

help control healthcare costs!



01

THE PATIENT'S JOURNEY BEGINS with an individualized Wellness Evaluation & Initial Health Exam.



Health Assessment Intake
 Biometric Screening
 Health Risk Baseline
 Wellness Coaching/Advocate

03

Holistic Care
 Chiropractic
 Acupuncture
 Nutrition
 IV Therapy
 Cardiology
 Naturopathy
 Supplements



AN EXPANDED FOCUS ON PREVENTATIVE HEALTH integrates modern western medicine and traditional eastern therapies to promote healthy living, prevent disease and extend health into the later years.



PEAKMED

02

Primary Care
 Urgent Care
 TeleMed
 Onsite Pharmacy
 Lab Draws

AN INITIAL HEALTH EXAM focuses on lifelong health, wellness foundations, daily care and chronic disease management.



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Benefit Resource Center
 855-874-0742 (Toll-Free)
 BRCMT@usi.com
 Monday - Friday 8:00 AM - 5:00 PM*

Call for assistance with:

- Benefit Elections
- Benefit Plan/Policy Questions
- Eligibility
- Claim Issues with Carriers
- Change in Family Status
- Plan Contact Information

Your one-call benefits information hotline

*Mountain, Pacific, and Alaskan Standard Time

The BRC line is equipped to answer your questions in languages other than English.





A Message from HR at Goodwill of Colorado

At Goodwill of Colorado, we recognize our ultimate success depends on our talented and dedicated workforce. We understand the contribution each employee makes to our accomplishments and so our goal is to provide a comprehensive program of competitive benefits to attract and retain the best employees available. Through our benefits programs we strive to support the needs of our employees and their dependents by providing a benefit package that is easy to understand, easy to access and affordable for all our employees. This brochure will help you choose the type of plan and level of coverage that is right for you.

Contact Information



POLICY	CARRIER	GROUP ID	PHONE	WEBSITE
Medical Plan	Simplified Benefits Administrators	UCHGWLL	1.800.207.1018	https://tpa.uchealth.org/
Prescription Benefits	SmithRx	UCHGWLL	1.844.454.5201	www.mysmithrx.com
Rx Home Delivery			1.800.759.3203	
Direct Primary Care	PeakMed*	UCHGWLL	1.844.673.2563 Option 2	www.peakmed.com
Concierge Specialty Care	Strata Med	UCHGWLL	1.719.428.2202	www.stratawell.com
Healthcare Bluebook	Healthcare Bluebook	UCHGWLL	1.800.207.1018	https://tpa.uchealth.org/
Wellness Program	HealthYou	UCHGWLL	1.719.314-3535	www.myhealthyou.com
Dental	Delta Dental of Colorado	9741	1-800-610-0201	www.deltadentalco.com
Vision	EyeMed	9805870	1.866.939.3633	www.eyemedcvisioncare.com
Health Savings Account (HSA)	Rocky Mountain Reserve (RMR)	RMRGID	1.888.722.1223	www.RockyMountainReserve.com
Flexible Spending Account (FSA)	Rocky Mountain Reserve (RMR)	RMRGID	1.888.722.1223	www.RockyMountainReserve.com
Basic Life and A&D Voluntary Life and AD&D	New York Life (NYL)	FLX-969333 OK970773CO1	Please contact the Goodwill Benefits Team for assistance	www.newyorklife.com
Short-Term Disability (STD) Voluntary Long-Term Disability (VLTD)	New York Life (NYL)	LK752628 VDT-936002	Please contact the Goodwill Benefits Team for assistance 1.800.362.4462	https://www.newyorklife.com/group-benefit-solutions/employees/group-insurance/disability/submit-disability-claim
Disability Claims				
Cigna Supplemental: Hospital Care Coverage Critical Illness Insurance Accident Insurance	Cigna Supplemental Health Solutions	HC 961179 CI 961910 AI 962000	1.800.997.1654 800-754-3207	www.suphealthclaims.com
Employee Assistance Program (EAP)	ComPsych Guidance Resources	Web IDs: NYLGBS or COM589	1.800.272.7255 or 1.800.344.9752	www.guidanceresources.com
Secure Travel Assistance	GBS Secure Travel	Goodwill of Colorado	1.888.226.4567	Email: ops@us.generaliglobalassistance.com
Financial Wellness	BrightPlan	UCHGWLL	Download the BrightPlan app	Brightplan.com/enroll
Medicare Consultant	My Benefit Advisor	Goodwill of Colorado	Jerry Dennis 1.612.509.2003	jerry.dennis@mybenefitadvisor.com www.mybenefitadvisor.com
Benefit Resource Center	USI Insurance	Goodwill of Colorado	1.855.874.0742	Email: BRCMT@usi.com
Goodwill Benefits Team	Sara Nelson: 303-412-4786 Carla Headley: 719-900-5834 Sally Thomas: 720-738-1073			Email: Benefits@goodwillcolorado.org
USI's Benefit Resource Center – your one-call benefits information specialists and advocates!			855-874-0742	Email: BRCMT@usi.com
How to Enroll				https://n23.ultipro.com

Plan Offerings Overview for 2024

Medical Premiums and plan designs for medical coverage are unchanged:

- HDHP (HSA) \$5,500 medical plan *with an HSA contribution match of up to \$500 per year*
- Value \$4,000 medical plan.
- Premier \$2,000 medical plan
- These are in-network plans only.
- All participants will now have the same Network, regardless of which plan you choose. The provider directory encompasses the Aetna First Health nationwide network as well as the UCHealth network.
- **New claims administrator: Simplified Benefits Administrators**

IMPORTANT REMINDERS:

- **If you enroll in the medical plan and “engage” with your PeakMed Direct Primary Care (DPC) doctor (or a PeakMed affiliate) then you will retain the Wellness Rate for medical coverage** (see the “Wellness Program” page for more details).
- **If you are enrolled in the High Deductible Health Plan, REMEMBER to also enroll in a Health Savings Account. Goodwill will make a generous dollar-for-dollar contribution of up to \$500 annually into your Health Savings Account.**
- You may look up provider in the **UCHealth and First Health Networks**. Both of these networks are included in your medical plan. Directories can be located online via both of these links:

<https://www.goperspecta.com/VPD/UHPA/public/ProviderSearch/ByPlan?Benefit=FHN&BenefitGroup=FHN>

<https://www.goperspecta.com/VPD/UHPA/public/ProviderSearch/ByPlan?Benefit=UCPA&BenefitGroup=UCPA>

PeakMed Direct Primary Care (DPC) – Automatically available to all employees enrolled in a medical plan and is a voluntary option for those employees not enrolled in the medical plan.

Summary of C3 Captive Plan Enhancements:

- Addition of **HealthYou Wellness**. HealthYou will manage the wellness evaluations, biometric screening, coaching, and wellness advocacy.
- **PeakMed labs and Rx** will be paid by the plan as a claim, delivering zero cost meds and labs to the member when available.
- Addition of **Strata Med**. Integrated holistic medicine with specialized focus on well-care.
- Network expansion to **UCHealth and First Health** (Aetna’s nationwide network). No narrow network, simplifying member’s plan choice. Exclusive contracts through UCHealth and other providers.
- Network steerage through **Healthcare Bluebook**. Providing members a monetary incentive for choosing “green” providers.
- Decreased pharmacy costs for both the plan and the members, through the **SmithRx Connect Programs**, for members who qualify.
- Addition of **BrightPlan**. Providing financial wellness to all covered employees and dependents.



Flexible Spending Account (FSA) and Health Savings Account (HSA) – Our FSA and HSA vendor is Rocky Mountain Reserve. Services include both a Health FSA as well as the Dependent Care FSA. Those enrolled in the high deductible health plan can enroll in an HSA and a Limited FSA (which is limited to use on dental, vision, & hearing expenses). **A New FSA and HSA Election MUST BE MADE for the 2024 plan year to continue this benefit.**

Delta Dental – Two plan options administered by Delta Dental: A Patient Direct Discount Plan, which is NOT insurance, it is a discount plan ONLY, and a Dental PPO plan. There will be no plan or cost changes to the dental plans.

EyeMed Vision – There will be no plan or cost changes to vision.

Life & Disability – New York Life is still our insurance carrier for Basic Life and Accidental Death & Dismemberment (AD&D), Supplemental and Dependent Life, Short-Term Disability (STD), and Voluntary Long-Term Disability (VLTD) policies.

Short-Term Disability (STD) is an employer paid benefit. Voluntary Long-Term Disability (VLTD) is paid for by the employee.

Voluntary Worksite Products: supplemental policies you may elect through Cigna Group Insurance include:

- Accident & Injury
- Hospital Care
- Critical Illness

This will be a **Passive enrollment**, which means your current benefits will roll over, except your FSA elections. This year's annual open enrollment period will be held starting November 10, 2023, and ending on November 26, 2023. Unless you make changes to your benefits or add/delete dependents, your 2023 benefits will remain in place for 2024.

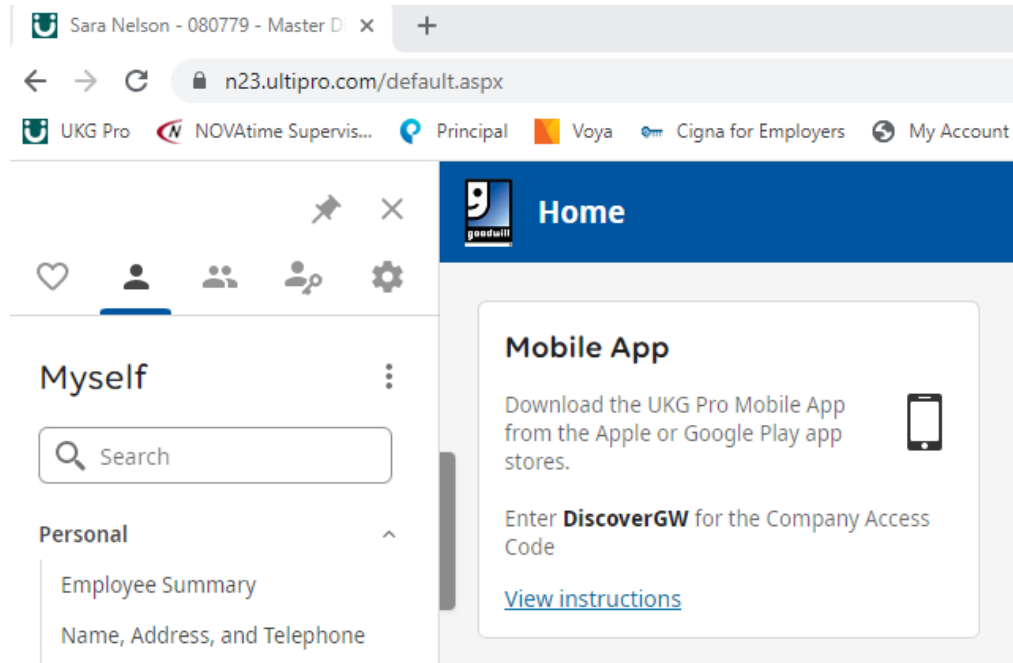


How to Enroll



How to access the system to complete your 2024 Open Enrollment for Employee Benefit Elections through UltiPro?

