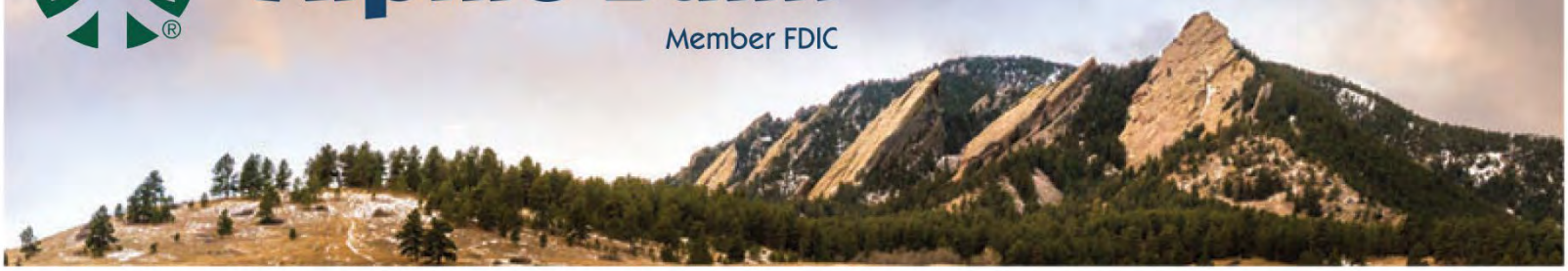
2025

EMPLOYEE BENEFITS GUIDE

Alpine Bank

Member FDIC



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

WELCOME

Human Resources

Meet your HR Team

Kristi Shelton, Executive Vice President	x4308
Gena Cooper, Senior Vice President	x1736
Barbara Koziol, Senior Vice President	x4314
Amy Plantz, Assistant Vice President	x4319
Cynthia Brekhus, Payroll Coordinator	x2020
Kris Erpestad, Benefits Coordinator	x4309
Jazmine Vogel, Wellness Program Coordinator	x4318
Pati Edquist, Administrative Assistant	x4323
Teresa Contreras, HR Generalist	x4315
Chrissy McCaslin, Onboarding Specialist	x4320
Jennifer Moser, Recruiting Coordinator	x4310
Katarina Harris, HR Benefits Assistant	x5982

Human Resources

The Human Resources department is full of information. We have a couple of different places to find what you may be looking for.

The UltiPro Website, https://ew42.ultipro.com, is where you may notify HR of changes to your insurance, address and more. **You will find all insurance policy information in this website. You may print out or view your Medical, Dental, Vision, Group Life, Voluntary Life, Flexible Spending, and Long-Term Disability policies.** You will also be able to find an abundance of information pertaining to Alpine Bank's Insurance and Benefits.

For all Summary Plan Descriptions (SPDs) and additional benefit information, please visit The Peek. You will find benefit and Human Resource Information under Support, then HR.

Alpine Bank Benefits Program

IMMEDIATE BENEFITS

Bank Services	Free Elite checking account and checks, safe deposit box, waived fees on cashier's checks, money orders, payroll direct deposit, one HSA account, reduced rates on installment loans.
***Paid Holidays**	11 paid holidays per year for full and part-time employees.
Employee Referral	Incentive bonus for referring an applicant who is hired. Additional compensation based on satisfactory employment with bank at 90 days, 180 days and 1 year.
Mortgage Dept. Referral	$100 per referral.
Wealth Management	10% of first year's fees per opened account (account must meet minimum requirements of $400,000).
Christmas/Holiday CD	$15,000 maximum, monthly variable rate based on Glenwood 1-year CD rate plus 1.5%, auto renews Nov. 1, penalty for early withdrawal.
Flex Time/Job Sharing/Remote Work	Available when it benefits both employee and bank without compromising customer service. (i.e. 4 – 10 hour days; 2-part timers: one works Mon, Tues, Wed; the other works Thurs, Fri, Sat am).
***Potential Year End Bonus**	Potential bonus based on profit performance.
Performance Based Incentives	Performance based incentives, dependent upon position.
Verizon	Discounts on your personal cell phone account
Microsoft	Discounts on Microsoft software for home use
Group Events	Regional Summer Party; Winter Holiday Party; Dues for professional and civic organizations
Paid Volunteer Time	3 days/24 hours per calendar year; no carry over.
Paid/Personal Sick Time	Non-exempt employees accrue 1 hour for each 30 hours worked.