Type this address into your internet browser – <https://n23.ultipro.com>



Current Active Employees:

- If you need assistance logging into UltiPro Employee Self Service, please contact your supervisor or Human Resources via the HRHelpdesk@goodwillcolorado.org email.
- Information about benefits is available on UltiPro home page.
- Review benefit programs you are currently enrolled in – Go to “Myself” then “Benefits Summary.”
- Review your employee demographic information and update as necessary (including dependent data). Go to “Myself” then “Employee Summary” page.
- Add any new dependent information, you must have a social security number and birthdate for each dependent. Go to “Myself” then “Personal” then “Contacts.”
- To access the 2024 Open Enrollment, go to “Myself” then “Open Enrollment”. Then select “Open Enrollment” and follow the prompts to elect or decline in all coverages.
- Provide and/or update your beneficiary information for the Basic Life and AD&D insurance and Supplemental Life insurance. To add or change your beneficiary information, go to “Myself” then “Personal” then “Contacts.”

Remember, you MUST have a beneficiary designation for the Basic Life and AD&D coverage supplied by Goodwill of Colorado at no cost to you. You can also update existing contacts through the “Open Enrollment” tab.



Eligibility

Eligible Employees:

You may enroll in the Goodwill of Colorado Employee Benefits if you are a **Full-Time employee** working 30 or more hours per week. You are eligible for medical, dental, vision, FSA, HSA, Basic Group Life and AD&D, Supplemental Life, Short-Term Disability (STD), Voluntary Long-Term Disability (LTD), and Cigna Group Insurance voluntary benefits.

Employees identified by their manager as Full-Time (FT) scheduled to work a minimum of 30 or more hours per week, or who become Full-Time (FT) due to ACA rules, are eligible to participate in our benefit plans beginning the first of the month following sixty (60) days from when they become a Full-Time employee.

Part-time employees who are scheduled to work 29 hours or less are eligible to voluntarily participate in PeakMed Direct Primary Care (DPC).

Eligible Dependents:

If you are eligible for our benefits, then your dependents are too. In general, eligible dependents include your legal spouse, and children up to age 26, regardless of student, marital or employment status. If your child is mentally or physically disabled, coverage may continue beyond age 26 once proof of the ongoing disability is provided. Children may include natural, adopted, stepchildren and children obtained through court-appointed legal guardianship

When Coverage Begins:

The effective date for your benefits is January 1, 2024. Newly hired employees and dependents will be effective in Goodwill of Colorado's benefits programs **first of month following sixty (60) days**. All elections are in effect for the entire plan year and can only be changed during Open Enrollment unless you experience a qualifying life event.

Open Enrollment:

The benefit plan year is January 1 through December 31st, 2024. **This year's annual open enrollment period will be held starting November 10, 2023 and ending on November 26, 2023.** Annual deductibles and/or out-of-pocket maximums cycle on a calendar year basis (January through December). If you elect to participate in the Flexible Spending Account (FSA), it also cycles on a calendar year basis.

Qualifying Life Events:

A change in family status is a change in your personal life that may impact your eligibility or dependent's eligibility for benefits. Examples of some family status changes include:

- Change of legal marital status (i.e., marriage, divorce, death of spouse, legal separation)
- Change in number of dependents (i.e., birth, adoption, death of dependent, ineligibility due to age)
- Change in employment or job status (spouse loses job, etc.)



If such a change occurs, you must make the changes to your benefits **within 30 days of the event date**. Documentation may be required to verify your change of status. Failure to request a change of status within 30 days of the event may result in your having to wait until the next open enrollment period to make your change. Please contact the Goodwill Benefits Team to make a qualifying life event mid-year change.

Direct Primary Care (DPC)



At PeakMed LifeCenters, we believe in treating people, not patients. Through relationship-based care, real-time communication and financial transparency, our innovative approach establishes a foundation for lifelong health, while reducing unnecessary medical spending.

Goodwill provides PeakMed Direct Primary Care (DPC) services to all Full-Time (FT) employees and their dependents enrolled in the Medical/Rx plans.

- ✔ **\$0 Cost Unlimited Primary Care**
- ✔ All-access pass to your provider through **office visits, phone calls, text messaging, email, and even virtual office visits**
- ✔ Convenient onsite **Pharmacy and Lab Services** (when available)
- ✔ Adult and Pediatric Care
- ✔ Chronic Disease Management
- ✔ Routine & Sports Physicals
- ✔ Proactive Care



PeakMed Direct Primary Care (DPC) services are also being offered as a stand-alone option, on a post-tax basis, to those who are not enrolled or are not eligible to participate in the core Medical/Rx plan.

Stand-Alone Employee Contributions Per Pay Period (24 Deductions)

Stand-Alone PeakMed Employee Contributions	Per Each Employee & Covered Adult (18+ Years)	Per Each Covered Dependent (Under 18 Years)
Per Pay Period Rates	\$34.50	\$22.50

Get Started with PeakMed Today!

- **Step 1** - Call PeakMed at [\(844\) 673-2563 \(option 2\)](tel:8446732563) to schedule an appointment at one of our conveniently located LifeCenters.
- **Step 2** - Meet your doctor and establish care (via TeleMed or in-person). Don't wait till you're sick, we want to get to know you when you are well!
- **Step 3** - Enjoy the PeakMed difference with unlimited access to your primary care provider via phone, text, email, or same-day or next-day appointments!

PeakMed LifeCenter Locations

PeakMed offers direct primary care across Colorado and the US. They believe everyone should have access to high quality, affordable health care. PeakMed continues to grow and offer convenient locations across Colorado and beyond!

Call (844) 673-2563 (option 2) to find a LifeCenter near you!

PeakMed was acquired by One Medical, an Amazon Company in 2022. This strategic acquisition marks an exciting step forward in our commitment to advancing health care for our members. The combined strength and resources of PeakMed and One Medical enables us to accelerate the development and delivery of cutting-edge health care technologies, treatments, and solutions.

Updated tools and resources will be coming to our members in 2024! Additional information will be shared as we approach the release.

These updates are only applicable to members accessing PeakMed owned and operated locations.

Important Information – PeakMed is not health insurance, it is health care. As such, it is not subject to COBRA continuation should you leave Goodwill, however, you may elect to continue your PeakMed membership via a direct pay arrangement if you so choose.



Goodwill of Colorado's Wellness Initiatives

Whether your goal is to have more energy, lose weight, manage stress, or improve your diet, Goodwill of Colorado Wellness program can help you. We consider Wellness to be a vital part of our overall benefits program.

As healthcare costs continue to rise, we strive to offer competitive health benefits to take care of you and your family. A successful wellness program is a win-win — it means our employees are improving their lives, and we are one step closer to managing rising health insurance costs.



ATTENTION!!

You can save \$69 per month on Medical Premiums simply by being proactive in managing your health!

1. If you are enrolled in a Goodwill medical plan you are automatically enrolled in Direct Primary Care with PeakMed (or a PeakMed affiliate).
2. What does “engage” mean? All you need to do is participate and establish care by scheduling an appointment, either in person or virtually, with a PeakMed provider, so they can get to know you and understand your health history and goals.
3. Once you are engaged with this doctor, they will be available to help you, for a \$0 office visit copay, in many cases, by phone or online, in situations where you might otherwise need to seek urgent care or an in-person doctor's office visit. Just think about how much you can save with \$0 copay!
4. So, to be clear, in order to retain your wellness rate for medical coverage, all you need to do is participate in an established care appointment with a PeakMed (or affiliate) provider. That's it, it's just that simple.
5. We assume all employees will take advantage of this opportunity will retain their wellness rate for medical coverage. An employee who chooses to not engage with a PeakMed / Affiliate doctor by the required deadline will pay the non-wellness monthly premium beginning in the month following the deadline.



Simplified Benefits Administrators administers the Medical plan and **SmithRx** administers the Pharmacy plan. The national network of providers (physicians, hospitals, and ancillary services) will fulfill your healthcare needs. These are in-network plans only. Therefore, please ensure your provider is in the UCHealth or First Health Network. Both of these networks are included in your medical plan. You may look up provider in the **UCHealth and First Health Networks**. Both of these networks are included in your medical plan. Directories can be located online via both of these links:

<https://www.goperspecta.com/VPD/UHPA/public/ProviderSearch/ByPlan?Benefit=FHN&BenefitGroup=FHN>

<https://www.goperspecta.com/VPD/UHPA/public/ProviderSearch/ByPlan?Benefit=UCPA&BenefitGroup=UCPA>

The chart below provides a brief outline of what is offered. Please refer to the summary plan description for complete plan details.

	High Deductible Health Plan (HDHP w/ HSA) In Network Only - \$5,500	Value Plan In Network Only - \$4,000	Premier Plan In Network Only - \$2,000
	In-Network Only Benefits	In-Network Only Benefits	In-Network Only Benefits
Calendar Year Deductible			
Individual	\$5,500	\$4,000	\$2,000
Family	\$11,000	\$8,000	\$4,000
Coinsurance	Plan Pays: 70% Member Pays: 30%	Plan Pays: 80% Member Pays: 20%	Plan Pays: 80% Member Pays: 20%
Annual Maximum Out-of-Pocket (Includes Copays, Deductible, & Coinsurance)			
Individual	\$7,050	\$6,500	\$5,500
Family	\$14,100	\$13,000	\$11,000
Office Visits			
PeakMed Direct Primary Care (Virtual or In-person)	No cost, unlimited visits	No cost, unlimited visits	No cost, unlimited visits
Primary Care Physicians (PCP)	30% after deductible	20% after deductible	20% after deductible
Strata Med Concierge (i.e. Chiropractic and Acupuncture care)	Deductible, then copay	\$15 copay	\$15 copay
Specialty Care	30% after deductible	20% after deductible	\$60 copay
Adult and Child Preventive Exams	\$0, Deductible Waived	\$0, Deductible Waived	\$0, Deductible Waived
Diagnostic Services			
X-ray and Lab Tests	30% after deductible	20% after deductible	20% after deductible
Complex Radiology	30% after deductible	20% after deductible	20% after deductible
Urgent Care Facility	30% after deductible	\$100 copay	\$100 copay
Emergency Room Facility Charge	30% after deductible	\$300 copay waived if admitted	\$300 copay waived if admitted
Inpatient Facility Charges	30% after deductible	20% after deductible	20% after deductible
Outpatient Facility and Surgical Charges	30% after deductible	20% after deductible	20% after deductible
Retail Pharmacy (30 Day Supply)			
Generic (Tier 1)	30% after deductible	\$15 copay	\$15 copay
Preferred (Tier 2)	30% after deductible	\$45 copay	\$45 copay
Non-Preferred (Tier 3)	30% after deductible	\$60 copay	\$60 copay
Preferred Specialty (Tier 4)	30% after deductible	20% copay	20% copay

Medical Insurance Costs

EMPLOYEE COST – HDHP - HSA (\$5,500) Medical Plan per Pay Period (24 Pay Periods/year)

Medical Plan Network	LocalPlus with Wellness	LocalPlus Non-Wellness
Employee Only	\$36.99	\$71.49
Employee + Spouse	\$168.48	\$202.98
Employee + Child(ren)	\$184.75	\$219.25
Family	\$258.24	\$292.74



If you are enrolled in this HDHP plan, you have the opportunity to receive an employer HSA contribution match of up to \$500 per year. Your employer will match dollar-for-dollar up to \$500 in your HSA contributions.

EMPLOYEE COST - Value (\$4,000) Medical Plan per Pay Period (24 Pay Periods/year)

Medical Plan Network	LocalPlus with Wellness	LocalPlus Non-Wellness
Employee Only	\$43.03	\$77.53
Employee + Spouse	\$191.64	\$226.14
Employee + Child(ren)	\$209.52	\$244.02
Family	\$290.00	\$324.50

EMPLOYEE COST - PREMIER (\$2,000) Medical Plan per Pay Period (24 Pay Periods/year)

Medical Plan Network	LocalPlus with Wellness	LocalPlus Non-Wellness
Employee Only	\$59.30	\$93.80
Employee + Spouse	\$215.34	\$249.84
Employee + Child(ren)	\$234.76	\$269.26
Family	\$325.28	\$359.78

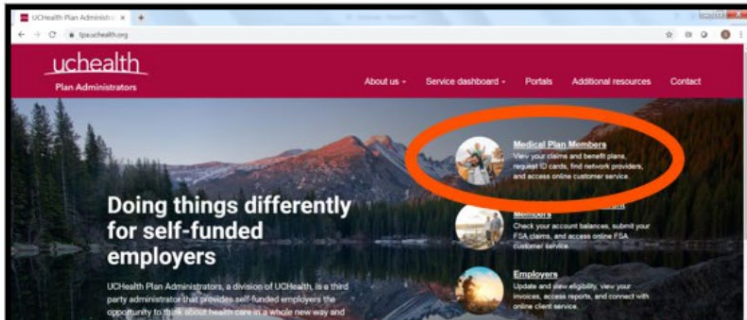
You can save \$69 per month and qualify for the “with Wellness” Premiums by doing one simple thing!

If you enroll in any Goodwill medical plan you are automatically enrolled in Direct Primary Care (DPC) with PeakMed (or a PeakMed affiliate). If you “engage” with your Direct Primary Care doctor, you will retain the wellness rate, which is \$69 less per month. See the “Wellness Initiatives” on Page 10 for more details.

How to Locate Medical Providers

Once you become a member on the medical plan, visit the **Simplified Benefits Administrators** website at <https://tpa.uchealth.org/> to register and login to your secure Member Portal. From there, you can access a wide range of tools to help you better understand your health benefits and to manage your claims.

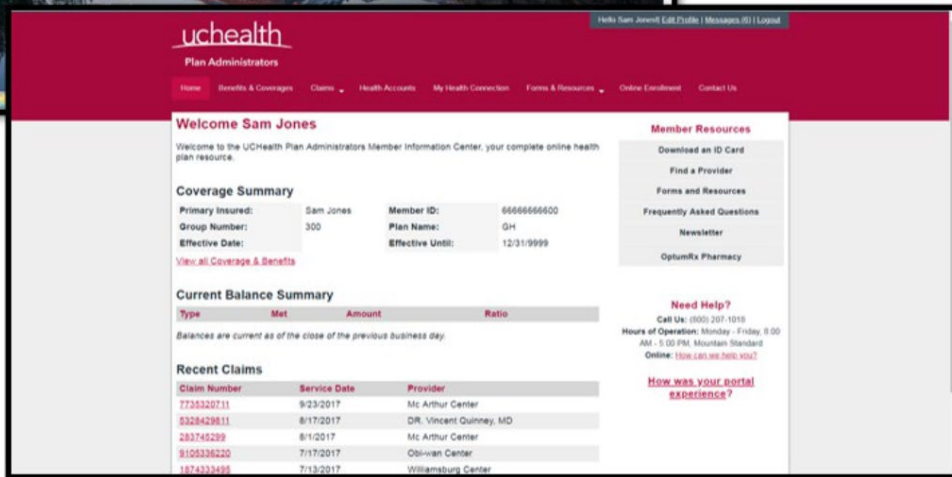
- ✓ Download ID cards
- ✓ Health Plan Dashboard
- ✓ Coverage Summaries
- ✓ View Explanation Of Benefits (EOB)
- ✓ Locate an In-Network Provider
- ✓ Member Educational Resources



Before you are a member on the medical plan, the network directories can be located online via both of these links:

<https://www.goperspecta.com/VPD/UHPA/public/ProviderSearch/ByPlan?Benefit=FHN&BenefitGroup=FHN>

<https://www.goperspecta.com/VPD/UHPA/public/ProviderSearch/ByPlan?Benefit=UCPA&BenefitGroup=UCPA>



Provider Directory

Through Simplified Benefits Administrators' secure Member Portal, click on "Find a Provider" located on the right-hand side of the webpage to access your customized provider directory. You can locate in-network providers based upon:

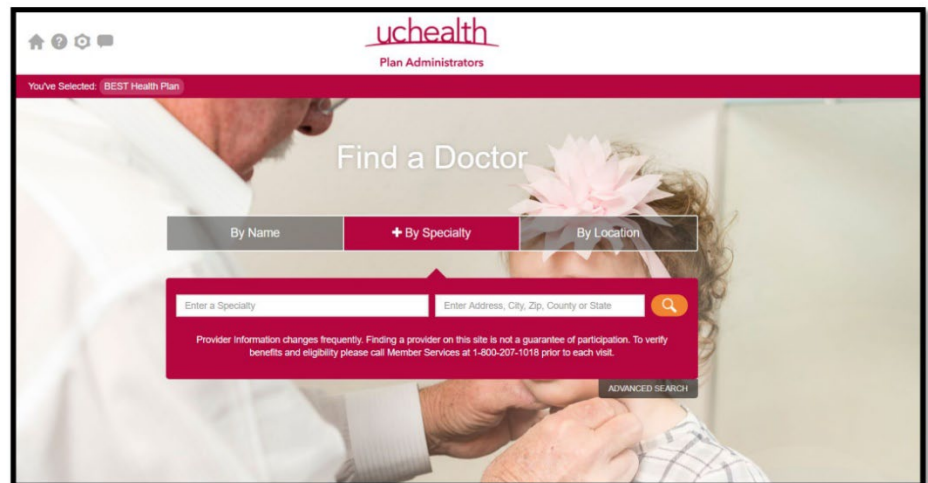
- Search by provider name
- Search by specialty
- Search by location

Questions?

Call Simplified Benefits Administrators to verify provider participation.

1.800.207.1018

tpacustomerservice@uchealth.org



Healthcare Bluebook Incentives



Your employer provides **Healthcare Bluebook** FREE as a benefit, so you can shop for medical procedures at in-network facilities in your area to find the best price and get an out-of-pocket cost estimate. If you utilize one of the high value “green” providers for select procedure categories, you will receive a cash-based reward of \$25-\$1,500. This is called the **Go Green to Get Green rewards program**. Healthcare Bluebook allows you to shop for procedures, compare facilities and their pricing, and find the best quality for medical services, all while saving money.



1

LOGIN AND FIND A FAIR PRICE!

Find the link in your member portal, scan the QR code with your phone, or use the link below to access **Healthcare Bluebook**.



healthcarebluebook.com/cc/UCHealthComply

2

Search for your medical procedure to access price information as well as a list of in-network facilities in your area. Use the green, yellow, and red color signs to guide you to **Fair Price™** (green) facilities.

COST
RATINGS



At or Below
Fair Price



Slightly Above
Fair Price



Highest
Price

What is a Fair Price?

A Fair Price is the reasonable amount you should expect to pay for a procedure or medical service.

Check out the reverse side for an example of dramatic price differences and out-of-pocket cost estimate.

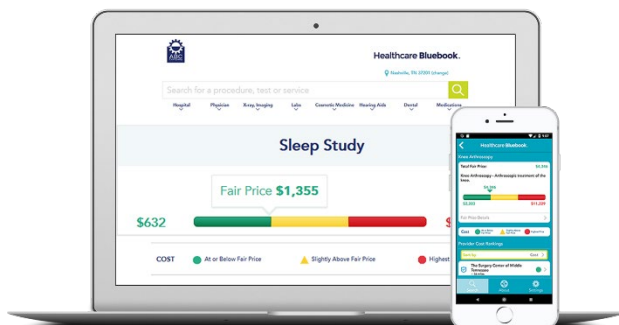
3

GET A COST ESTIMATE

Select a **Fair Price™** (green) facility and you'll see your estimated out-of-pocket cost pertaining to the selected in-network facility as well as details correlated to your deductible.

Incentive Reward Highlights:

- Standard reward amounts range from \$25 to \$1,500
- Incentive rewards issued via check
- Rewards are processed monthly following receipt of claims data






REFERENCE GUIDE



Pharmacies

SmithRx partners with over 83,000 retail pharmacies across the nation including the major national chains, regional chains, grocers and independent pharmacies. In addition, we have three preferred mail order pharmacies and two specialty pharmacies. You can always find the pharmacy with the best price by using the Find My Meds search tool in the Member Portal at mysmithrx.com.

Mail order pharmacies:

	<p>Register at www.amazon.com/smithrx. Doctors can send prescriptions via electronic prescribing, fax or phone:</p> <ul style="list-style-type: none"> • Name/E-scribe: Amazon Pharmacy Home Delivery • Amazon Pharmacy fax: 512-884-5981 • Amazon prescriber and pharmacy line: 855-206-3605
	<p>Doctors can send prescriptions via electronic prescribing, fax or phone:</p> <ul style="list-style-type: none"> • Walmart Pharmacy fax: 1 (800) 406-8976 • Walmart prescriber and pharmacy line: 1 (800) 273-3455 • Website: https://www.walmart.com/cp/1042239
	<p>See whether your medications are available: https://costplusdrugs.com/medications. Doctors can send prescriptions via electronic prescribing to:</p> <ul style="list-style-type: none"> • Name/E-scribe: Mark Cuban Cost Plus Drug Company (MCCPD)

Specialty pharmacies:

	<p>For enrollment assistance patients can call: 888-355-4191. Prescribers can visit www.krogerspecialtypharmacy.com and fill out the appropriate forms for the appropriate department. Faxed prescriptions will ONLY be accepted from the prescriber.</p>
	<p>For enrollment assistance patients can call: 888-777-5547. Prescribers can visit https://senderrax.com/prescribers/forms and fill out the appropriate forms for the appropriate department. Faxed prescriptions will ONLY be accepted from the prescriber.</p>

Retail pharmacies: Here are just a few of the retail pharmacies in our network.