Note: * Some benefits may be prorated for part-time employees.

Alpine Bank Benefits Program (continued)

Insurance Coverage	Bank pays the following premiums in full for employees: Dental plan, Vision plan, Life insurance, and Long-Term Disability. Medical plan has a small charge for Employee Only PPO Coverage.
Supplemental Insurance Coverage	Alpine offers a variety of supplemental insurance policies. Enrollment is available during Open Enrollment only
Health & Wellness Management	
Half Price Program	Up to $750 annual allowance for nutrition counseling, personal trainers, smoking cessation and more.
Alpine Fit Wellness Program	You can earn up to $1,400 per year allowance for participating in the Alpine Fit wellness program.
Health Screening	The Health Screening is comprised of a blood test (venipuncture) and biometrics (blood pressure, height and weight) to help identify health issues. The result is a comprehensive Health Screening Report.
Integrative Health & Wellness Coaching	***Limited Capacity Personalized health and wellness coaching is available to a limited amount of employees per year. This program is designed to help you live a better and healthier life.
Employee Assistance (EAP)	Triad Employee Assistance Program is a free and confidential service offered by Alpine Bank. Triad works with highly trained and qualified professionals who are experts in fields such as well-being, family matters, relationships, debt management, consumer rights, and much more. EAP benefits include short-term counseling for full-time and part-time employees, spouses, and dependent family up to 26 years old. It includes up to three counseling sessions per year, per incident.

Note: Your privacy is not compromised, and the results of your health screening are not disclosed to Alpine Bank

UPON 3 MONTHS EMPLOYMENT

Dependent Care Flex Plan	Contribute up to $5,000 per calendar year.
Employee Benefit Loan	Interest free benefit loan may be used towards the purchase of a computer, clothing or down payment toward a hybrid vehicle. Terms are a maximum amount of $2,000 for up to 20 months. Only one loan per employee may be outstanding at a time.
Jury Duty	If you are called for jury duty, 3 days/24 hours paid for scheduled work time.
Funeral Leave	Upon the death of a member of your immediate family, you may be granted up to 3 days of paid leave.
Employee Education Assistance	Tuition and textbooks for bank related course work (i.e. finance, bookkeeping, computer, Spanish) with management pre-approval.
401(k)	You have the opportunity to contribute a portion of your pay to a Traditional 401(k) and/or a Roth 401(k) through convenient payroll deduction. Contributions are then allocated to the investment options you select. You are eligible for the 401(k) after three months of service and may join on a quarterly basis. You are always 100% vested in your plan contributions and your rollover contributions, plus any earnings they generate. You can change your investment selections at any time. Enrollment, changes to the amount you are contributing to the plan, and your investment selections can be made on www.newportgroup.com.

Alpine Bank Benefits Program

UPON 1 YEAR EMPLOYMENT

Employee Stock Ownership Plan (ESOP)
The Alpine Banks of Colorado Employee Ownership Plan (ESOP) is an important part of our culture as well as a valuable retirement benefit plan. The single largest shareholder of Alpine Banks of Colorado stock is the ESOP, so as employee owners we all play an important part in the success of our organization.

The ESOP is completely funded by Alpine Bank, and the 401(k) is an opportunity for employees to save their own money for retirement. Participating in both components of the plan is easy!

ESOP:
Alpine Bank makes a discretionary contribution to the ESOP each year. Historically, this contribution has been 7% of total salaries. Again, the plan is fully funded by the bank – free to eligible employees!

You are eligible for the ESOP after one year of service (a year of service is defined as having worked 1,000+ hours in a consecutive 12-month period from your hire date). Upon meeting eligibility requirements, you are automatically enrolled on the next entry date. The entry dates in the plan are January 1 and July 1.

You are 100% vested after 6 years of service.

Years of Service	Vested Percentage
1	0%
2	20%
3	40%
4	60%
5	80%
6	100%

Please contact Gena Cooper x1736, genacooper@alpinebank.com or Katarina Harris x5985, katarinaharris@alpinebank.com if you have questions.