CHAT: www.smithrx.com

P: 844.454.5201 | E: help@smithrx.com

smithrx.com



Dental Insurance



	Delta Dental of Colorado Patient Direct Discount Plan	Delta Dental of Colorado PPO Plus Premier		
	Schedule of Benefits*	Delta PPO	Delta Premier	Non-Network
Annual Deductible				
Annual Maximum (Applies for Basic and Major Expenses)	\$0		\$2,000	
Calendar Year Annual Deductible – Individual / Family	\$0		\$50 / \$150	
Annual Maximum (Applies to Basic and Major Expenses)				
Diagnostic & Preventive Oral Exams Routine Cleanings and X-rays Fluoride Application Sealants Space Maintainers (limited to non-orthodontic) Emergency Care to Relieve Pain	Services are discounted according to a Fee Schedule. For example: Routine Office Visits: \$0 Full-mouth X-ray: \$39 Adult Cleaning: \$50	100%, no ded	80%, no ded	80%, no ded
Basic Fillings Oral Surgery Simple Extractions General Anesthesia Relines, Rebases and Adjustments	Services are discounted according to a Fee Schedule. For example: Filling: \$135	80%, after ded	80%, after ded	80%, after ded
Major Minor and Major Periodontics Root Canal Therapy / Endodontics Bridges / Crowns / Dentures / Repairs / Adjustments	Services are discounted according to a Fee Schedule. For example: Crown: \$725	50%, after ded	50%, after ded	50%, after ded
Orthodontia				
Benefit Percentage	See Schedule		50%, no ded	
Adults (and Covered Full-Time Students, if Eligible)	Covered		Not covered	
Dependent Child(ren)	Covered		Covered to age 19	
Lifetime Maximum	N/A		\$1,000 per covered child	
Benefit Waiting Periods	N/A		12-Month Waiting Period on Orthodontia Services	

*You may request the full Patient Direct Fee Schedule from Goodwill's Benefits Team: Benefits@goodwillcolorado.org

Employee Contributions per Pay Period (24 Pay Periods/year)

Delta Dental of Colorado - Patient Direct Discount Plan	
Employee	\$2.94
Employee & Spouse	\$4.94
Employee & Child(ren)	\$4.94
Employee & Spouse & Child(ren) (Family)	\$6.94
Delta Dental of Colorado - PPO Plus Premier Plan	
Employee	\$7.76
Employee & Spouse	\$16.21
Employee & Child(ren)	\$18.64
Employee & Spouse & Child(ren) (Family)	\$29.63



Dental Plan Provider Overview



Delta Dental of Colorado - PPO Plus Premier Plan

Under the Dental PPO network program, members have the ability to select any licensed dentist for treatment; however, if a member selects either a PPO or Premier dentist, the member's Out-of-Pocket costs are reduced as participating dentists agree to accept Delta Dental's contracted rate as payment in full for covered services and collect only applicable deductible and/or coinsurance amounts from the member.

In addition, participating dentists file claims on behalf of the member. Pre-treatment authorization for any amount over \$250 is highly recommended. Have your dentist contact Delta Dental to obtain a pre-treatment authorization before any services are performed.

Find your network provider and print your ID card at www.deltadentalco.com.



Getting started

Delta Dental's mobile app is optimized for iOS (Apple) and Android devices. To download our app on your device, visit the App Store (Apple) or Google Play (Android) and search for Delta Dental. Or, scan the QR code at right. You will need an internet connection in order to download and use most features of our free app.



SCAN TO DOWNLOAD
DELTA DENTAL
MOBILE APP

Logging in to view benefits

Delta Dental subscribers can log in using the username and password they use to log in to our website. If you haven't registered for an account yet, you can do that within the app. If you've forgotten your username or password, you can also retrieve these via the Delta Dental mobile app.

Delta Dental of Colorado - Patient Direct Plan

Delta Dental Patient Direct is a dental plan for groups. **Patient Direct is not an insurance plan. It is a dental savings plan that provides members significant savings on certain dental procedures.** With Patient Direct, you have no maximums, no waiting periods, no annual deductible, and no claims to file. Payment is from the patient directly to the provider.

► ENROLLING IN PATIENT DIRECT

With Patient Direct, you can select a dentist from the growing 500-provider Patient Direct network. It's easy to enroll. Simply follow these steps:

- Select a dentist from the online search tool at DeltaDentalCO.com/dentist-search.html.
- Wait to receive your Patient Direct ID card.
- Schedule an appointment to see your Patient Direct dentist.

To find a Patient Direct dentist or to see if your current dentist is in the network, visit DeltaDentalCO.com/dentist-search.html and select Delta Dental Patient Direct in the Plan dropdown menu.

Patient Direct is not insurance—it is a discount plan—but it will still save you a lot of money.			
Procedure	Standard Fees* (non-discounted)	Your Cost with Patient Direct*	Your Savings*
Routine Office Visit	\$72	\$0	\$72
Full-mouth X-ray	\$87	\$39	\$48
Adult Cleaning	\$123	\$50	\$73
Filling	\$310	\$135	\$175
Crown	\$1,475	\$725	\$750

*The chart above serves as an illustration only. Actual costs and savings may vary. Members can access interest-free financing up to \$1,000 on dental, hearing, and vision expenses through our partner, Paytient. An estimated 97% of participants will qualify for financing for up to 36 months.

Vision Insurance



This plan offers in-network and out-of-network-benefits; however, to receive the maximum benefit, you should always use participating providers. To find a provider, visit www.eyemedvisioncare.com.

	EyeMed Vision Care	
	In-Network (Select Network)	Out-of-Network
Frequencies		
Exam	Once Every 12 Months	
Lenses	Once Every 12 Months	
Frames	Once Every 24 Months	
Routine Vision Exams	\$10 copay	Reimbursement up to \$30
Vision Materials		
Materials Copay Standard Plastic Lenses: Single, Bifocal, Trifocal, Lenticular, or Progressive	\$25 copay	Reimbursement of \$25-\$55, depending on lens type
Lens Options	Copays Vary by Type of Option	Reimbursement up to \$5 for Standard Plastic Scratch Coating
Contacts -Covered in lieu of frames. Medically necessary contacts may be covered at a higher benefit level	\$150 allowance, 15% discount off balance over \$150	Reimbursement up to \$120
Frames	\$150 Allowance, 20% off balance over \$150	Reimbursement up to \$75

*Limited reimbursements are available when using an Out-of-Network provider. See the summary of benefits or contact EyeMed for more information.

Employee Contributions (Semi Monthly 24 per yr)	
Vision	
Employee	\$2.77
Employee & Spouse	\$5.25
Employee & Child(ren)	\$5.53
Employee & Spouse & Child(ren) (Family)	\$8.12

Your vision is very important to your overall health. Whether your vision is 20/20 or less than perfect, everyone should receive regular vision care. Did you know that regular comprehensive eye exams can spot symptoms of many underlying health problems, such as diabetes, hypertension, high cholesterol, glaucoma, and cataracts? We partner with a network of providers where members receive comprehensive vision care.

EyeMed providers deliver a complete vision examination, arriving at both a diagnosis and treatment plan (if needed). Don't take chances with your most precious possession – the gift of sight. Use your vision plan today!

Find your network provider and print your ID card at www.eyemedvisioncare.com.

Find an eye doctor (Select Network)

- eyemed.com
- EyeMed Members App
- For LASIK, call 1.800.988.4221

Heads up

You may have additional benefits. Log into eyemed.com/member to see all plans included with your benefits.



40% OFF

additional complete pair of prescription eyeglasses

20% OFF

non-covered items, including non-prescription sunglasses



Flexible Spending Accounts (FSA)



The Flexible Spending Account (FSA) plan with Rocky Mountain Reserve allows you to set aside pre-tax dollars to cover qualified expenses you would normally pay out of your pocket with post-tax dollars. The plan is comprised of a health care spending account and a dependent care account. You pay no federal or state income taxes on the money you place in an FSA.

How an FSA works:

- Choose a specific amount of money to contribute each pay period, pre-tax, to one or both accounts during the year.
- The amount is automatically deducted from your pay at the same level each pay period.
- As you incur eligible expenses, you may use your flexible spending debit card to pay at the point of service OR submit the appropriate paperwork to be reimbursed by the plan.

Important rules to keep in mind:

- FSAs are commonly referred to as “use it or lose it” accounts. However, if you have a balance at the end of the year, \$610 is allowed to rollover.
- Once you enroll in the FSA, you cannot change your contribution amount during the year unless you experience a qualifying life event.
- You cannot transfer funds from one FSA to another.

Please plan your FSA contributions carefully, as any funds over \$610 that are not used by the end of the year will be forfeited. Re-enrollment is required each year.

Limited Purpose Flexible Spending Account May be used in conjunction with participation in a Qualified High Deductible Health Plan (QHDHP) and a Health Savings Account (HSA) and may ONLY be used for eligible dental, vision, and hearing expenses.

Example of Savings Using a Flexible Spending Account (FSA)

	Without an FSA	With an FSA
Gross Income	\$40,000	\$40,000
Pre-Tax Expenses for Health/Dependent Care	\$0	\$1,500
Taxable Income	\$40,000	\$38,500
Less Taxes	\$10,279	\$10,010
After-Tax Expenses for Health	\$2,500	\$0
Spendable Income	\$27,221	\$28,490
Your Savings With Flexible Spending	—	\$1,269

MAXIMUM ANNUAL ELECTION

Health Care FSA	\$2,000
Dependent Care FSA	Up to \$5,000 (or \$2,500 if married and filing individually)



Flexible Spending Account (FSA) Contributions –



Flexible Spending Account (FSA) Contribution Example –

Bob elects \$1,080 annually to his Health Care Flexible Spending Account (HCFSA) starting on January 1st. Per the plan design, his contribution would be \$45 per pay period (\$1,080 divided by 24 pay periods equals \$45).

Health Care Flexible Spending Account (HCFSA) Contribution Calculation*

Full-Time (FT) Employee Contributions Are Based Upon 24 Pay Period Deductions

Cannot exceed \$2,000 for the Year

$$\frac{\$ \text{Your HCFSA Annual Amount}}{\div \text{by \# of Contributing Pay Periods* Remaining in the Year}} = \$ \text{Per Pay Period Contribution}$$

You will have full access to any HCFSA funds on the first day you're eligible and have elected this benefit!

Dependent Care Flexible Spending Account (DCFSA) Contribution Calculation*

Full-Time (FT) Employee Contributions Are Based Upon 24 Deductions

Cannot exceed \$5,000 for the Year

$$\frac{\$ \text{Your DCFSA Annual Amount}}{\div \text{by \# of Contributing Pay Periods* Remaining in the Year}} = \$ \text{Per Pay Period Contribution}$$

You will not have access to any DCFSA funds until you actually have money in your account.

Limited Purpose Flexible Spending Account (LPFSA) Contribution Calculation*

HDHP - HSA \$5,500 Medical Plan Participants Only

Full-Time (FT) Employee Contributions Are Based Upon 24 Deductions

Cannot exceed \$2,000 for the Year

$$\frac{\$ \text{Your LPFSA Annual Amount}}{\div \text{by \# of Contributing Pay Periods* Remaining in the Year}} = \$ \text{Per Pay Period Contribution}$$

You will have full access to any LPFSA funds on the first day you're eligible and have elected this benefit!

* Contributions are only taken from the first two (2) pay periods each month.