Note: This is a general summary. The complete terms of the plan are set forth in the plan document. In the event of any differences between this summary and the provisions of the plan, the actual plan document will govern.

***Paid Vacation**	3 weeks after 1 year; 4 weeks after 10 years; 5 weeks after 15 years; 5+ weeks after 25+ years. Options to sell up to 5 days after a 2-week vacation has been taken. Prorated for part time.
Medical Flex Plan	Maximum of $3,300.00 per calendar year.
First Time Homebuyers	Bank assistance, based on qualifications, for first time home buyers. Please contact your regions Mortgage Representative for more information.

Alpine Bank Benefits Program

UPON 2 YEARS OF EMPLOYMENT

Dependent Education Assistance Program (DEAP)	$750 per semester/$1,500 per calendar year, maximum assistance $6,000 per child, Full time college, vocational/technical schools, up to age 26.

SUMMARY OF INSURANCE PLANS

MEDICAL, PRESCRIPTION, DENTAL and VISION

UMR is your medical claims payer: **Group ID: 76-414959**

A spouse and/or dependent on the employee's plan will use the employee's card with his/her name andID number for identification, to receive benefits on the plan.

Claims/Eligibility Questions: 800-826-9781/ Website: www.umr.com

Your insurance card is a valuable source of information. Please keep them handy to show your providers and to call with any questions on claims.

UnitedHealthcare Choice Plus is our network for doctors, hospitals, labs, radiologist, etc. Visit www.umr.com or call your provider's office to confirm that the provider is contracted with UHC. Staying in-network saves you money.

Submit In-Network and Non-Network Medical Claims to: Most providers will do this for you electronically.

UMR
P.O. Box30541
Salt Lake City, UT 84130-0541

RxBenefits administers prescription drug benefits through the **Express Scripts network**. Copay and coinsurance amounts can be found on the front of your medical ID card.

Express Scripts Rx Group: 35242RX RxBin: 610014

RxBenefits Hotline: 800-334-8134 / Email: RxHelp@rxbenefits.com

Delta Dental is your dental claims payer: Group No. DD000002470
Claims/Eligibility Questions: 800-610-0201 / Website: www.deltadentalco.com

Submit Dental Claims to: Your provider may do this for you electronically.

Delta Dental
Group Dental Claims
PO Box 2459
Spokane, WA 99210-2459

Vision Service Plan (VSP) is your vision plan network: Group No. G-10-26573
Your member ID is your social security number.
In-network Claims/Eligibility Questions: 800-877-7195
Out- of-network Claims Questions: 800-877-7195
Website: www.vsp.com

MEDICAL

MEDICAL COVERAGE

Medical Coverage by UMR

Note: Proof of marriage and birth are required to add your spouse and/or child to your plans.

UnitedHealthcare PPO Plan		
Services	**In-Network**	**Out-of-Network**
Deductible Individual/Family	$1,000 Individual $2,000 Family	$2,000 Individual $4,000 Family
Out of Pocket Calendar Year Maximum Individual/Family	$3,300 Individual $6,600 Family	$20,000 Individual $40,000 Family
Preventative Care	Covered 100%	50% after deductible
Office Visits Primary Care/Specialist	20% after deductible	50% after deductible
Urgent Care	20% after deductible	20% after deductible
Emergency Room	20% after deductible	20% after deductible
Inpatient Hospital Services (pre-certification required)	20% after deductible	50% after deductible
Outpatient Hospital (pre-certification required)	20% after deductible	50% after deductible
Pharmacy	Non-Specialty: $10/$35/$70 Specialty: $150/$200/$250 $100 ded. per covered person; $200 per family	

Should you have any questions, please call the following resources:
Plan administrator: UMR 1-800-826-9781 www.umr.com
Provider network: UHC Choice Plus 1-800-804-1290 www.umr.com
Pharmacy benefits: ExpressScripts by RxBenefits 1-800-334-8134
Email:RxHelp@rxbenefits.com www.express-scripts.com

This is a brief description of your medical plan. Please refer to the actual plan documents or your plan administrator for more information.

MEDICAL

Medical Coverage by UMR

Note: Proof of marriage and birth are required to add your spouse and/or child to your plans.