Qualified expenses with FSA/HSA Dollars



Wondering what you can use your funds on? Visit <https://www.rockymountainreserve.com/whats-covered> to see a comprehensive and up-to-date list of services and products, and under what circumstances they are eligible.

Below is a partial list of reimbursable expenses that may be incurred by you, your spouse, or qualified dependents.

NOTE: If you (or your spouse) enroll in an HSA Plan, you may only enroll in a Limited-Purpose Healthcare FSA (LPHSA). The eligible expenses under an LPHSA are limited to Dental and Vision expenses only.

Eligible Medical Expenses

- Acupuncture
- Artificial limbs
- Bandages & dressings
- Birth control, contraceptive devices
- Birthing classes/Lamaze – only the mother's portion (not the coach/spouse) and the class must be only for birthing instruction, not child rearing
- Blood pressure monitor
- Chiropractic therapy/exams/adjustments
- Contact lens and contact lens solutions
- Co-payments
- Crutches (purchased or rented)
- Deductibles & co-insurance
- Diabetic care & supplies
- **Feminine care products** (tampons, pads, etc.)
- Eye exams
- Eyeglasses, contacts, or safety glasses (prescription)
- First aid kits & supplies
- Hearing aids & hearing aid batteries
- Heating pad
- Incontinence supplies
- Infertility treatments
- Insulin
- Lactation expenses (breast pumps, etc.)
- Laser eye surgery; LASIK
- Legal sterilization
- Medical supplies to treat an injury or illness
- Mileage to and from doctor appointments
- Optometrist's or ophthalmologist's fees
- Orthopedic inserts
- **Personal Protection Equipment (PPE)** (facial masks, hand sanitizer, sanitizing wipes)*

Eligible Dental Expenses

- Braces and orthodontic services
- Cleanings
- Crowns
- Deductibles, co-insurance
- Dental implants
- Dentures, adhesives
- Fillings

For more information regarding eligible expenses, please review IRS Publication 502/503 at [irs.gov](https://www.irs.gov)

- Physical exams
- Physical therapy (as medical treatment)
- Physician's fee and hospital services
- Pregnancy tests
- Prescription drugs and medications
- Psychotherapy, psychiatric and psychological service
- Sales tax on eligible expenses
- Sleep apnea services/products (as prescribed)
- Smoking cessation programs & deterrents (gum, patch)
- Treatment for alcoholism or drug dependency
- Vaccinations & Flu Shots
- X-ray fees

Eligible OTC Medicines and Drugs

Over-the-counter (OTC) medicines and drugs are reimbursable via FSA, HRA, and HSA without a prescription or physician's note if purchased on or after 01/01/2020.

Eligible OTC products include items that are primarily for a medical purpose, and are compliant with federal tax rules under IRS Code Section 213(d).

- Allergy, cough, cold, flu & sinus medications
- Anti-diarrheals, anti-gas medications & digestive aids
- Canker/cold sore relievers & lip care
- Family planning items (contraceptives, pregnancy tests, etc.)
- Foot care (corn/wart medication, antifungal treatments, etc.)
- Hemorrhoid creams & treatments
- Itch relief (calamine lotion, Cortizone cream, etc.)
- Oral care (denture cream, pain reliever, teething gel, etc.)
- Pain relievers - internal/external (Tylenol, Advil, Bengay, etc.)
- Skin care (sunscreen w/SPF15+, acne medication, etc.)
- Sleep aids & stimulants (nasal strips, etc.)
- Stomach & nausea remedies (antacids, Dramamine, etc)
- Wound Treatments/Washes (Hydrogen Peroxide, Iodine)

Eligible Dependent Care Expenses

- Fees for licensed day care or adult care facilities
- Before and after school care programs for dependents under age 13
- Amounts paid for services (including babysitters or nursery school) provided in or outside of your home
- Nanny expenses attributed to dependent care
- Nursery school (preschool) fees
- Summer Day Camp – primary purpose must be custodial care and not educational in nature
- Late pick-up fees
- Does not cover medical costs; use Healthcare FSA for medical expenses incurred by you or your dependents



Health Savings Account (HSA)

When you are enrolled in a Qualified High Deductible Health Plan (QHDHP) and meet the eligibility requirements, the IRS allows you to open and contribute to an HSA Account.

What is a Health Savings Account (HSA)?

An HSA is a tax-sheltered bank account that you own to pay for eligible health care expenses for you and/or your eligible dependents for current or future healthcare expenses. The Health Savings Account (HSA) is yours to keep, even if you change jobs or medical plans. There is no “use it or lose it” rule; your balance carries over year to year.

Plus, you get extra tax advantages with an HSA because:

- Money you deposit into an HSA is exempt from federal income taxes
- Interest in your account grows tax free; and
- You don't pay income taxes on withdrawals used to pay for eligible health expenses. (If you withdraw funds for non-eligible expenses, taxes and penalties apply).
- You also have a choice of investment options which earn competitive interest rates, so your unused funds grow over time.

Are you eligible to open a Health Savings Account (HSA)?

Although everyone can enroll in the Qualified High Deductible Health Plan, not everyone is eligible to open and contribute to an HSA. If you do not meet these requirements, you cannot open an HSA.

- You must be enrolled in a Qualified High Deductible Health Plan (QHDHP)
- You must not be covered by another non-QHDHP health plan, such as a spouse's PPO plan.
- You are not enrolled in Medicare.
- You are not in the TRICARE or TRICARE for Life military benefits program.
- You have not received Veterans Administration (VA) benefits within the past three months.
- You are not covered by a traditional health care flexible spending account (FSA). This includes your spouse's FSA. (Enrollment in a limited purpose health care FSA is allowed).

2024 HSA Contributions

You can contribute to your Health Savings Account on a pre-tax basis through payroll deductions up to the IRS statutory maximums. The IRS has established the following maximum HSA contributions:

FOR THE 2024 TAX YEAR:

- **\$4,150 Individual**
- **\$8,300 with Dependents enrolled in your medical**
- If you are age 55 and over, you may contribute an extra **\$1,000 catch up contribution**.

You have the opportunity to receive an employer HSA contribution match of up to \$500 per year. Your employer will match dollar-for-dollar up to \$500 in your HSA contributions

Keep in mind, total combined employer and employee contributions to an employee's HSA cannot exceed the annual limit set by the IRS. With the HSA you may make changes to the amount of your contribution throughout the year.



How do I get reimbursed for my eligible expenses?

The easiest way to use your HSA dollars is by using your HSA Debit Card at the time you incur an eligible expense. Or you can withdraw money from an ATM. But keep your receipts! You must be able to prove that you were reimbursing yourself for an eligible expense if you are audited. If you use your HSA funds for non-eligible expenses, you will be charged a 20% penalty tax (if under age 65) as well as federal income taxes. You can manage your HSA through www.rockymountainreserve.com 24 hours a day, seven days a week. Rocky Mountain Reserve provides helpful information about your HSA, including online calculators to help you add up your tax savings and see your HSA's possible future growth. For additional guidelines, please go online or call Rocky Mountain Reserve at 888-722-1223.



Use of HSA Funds

Spending HSA Dollars Just Got Easier



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

Benefits of Using the Debit Card

- Easy to use - the Benefits Card is a stored-value card that simplifies the process of paying for qualified expenses.
- Works at merchants where MasterCard is accepted.
- It pays directly at the point of sale - no waiting for reimbursement!



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



Online Access

To Create Your Online Account:

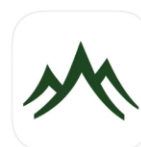
1. Go to <https://rockymountainreserve.com>
2. Click on "Login/Register" in the top right-hand corner
3. Click on "Employee Registration"
4. Username will be the name you use to log in for the web portal and mobile application.
5. The password must contain at least 3 of these: special character, number,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

Mobile Application:

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

Goodwill employer ID: **RMRGID**.

Search "RMR Benefits" on the app store



RMR Benefits Mobile
Rocky Mountain Reserve Mobile



Life and AD&D

We believe we should offer our employees the opportunity to provide for their family's future rather than leaving it to chance. Life insurance can provide your dependents with a lifetime of financial security and upon your death, can be used to pay off your debts – such as credit cards and your mortgage – or other expenses that could burden your family.

As an eligible employee, you are automatically covered by a Basic Life and Accidental Death & Dismemberment (AD&D) Insurance benefit **AT NO COST TO YOU of 1 times your annual salary** (up to a maximum of \$500,000).

You do not have to enroll for Group Basic Life and AD&D; however, you must designate a beneficiary.

New York Life Insurance Company Life and AD&D	
Life and AD&D Benefit Amount	Class 1: 2 times annual compensation rounded up to the next higher \$1,000 not to exceed \$500,000 Class 2: 1 times annual compensation rounded up to the next higher \$1,000 not to exceed \$500,000
Employee Eligibility	Class 1: Officers, Directors, or Managers Class 2: All other active, Full-time Employees of Goodwill
Coverage Reduction Schedule	Benefit reduces to 65% at age 65 and 50% at age 70
Accelerated Death Benefit	Included, but not to exceed 80% of the Employee's Amount or \$400,000
Waiver of Premium	Yes, prior to age 60
Portability / Conversion	Yes

Be sure to assign a beneficiary or living trust to ensure your assets are distributed according to your wishes.

You must select a beneficiary – A person (or more than one person), a legal entity or group (or more than one group) who receives a benefit payment if you die while covered by the plans. This beneficiary designation will be for ALL group life and/or accidental death insurance coverage issued by New York Like for you, unless specifically named otherwise. Please make sure that you also name a contingent beneficiary – who will receive your benefit if your primary beneficiary dies first. If you name more than one primary or contingent beneficiary, show the percentage of your benefit to be paid to each.

Log in to the UltiPro HR/Payroll system to update your beneficiaries. Your beneficiaries are located in your "Contacts" page.



Supplemental (Voluntary) Life / AD&D



If you want additional financial protection for you and your family, then employees may purchase Supplemental Term Life Insurance and Accidental Death and Dismemberment (AD&D) coverage for themselves as well as Supplemental Dependent Life Insurance Coverage.

Supplemental Life Insurance is coverage you pay for, in addition to the basic coverage already provided by Goodwill. Life insurance pays your beneficiary, a benefit to them if you die while you are covered under the policy. Your contributions will depend on your age and the amount of coverage you elect. Any amount elected beyond your initial eligibility date, or any amount over the guaranteed issue amount will be subject to Evidence of Insurability.

New York Life Insurance Company Supplemental (Voluntary) Life / AD&D	
You	
Benefit Maximum	Increments of \$10,000 not to exceed \$500,000
Guaranteed Issue	\$200,000
Your Spouse	
Benefit Maximum	Increments of \$5,000 not to exceed \$250,000
Guaranteed Issue	\$30,000
Your Child	
Benefit Maximum	Increments of \$5,000 not to exceed \$20,000
Guaranteed Issue	\$20,000
Coverage Reduction Schedule	Benefit reduces to 65% at age 65 and 50% at age 70
Accelerated Death Benefit	Included, but not to exceed 80% of the Employee's Amount or \$400,000
Waiver of Premium	Yes, prior to age 60
Portability / Conversion	Yes

EMPLOYEE SUPPLEMENTAL (VOLUNTARY) LIFE / AD&D INSURANCE RATES per \$1,000 Full-time Employee Contributions Per Pay Period (24 Deductions)												
AGE	UNDER 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
RATE	\$0.085	\$0.095	\$0.100	\$0.130	\$0.180	\$0.280	\$0.390	\$0.610	\$0.800	\$1.620	\$2.820	\$4.970

If you purchase Supplemental Life Insurance for yourself, you may also purchase Supplemental Life Insurance for your legal Spouse in increments of \$5,000. The maximum amount you can purchase cannot be more than the lesser of \$250,000 or 50% of your Employee Voluntary / Supplemental Life Insurance coverage. If you elect an amount which exceeds the guaranteed issue amount of \$30,000, your Spouse will need to provide evidence of good health, called an Evidence of Insurability (EOI), that is satisfactory to Cigna before the amount over \$30,000 becomes effective. Costs are based on the employee's age.

Goodwill will only bill you on the guaranteed issue amount until the Evidence of Insurability (EOI) is approved by Cigna.

SPOUSE SUPPLEMENTAL (VOLUNTARY) LIFE / AD&D INSURANCE RATES per \$1,000 Full-time Employee Contributions Per Pay Period (24 Deductions)												
AGE	UNDER 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
RATE	\$0.085	\$0.095	\$0.100	\$0.130	\$0.180	\$0.280	\$0.390	\$0.610	\$0.800	\$1.620	\$2.820	\$4.970

If you purchase Supplemental Life Insurance for yourself, you may also purchase Supplemental Life Insurance for your Dependent Child(ren), up to age 26, in the amount(s) \$20,000. Child(ren) between the ages of live birth and 6 months are limited to coverage in the amount of \$1,000. Child life coverage is at a monthly cost of \$4.00 (cost is for all covered children whether it be one or five).





Supplemental Life Insurance Premium Calculation Example –

Bob is between 25 to 29 years of age.

- He elects \$200,000 of Life / AD&D insurance coverage for himself, which is the guaranteed issue amount.
- His rate is \$0.095 per \$1,000 of life benefit.

According to the plan design:

- His monthly premium is \$19.00 (\$200,000 divided by \$1,000 times \$0.075)
- His per pay period cost is \$9.50 (\$19.00 times 12 months divided by 24 pay periods).

Refer below to make your own life insurance premium calculations for both you and your spouse.

Employee Supplemental (Voluntary) Life / AD&D Premium Calculation

Full-Time Employee Contributions Based Upon Per Pay Period (24 Deductions)
Cost may change when you move into a new age category.

AGE	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
RATE	\$0.085	\$0.095	\$0.100	\$0.130	\$0.180	\$0.280	\$0.390	\$0.610	\$0.800	\$1.620	\$2.820	\$4.970

To calculate your per pay period cost, please use the following formula(s):

$$\frac{\$ \text{Your Life Benefit Amount}}{\$1,000} = \$ \text{Rate} \times \$ \text{Rate} \times 12(\text{months}) \div 24 (\text{pay periods}) = \$ \text{Per Pay Period Cost}$$

Spouse Supplemental (Voluntary) Life / AD&D Premium Calculation

Full-Time Employee Contributions Based Upon Per Pay Period (24 Deductions)
Cost may change when your spouse moves into a new age category.

AGE	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
RATE	\$0.085	\$0.095	\$0.100	\$0.130	\$0.180	\$0.280	\$0.390	\$0.610	\$0.800	\$1.620	\$2.820	\$4.970

To calculate your spouse's per pay period cost, please use the following formula(s):

$$\frac{\$ \text{Spouse Life Benefit Amount}}{\$1,000} = \$ \text{Rate} \times \$ \text{Rate} \times 12(\text{months}) \div 24 (\text{pay periods}) = \$ \text{Per Pay Period Cost}$$



Short-Term Disability Insurance

All active employees meeting minimum eligibility requirements will be eligible for **employer-paid** Short-Term Disability (STD) protection, designed to replace a portion of the disabled employee's income while they are unable to work and to encourage their timely return-to-work.

Employer-Paid Short-Term Disability (STD) –

The STD plan provides covered employees with weekly benefits for disability due to sickness and off-the-job accidents. Coverage is not provided for on-the-job accidents (refer to Goodwill's workers' compensation policies for additional information regarding work-related accidents).

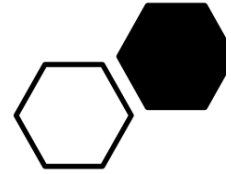
The Short-Term Disability (STD) benefit is provided at no cost to eligible Full-Time (FT) employees.



SHORT-TERM DISABILITY (STD) INSURANCE			
CLASS DESCRIPTION	BENEFIT PERCENT	MINIMUM AMOUNT	MAXIMUM AMOUNT
All Other Employees	60% of Pre-Disability Salary	\$25 / Week	\$1,500 / week
Elimination Period	Fourteen (14) Consecutive Days for Accident or Sickness; Use of Goodwill Sick Leave is required; Benefits Begin on the 15 th Day		
Maximum Duration	11 Weeks		
Non-Occupational	Provides benefits for non-work related illnesses/injuries only		
<p><i>This summary of benefits is provided for informational purposes only. In the event of a conflict between this benefits summary and the Certificate of Coverage, the Certificate will prevail.</i></p>			

Voluntary Long-Term Disability Insurance

All active employees meeting the minimum eligibility requirements are eligible for voluntary employee-paid Long-Term Disability (LTD) protection, designed to replace a portion of the disabled employee's income while they are unable to work and to encourage their timely return-to-work.



Voluntary Long-Term Disability (VLTD) –

The voluntary Long-Term Disability (LTD) plan provides covered employees with monthly benefits for disability due to sickness and off-the-job accidents. LTD helps replace your income if you are sick or injured and cannot work. It is designed to begin after you have been disabled for a predetermined waiting period.

The voluntary Long-Term Disability (LTD) benefit is paid for by eligible Full-Time (FT) employees.

Elimination Period	90 Days
Monthly Benefit Percentage	60% of your monthly covered earnings
Monthly Maximum Benefit Amount	\$6,000 per month
Maximum Benefit Duration	Social Security Normal Retirement Age (SSNRA)
Definition of Disability	Employees are considered disabled, due to injury or sickness, if they are unable to perform the material duties of their regular occupation for a specified period; And, solely due to injury or sickness, they are unable to earn more than 80% of their Indexed Covered Earnings
Pre-Existing Condition Limitation	Three (3) Months Prior / Twelve (12) Months Insured
Mental Nervous / Substance Abuse	Twenty-Four (24) Months (Lifetime)
Subjective Conditions Limitation	None
<i>This summary of benefits is provided for informational purposes only. In the event of a conflict between this benefits summary and the Certificate of Coverage, the Certificate will prevail.</i>	

Voluntary Long-Term Disability (VLTD) Rates and Premium Calculation

Full-Time Employee Contributions Are On A Per Pay Period Basis (24 Deductions)

Your cost may change when you move into a new age category.

AGE	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74+
RATE	\$0.16	\$0.205	\$0.395	\$0.615	\$0.920	\$1.240	\$1.715	\$1.820	\$1.920	\$2.000	\$2.050

To calculate your per pay period cost, please use the following formula:

$$\frac{\$ \text{Your Annual Salary}}{\text{Your Annual Salary}} \div 12 = \frac{\$ \text{Your Monthly Salary}}{\text{Your Monthly Salary}} \div 100 = \$ \text{Rate} \times \frac{\$ \text{Rate}}{\text{Rate}} = \frac{\$ \text{Monthly Cost}}{\text{Monthly Cost}}$$

$$x 12 (\text{months}) \div 24 (\text{pay periods}) = \frac{\$ \text{Per Pay Period Cost}}{\text{Per Pay Period Cost}}$$





Voluntary Worksite Products

Accident & Injury - Cigna

No one plans to have an accident. But it can happen at any moment throughout the day, whether at work or at play. Most major medical insurance plans only pay a portion of the bills.

Accidental Injury coverage provides a fixed cash benefit according to the schedule below when a Covered Person suffers certain injuries or undergoes a broad range of medical treatment or care resulting from a Covered Accident. This plan provides off the job only coverage.

Benefit Percentage Amount (unless otherwise indicated)	Employee 100% of benefits shown	Spouse 100% of benefits shown	Children 100% of benefits shown
Initial & Emergency Care		Plan	
Emergency Care Treatment		\$200	
Physician Office Visit		\$200	
Diagnostic Exam (x-ray or lab)		\$50	
Ground or Water Ambulance/Air Ambulance		\$400/\$1,600	
Hospitalization Benefits		Plan	
Hospital Admission		\$1,000	
Hospital Stay		\$300	
Intensive Care Unit Stay		\$600	
Fractures and Dislocations		Plan	
Per covered surgically-repaired fracture		\$200-\$8,000	
Per covered non-surgically-repaired fracture		\$100-\$4,000	
Chip Fracture (percent of fracture benefit)		25%	
Per covered surgically-repaired dislocation		\$200-\$6,000	
Per covered non-surgically-repaired dislocation		\$100-\$3,000	
Follow-Up Care		Plan	
Follow-up Physician Office Visit		\$75	
Follow-up Physical Therapy Visit		\$50	
Enhanced Accident Benefits		Plan	
Examples:			
Small Lacerations (Less than or equal to 6 inches long and requires 2 or more sutures)		\$100	
Large Lacerations (more than 6 inches long and requires 2 or more sutures)		\$600	
Concussion		\$500	
Coma (lasting 7 days with no response)		\$10,000	

Additional Accidental Injury benefits included - See certificate for details, including limitations & exclusions. Virtual Care accepted for Initial Physician Office Visit and Follow-Up Care.



Accident & Injury - continued

Accidental Death and Dismemberment Benefit	Plan
Examples of benefits include (but are not limited to) payment for death from Automobile accident; total and permanent loss of speech or hearing in both ears. Actual benefit amount paid depends on the type of Covered Loss. The Spouse and Child benefit is 50% and 25% respective of the benefit shown.	Loss of Life: \$25,000 - \$75,000 Dismemberment: \$1,000 - \$20,000

Health Screening Test Benefit*	Plan
Health Screening Test Benefit:* Examples include (but are not limited to) mammography and certain blood tests. Benefit paid for all covered persons is 100% of the benefit shown. <i>Also includes COVID-19 Immunization, Tests, and Screenings. Virtual Care accepted.</i>	\$50

EMPLOYEE'S COST OF COVERAGE per Pay Period (24 Pay Periods/year)	
EMPLOYEE	\$3.39
EMPLOYEE AND SPOUSE	\$5.77
EMPLOYEE AND CHILD(REN)	\$6.84
FAMILY	\$9.21

Hospital Care - Cigna

Hospital Care coverage provides a benefit according to the schedule below when a covered person incurs a hospital stay resulting from a covered injury or covered illness.