UnitedHealthcare HDHP w/ HSA Option		
Services	**In-Network**	**Out-of-Network**
Deductible Individual/Family	$1,650 Individual $3,300 Family	$5,500 Individual $11,000 Family
Out of Pocket Calendar Year Maximum Individual/Family	$3,300 Individual $6,600 Family	$20,000 Individual $40,000 Family
Preventative Care	Covered 100%	50% after deductible
Office Visits Primary Care/Specialist	20% after deductible	50% after deductible
Urgent Care	20% after deductible	20% after deductible
Emergency Room	20% after deductible	20% after deductible
Inpatient Hospital Services (pre-certification required)	20% after deductible	50% after deductible
Outpatient Hospital (pre-certification required)	20% after deductible	50% after deductible
Pharmacy	20% after deductible	50% after deductible

*If enrolled in coverage other than employee only coverage, the entire family deductible must be met before coinsurance applies

Should you have any questions, please call the following resources:
Plan administrator: UMR 1-800-826-9781 www.umr.com
Provider network: UHC Choice Plus 1-800-804-1290www.umr.com
Pharmacy benefits: ExpressScripts by RxBenefits 1-800-334-8134
Email:RxHelp@rxbenefits.com www.express-scripts.com

This is a brief description of your medical plan. Please refer to the actual plan documents or your plan administrator for more information.

Prescription Drug Vendor – RX Benefits

RxBenefits is your pharmacy benefit administrator (PBA) and we have partnered with Express Scripts to bring Alpine Bank of Colorado members greater discounts, better access to more than 60,000 pharmacies, and improved member services.

Member Services

As part of your enhanced pharmacy benefits experience, you will have access to *RxAssure*, RxBenefits' in-house Member Service Team, available to assist you with questions such as:

- Is my drug covered? What will it cost?
- Is my pharmacy in the network?
- Can you help me transition my mail order scripts?
- Are there lower cost alternatives?
- Can you assist me with my claim questions?

RxAssure can assist you with every aspect of your pharmacy benefit plan, from answering coverage questions and ordering ID cards to resolve complex issues. Unlike an automated call center, our service line is staffed by "live" knowledgeable representatives, averaging more than eight years of experience. Our goal is to understand your needs and to deliver honest relevant information, ensuring you can fully understand your options.

Contact Us

Questions? Contact *RxAssure* at *1.800.334.8134* or *RxHelp@rxbenefits.com*

RxAssure team members are available from 7:00 am to 6:00 PM CST, Monday – Friday. During weekend and after hours and holidays, members are given the option to speak with an Express Scripts representative or leave a message for us to return theircall.

MEDICAL

HEALTH SAVINGS ACCOUNTS (HSA)

What is it?

- Bank account for health care expenses
- Must be enrolled in a High Deductible Health Plan (HDHP) and not enrolledin any traditional health insurance or Health Care FSA to make contributions
- Establish a Health Savings Account (HSA) through Alpine Bank free of charge.
- Portable – you can take it with you!
- Tax-free when used for qualified health care expenses for you and your qualified dependents, even if not participating in a HDHP
- No use-it-or-lose-it rule

Contributing to Your HSA

Set up direct deposit with Alpine Bank to contribute with pre-tax payroll deductions, or make your own HSA deposits and take a deduction on your personal tax return

How Much Can I Contribute to My Health Savings Account?

- For 2025, you can contribute up to $4,300.00 for individual coverage, or up to $8,550.00 for Family coverage.
- Participants age 55 or older may contribute an additional $1,000 to their HSA in 2025.
- See IRS Publication 969 for more information on the rules about HSA contributions and IRS Publication 502 for eligible and ineligible expenses.

FLEXIBLE SPENDING ACCOUNTS (FSA)

TASC Flexible Spending Accounts

Alpine Bank offers you the opportunity to enroll in a Flexible Spending Account (FSA) through TASC. Flexible Spending Accounts allow you to pay for eligible health care expenses using **tax-free** dollars – money taken out of your paycheck before income or Social Security taxes have been calculated.

There are two types of Flexible Spending Accounts:

Health Care FSA

This account allows you to set aside pre-tax dollars to help pay for qualified health care expenses such as deductibles, copays, prescribed over-the-counter medications, prescription drugs, hearing services, vision services, dental services, orthodontia, acupuncture, and chiropractic services. The maximum amount you can contribute is **$3,300.00** per year.