Hospitalization Benefits	Plan
Hospital Admission No Elimination Period. Limited to 1 day, 1 benefit(s) every 365 days.	\$1,000
Hospital Chronic Condition Admission No Elimination Period. Limited to 1 day, 1 benefit(s) every 365 days.	\$50
Hospital Stay No Elimination Period. Limited to 30 days, 1 benefit(s) every 365 days.	\$150
Hospital Intensive Care Unit (ICU) Stay No Elimination Period. Limited to 30 days, 1 benefit(s) every 365 days.	\$150
Hospital Observation Stay 24 hour Elimination Period. Limited to 72 hours.	\$100 per 24-hour period
Additional Benefits	Plan
Health Screening Test Benefit* Examples include (but are not limited to) mammography, and certain blood tests. <i>Also includes COVID-19 Immunization. Virtual Care accepted.</i>	\$50, limited to 1 per year.

EMPLOYEE'S COST OF COVERAGE per Pay Period (24 Pay Periods/year)	
EMPLOYEE	\$7.06
EMPLOYEE AND SPOUSE	\$14.19
EMPLOYEE AND CHILD(REN)	\$11.26
FAMILY	\$18.39



Critical Illness - Cigna

The signs pointing to a critical illness are not always clear and may not be preventable, but our coverage can help offer financial protection in the event you are diagnosed.

Critical Illness insurance provides a cash benefit when a covered person is diagnosed with a covered critical illness or event after coverage is in effect.

*This is a sample of covered conditions. Please review the Summary of Benefits for more details.

Available Coverage:

The benefit amounts shown will be paid regardless of the actual expenses incurred. The benefit descriptions are a summary only. There are terms, conditions, state variations, exclusions and limitations applicable to these benefits. Please read all of the information in this Summary and your Certificate of Insurance for more information. All Covered Critical Illness Conditions must be due to disease or sickness.

	Benefit Amount	Guaranteed Issue Amount
Employee	\$15,000, \$30,000	Up to \$30,000
Spouse	\$7,500, \$15,000	Up to \$15,000
Children	50% of employee amount, including Childhood Conditions.	All guaranteed issue

See "Guaranteed Issue" section below for more information.

Covered Conditions	Benefit Amount
Cancer Conditions	
Skin Cancer*	\$250 1x per lifetime

Covered Conditions	Initial Benefit Amount %	Recurrence % of Initial Benefit Amount
Invasive Cancer	100%	100%
Carcinoma in Situ	25%	25%
Vascular Conditions		
Heart Attack	100%	100%
Stroke	100%	100%
Coronary Artery Disease	25%	25%

Health Screening Test Benefit	Benefit Amount
Examples includes (but are not limited to) mammography, and certain blood tests. The benefit amount shown will be paid regardless of the actual expenses incurred and is paid on a per day basis. <i>Also includes COVID-19 Immunization. Virtual Care accepted.</i>	\$50 1 per year

Benefits	
Initial Critical Illness Benefit	Benefit for a diagnosis made after the effective date of coverage for each Covered Condition shown above. The amount payable per Covered Condition is the Initial Benefit Amount multiplied by the applicable percentage shown. Each Covered Condition will be payable one time per Covered Person, subject to the Maximum Lifetime Limit. A 180 days separation period between the dates of diagnosis is required.*
Recurrence Benefit	Benefit for the diagnosis of a subsequent and same Covered Condition for which an Initial Critical Illness Benefit has been paid, payable after a 6 month separation period from diagnosis of a previous Covered Condition, subject to the Maximum Lifetime Limit.
Skin Cancer Benefit	Pays benefit stated above.
Maximum Lifetime Limit	The maximum benefit payable per Covered Person is the lesser of 5 times the elected Benefit Amount or \$150,000. The following benefits are not subject to this limit: Skin Cancer

Critical Illness Cost

Employee's Cost of Coverage per Pay Period (24 Pay Periods/year):



Age Band	Employee	
	\$15,000	\$30,000
<25	\$2.15	\$4.29
25 to 29	\$2.84	\$5.67
30 to 34	\$3.36	\$6.72
35 to 39	\$4.41	\$8.81
40 to 44	\$5.31	\$10.61
45 to 49	\$6.33	\$12.65
50 to 54	\$9.86	\$19.71
55 to 59	\$9.72	\$19.44
60 to 64	\$19.88	\$39.75
65 to 69	\$34.92	\$69.83
70 to 74	\$34.92	\$69.83
75 to 79	\$34.92	\$69.83
80 to 84	\$34.92	\$69.83
85 to 89	\$34.92	\$69.83
90 to 94	\$34.92	\$69.83
95+	\$34.92	\$69.83

Age Band	Spouse	
	\$7,500	\$15,000
<25	\$1.08	\$2.15
25 to 29	\$1.42	\$2.84
30 to 34	\$1.68	\$3.36
35 to 39	\$2.20	\$4.41
40 to 44	\$2.65	\$5.31
45 to 49	\$3.16	\$6.33
50 to 54	\$4.93	\$9.86
55 to 59	\$4.86	\$9.72
60 to 64	\$9.94	\$19.88
65 to 69	\$17.46	\$34.92
70 to 74	\$17.46	\$34.92
75 to 79	\$17.46	\$34.92
80 to 84	\$17.46	\$34.92
85 to 89	\$17.46	\$34.92
90 to 94	\$17.46	\$34.92
95+	\$17.46	\$34.92

Children covered at no additional cost

Employee Assistance Program (EAP)

The Employee Assistance Program (EAP) is provided at no cost to you, and care is coordinated through highly trained master's and doctoral level clinicians.

EAP offers confidential support services to help you and your household members with work/life issues, including financial and legal consultation. You can reach assistance by phone 24/7 or speak with a professional face to face.

Some ways in which they can assist you are:

- Parenting guidance
- Marital and family conflicts
- Stress, depression or other conditions
- Childcare and senior Care concerns
- Alcohol or drug dependency
- Legal or financial consultation
- Pet care
- Counseling

EAP is available to help you and your family find solutions to many of life's challenges and restore your peace of mind.

As an employee of Goodwill, you have access to two EAPs, at no cost to you. Each program provides 3 free sessions, per person, per incident, per year for everyone in your household.

- To utilize the EAP through ComPsych GuidanceResources, call 1.800.272.7255 or visit www.guidanceresources.com. **Goodwill Company Web ID is COM589.**
- To utilize the Life Assistance Program through New York Life Group Benefit Solutions, call 1.800.344.9752 or visit www.guidanceresources.com. **Goodwill Company Web ID is NYLGBS**





Secure Travel Assistance

Worldwide emergency travel assistance services are available to you with just one phone call. When traveling for business or pleasure, in a foreign country or just 100 miles or more away from home, you and your family can count on getting help in the event of a medical emergency.

Additional protection when you travel.

Emergencies can happen while traveling, but help is only a phone call away with New York Life Group Benefit Solutions Secure Travel.


New York Life Group Benefit Solutions (NYL GBS) Secure Travel provides emergency medical transportation benefits for covered persons traveling 100 miles or more from home (see your plan for details). Service is a phone call away, 24/7/365 – in an emergency you can even call collect.

Transportation related to medical emergencies

- Emergency evacuation to the nearest adequate medical facility if one is not available locally, and your condition, which if left untreated, could result in a significant deterioration of health.*
- Any increase in cost of return transportation above the original cost for you and your travel companion (including dependent children under age 18) if a covered medical emergency delays your return trip.
- Assistance with making emergency travel arrangements and toll-free emergency message relay.
- Friend or family member visitation, including round-trip economy class transportation and up to \$150 per day for meals and lodging, up to seven days, if you are hospitalized for seven or more consecutive days.
- Repatriation of your remains if you die while traveling.

Additional services available

- Pre-trip planning assistance, including inoculation and visa requirements in foreign countries; information about cultural and special events; temperature and weather information; foreign exchange rates.
- Language interpretation by telephone and referrals to embassies or consulates in an emergency.
- Assistance with locating or replacing lost or stolen items, medications or travel documents; assistance locating medical or dental providers.
- Emergency cash advances (up to \$1,500) and emergency medical payment advances (up to \$10,000), when secured with a credit card. Please note that medical benefits are not provided, and all costs of medical treatment are the responsibility of the patient or his or her medical insurance carrier.



**For assistance
or to learn more, call
(888) 226-4567**

NYL GBS Secure Travel
 From the United States and Canada, call **(888) 226-4567**
 From other locations, call collect **(202) 331-7635**
 Fax: **(202) 331-1528**
 Email: ops@us.generaliglobalassistance.com
Emergency services must be coordinated through Generali Global Assistance. Services coordinated outside of this program may not be eligible for payment.

Policyholder name: _____
 Policy # _____ Group#57







Total Financial Wellness

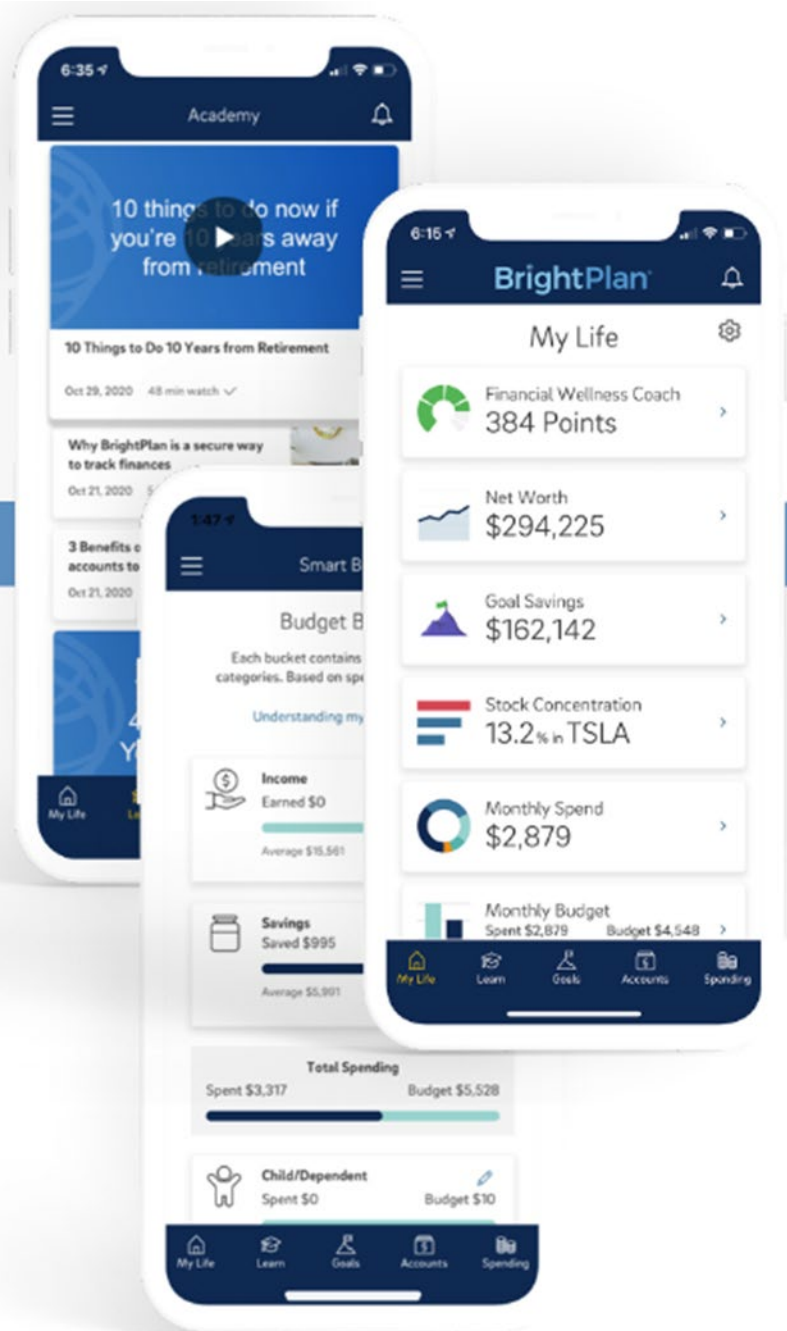


Your Financial Wellness Benefit

Your company has partnered with C3 to offer BrightPlan as your financial wellness benefit at no cost to you.

What's in it for you?

-  Take the pulse of your financial health
-  Meet with a financial planner
-  Create a custom plan for every goal
-  Financial education tailored to C3 benefits



Get Started Today!

Enroll at brightplan.com/enroll

Enroll at brightplan.com/enroll or download the BrightPlan app to get started.

Plan on-the-go!



Have questions? Contact BrightPlan Client Success at customer-service@brightplan.com or click "Contact Us" in the app.



HOW TO ACCESS MEDICAL ID CARDS

Download your ID Card in a few simple steps:

1. Go to Simplified Benefits Administrators' secure Member Portal at <https://tpa.uchealth.org/portals/>;
2. Follow the onscreen prompts to either register (if a first-time visitor to the site) or to login;
3. Once logged-in, select "ID Cards" on the upper right-hand side of the webpage; follow the instructions to access and print your ID Card. You can also request a permanent replacement card.

Understanding Your Medical Plan ID Card:

Your member ID card has valuable information for you and your medical provider. It is important that you keep your card with you at all times as the numbers, addresses, and logos on your card play a key role in the administration of your benefits plan.

DENTAL & VISION ID CARDS

For dental, Delta Dental will send an ID card for you and each enrolled family member to your address of record. If you misplace your card, call 1.80.610.0201 or go to www.deltadentalco.com to register and request a new card.

For vision, EyeMed typically does not send out an ID card – just tell your vision provider you're with EyeMed and they'll look you up online. Call EyeMed at 1.866.939.3633 or go to www.evemedcvisioncare.com to register and request a card should you need one.

NEED HELP UNDERSTANDING PRESCRIPTION BENEFITS?

You can access your drug formulary by visiting the SmithRx member portal at www.mysmithrx.com.

If you have questions regarding your prescription coverage you can also contact SmithRx Member Support for assistance at 1.844.454.5201. SmithRx's dedicated Member Support team is available to help you:

- Answer questions, help you resolve problems and give you helpful information
- Check whether your preferred pharmacy is in-network
- If you want to speak with someone in Spanish, bilingual representatives are available.



CLAIMS ISSUES OR SERVICE CONCERNS

Refer to the contact information provided on the back of your respective medical / dental / vision ID card. If further assistance is required, then contact the USI Insurance Services Benefit Resource Center.

Contact the Benefit Resource Center ("BRC")!

Toll Free: 855-874-0742

BRCMT@usi.com

Our Benefits Specialists can assist you Monday through Friday,
8am to 5pm MST, PST and AST





USI Partners with Language Line Services®

USI is pleased to announce our partnership with Language Line Services® to provide over the phone interpretation for employees and their dependents who are non-English Speaking or speak English as their second language.

Upon calling, simply indicate to the Agent who answers the call what language needs you have, and we will bring an interpreter onto the line.

There is no charge to you for utilizing this service. This is just another way USI is committed to providing quality customer service, regardless of what language is spoken.

Below are the languages that have over-the-phone interpretation available by calling 1-855-874-0742:

Acholi	French	Latvian	Romanian
Afrikaans	French Canadian	Lingala	Russian
Akan	Fukienese	Lithuanian	Samoa
Albanian	Fula	Luganda	Serbian
Amharic	Fulani	Lusoga	Shanghainese
Armenian	Fuzhou	Luxembourgeois	Shona
Assyrian	Gaddang	Maay	Sicilian
Azervajjani	Gaelic	Macedonian	Sinhalese
Azeri	Georgian	Malagasy	Sindhi
Bajuni	Gorani	Malayalam	Slovenian
Bambara	Greek	Maltese	Somali
Basque	Gujarati	Mandarin	Sorani
Behdini	Haitian Creole	Mandingo	Spanish
Belorussian	Hakka	Mandinka	Sudanese Arabic
Bengali	Hakka – China	Mankon	Swahili
Berber	Hausa	Marathi	Swedish
Bosnian	Hebrew	Marshallese	Sylhetti
Bravanese	Hindi	Mien	Szechuan
Bulgarian	Hmong	Mina	Tagalog
Burmese	Hungarian	Mirpuri	Taiwanese
Cantonese	Ibanag	Mixteco	Tajik
Catalan	Ibo	Moldovan	Tamil
Chaldean	Icelandic	Mongolian	Telugu
Chaochow	Igbo	Navajo	Thai
Chamorro	Ilocano	Neapolitan	Tibetan
Chavacano	Indonesian	Nepali	Tigre
Cherokee	Italian	Nigerian Pidgin English	Tigrinya
Chuukese	Jakartanese	Norwegian	Toishanese
Croatian	Japanese	Nuer	Tongan
Czech	Karen	Oromo	Tshiluba
Dakota	Kashmiri	Pahari	Turkish
Danish	Khmer (Cambodian)	Pampangan	Twí
Dari	Kinyarwanda	Pangasinan	Ukrainian
Dinka	Kirundi	Papiamento	Urdu
Dutch	Korean	Pashto	Vietnamese
Estonian	Kosovan	Patois	Visayan
Ewe	Krio	Pidgin English	Welsh
Farsi	Kurdish	Polish	Yiddish
Fijian Hindi	Kurmanji	Portuguese	Yoruba
Finnish	Lakota	Portuguese Creole	Yupik
Flemish	Laotian	Punjabi	

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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 coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

NEWBORNS ACT DISCLOSURE - FEDERAL

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

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.



- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.

No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 per day, until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

CONTACT INFORMATION

Questions regarding any of this information can be directed to:

Sara Nelson
 1460 Garden Of the Gods Road .
 Colorado Springs, Colorado, 80907
 303-412-4786
snelson@goodwillcolorado.org



THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

Your Information. Your Rights. Our Responsibilities.

Recipients of the notice are encouraged to read the entire notice. Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.



Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices



For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- In these cases we never share your information unless you give us written permission:

Marketing purposes

Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?

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

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications



- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

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

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.



MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE
FOR USE ON OR AFTER APRIL 1, 2011

If you are receiving this electronically, you are responsible for providing a copy of this notice to any Medicare Part D-eligible dependents who are covered under the group health plan.

Important Notice from Goodwill Of Colorado 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 Goodwill Of Colorado 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. Goodwill Of Colorado has determined that the prescription drug coverage offered by the 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.

CMS Form 10182-CC

Updated April 1, 2011

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.



MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE
FOR USE ON OR AFTER APRIL 1, 2011

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 Goodwill Of Colorado coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Goodwill Of Colorado coverage, be aware that you and your dependents will be able to get this coverage back.

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 Goodwill Of Colorado 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...

You'll 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 Goodwill Of Colorado changes. You also may request a copy of this notice at any time.

CMS Form 10182-CC

Updated April 1, 2011

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

OMB 0938-0990



MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE
FOR USE ON OR AFTER APRIL 1, 2011

For More Information About Your Options Under Medicare Prescription Drug Coverage...

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:	01/01/2024
Name of Entity/Sender:	Goodwill of Colorado
Contact--Position/Office:	Benefits Manager
Address:	1460 Garden of the Gods Road, Colorado Springs, CO 80907
Phone Number:	303-412-4786

CMS Form 10182-CC

Updated April 1, 2011

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.



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, 2023. Contact your State for more information on eligibility –

<p style="text-align: center;">ALABAMA – Medicaid</p> <p>Website: http://myalhipp.com/ Phone: 1-855-692-5447</p>	<p style="text-align: center;">ALASKA – Medicaid</p> <p>The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx</p>
<p style="text-align: center;">ARKANSAS – Medicaid</p> <p>Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)</p>	<p style="text-align: center;">CALIFORNIA – Medicaid</p> <p>Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov</p>
<p style="text-align: center;">COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)</p> <p>Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442</p>	<p style="text-align: center;">FLORIDA – Medicaid</p> <p>Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268</p>

<p align="center">GEORGIA – Medicaid</p> <p>GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2</p>	<p align="center">INDIANA – Medicaid</p> <p>Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584</p>
<p align="center">IOWA – Medicaid and CHIP (Hawki)</p> <p>Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562</p>	<p align="center">KANSAS – Medicaid</p> <p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660</p>
<p align="center">KENTUCKY – Medicaid</p> <p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms</p>	<p align="center">LOUISIANA – Medicaid</p> <p>Website: www.medicicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>
<p align="center">MAINE – Medicaid</p> <p>Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711</p>	<p align="center">MASSACHUSETTS – Medicaid and CHIP</p> <p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com</p>
<p align="center">MINNESOTA – Medicaid</p> <p>Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739</p>	<p align="center">MISSOURI – Medicaid</p> <p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>
<p align="center">MONTANA – Medicaid</p>	<p align="center">NEBRASKA – Medicaid</p>

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfnv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
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	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 8-31-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution –as well as your employee contribution to employer-offered coverage– is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Goodwill of Colorado's Benefits Manager, snelson@goodwillcolorado.org, 303-412-4786.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer – Goodwill of Colorado	4. Employer Identification Number (EIN) – 84-0513404	
5. Employer address – 1460 Garden of the Gods Road	6. Employer phone number – 719-635-4483	
7. City – Colorado Springs	8. State - CO	9. ZIP code - 80907
10. Who can we contact about employee health coverage at this job? – Sara Nelson		
11. Phone number – 303-412-4786	12. Email address – snelson@goodwillcolorado.org	

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

- As your employer, we offer a health plan to:

All employees. Eligible employees are:

Full-time = 30 hours per week

Some employees. Eligible employees are:

- With respect to dependents:

We do offer coverage. Eligible dependents are:

Legal Spouse

Children to age 26 or beyond if proved to be mentally or physically disabled

We do not offer coverage.

If checked, this coverage meets the minimum value standard*, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

- An employer – sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36 B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

The information provided in this brochure is for summary purposes only and is not a guarantee of benefits.



Goodwill of Colorado
1460 Garden of the Gods Road,
Colorado Springs, CO 80907
www.goodwillcolorado.org

This guide summarizes the benefit plans that are available to Goodwill of Colorado eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Goodwill Benefits Team.