Dependent Care FSA

This account allows you to set aside pre-tax dollars to help pay for day care services for your eligible dependents which include child up to age 13 as well as disabled dependent adults. The maximum amount you can contribute is **$5,000.00** per year ($2,500 per year if married and filing separately).

Note: These accounts are separate. You cannot use money from one account to pay for expenses that are eligible under the other. Claims must be incurred during the plan year. If you are enrolled in a HDHP and have an HSA, you are NOT eligible to elect a Health Care FSA. If you are enrolled in the PPO plan, you are also eligible to enroll in a Health Care FSA.

How to Use

- Employees who choose to participate will receive a FlexSystem Claim card from TASC. This acts as a debit card on qualified health care expenses.

- Throughout the year you can use your FSA to reimburse yourself for qualified expenses on health care and daycare. To file a claim simply complete a claim form, attach a copy of the bill or receipt, and mail or fax it to TASC.

•Carefully review and estimate your expected expenses for the year before youmake your elections. FSA's are use it or lose it, so any amounts left over at the end of the year will be forfeited. **Please note: You may rollover up to $660 of unused medical FSA funds into your account for the next plan year**

REALMD TELEMEDICINE

What is it?

As an employee of Alpine Bank, you have 24/7/365 access to U.S. board-certified physicians who can consult, diagnose, and even prescribe medication via interactive audio or video through a webcam or mobile device!

Benefits to Using Telemedicine	When to Use Telemedicine
• 24/7 Access to a physician • Speak to a doctor at work, while home! • Save money by avoiding trips to the Urgent Care	• You are considering going to the ER or Urgent Care for a non-emergent issue traveling, or from • Don't want to drive to the doctor, at home, on your lunch break, business Emergency Room and trip, vacation
Common Conditions That Can Be Treated	
• Cold/Flu • Urinary tract infection more	• Cough, Congestion, sinus issues • Nausea, Rashes, Pink Eye, Constipation, and
To Schedule a Consult, Call 855-879-4332 Member Copay: $49	

How to Access Your Account

It's important to remember, the primary benefits holder must first activate their account before dependents can use the service. Dependents under 18 can be added within the primary member's account. Dependents 18 and older must create their own account and then follow the instructions to verify eligibility prior to starting a new visit. ***Providers can see dependents ages 2+.***

1. Go to **patient.relymd.app** and click **"Sign Up" if you are new** or click **"Login" if you have an existing account.**
2. Complete the fields and enter your email address and password and click **"Continue."**
3. Once you login you will need to **verify your benefits**. To do this, select **"Find benefit sponsor"** and start typing your **employer's name**, select it when it appears.
4. Once complete, you can start a visit. If you face any issues, please contact **855-879-4332** to speak with a care coordinator.

DENTAL

DENTAL COVERAGE

Smile! You have dental Insurance.
The Delta Dental plan provides a high level of family benefits. You can get discounts on services offered by dentists who are members of Delta's panel of dentists (see certificate for complete details.)

Delta Dental Plan Features Network Level	PPO Network	Premier Network	Out-of-Network
Calendar Year Deductible		$50 per Individual $150 per Family	
Calendar Year Maximum		$2,000	
Preventative Care (cleanings, x-rays, fluoride treatments)	Plan pays 100%	Plan pays 100%	Plan pays 100% of R&C
Basic Services (fillings, root canal, periodontics, extractions)	Plan pays 80%	Plan pays 80%	Plan pays 80% of R&C
Major Services (bridges, crowns, dentures, implants)	Plan pays 50%	Plan pays 50%	Plan pays 50% of R&C
Orthodontia (Children and Adults)	Plan pays 50% up to lifetime max of $1,000	Plan pays 50% up to lifetime max of $1,000	Plan pays 50% of R&C up to lifetime max of $1,000
Temporomandibular Joint Treatment (TMJ)	Plan pays 50% up to lifetime max of $1,000	Plan pays 50% up to lifetime max of $1,000	Plan pays 50% of R&C up to lifetime max of $1,000

R&C: The prevailing charge made by providers of similar expertise for a similar procedure in a particular geographic area. Out-of-Network pays at a percentage of R&C, which may result in more out of pocket for the employee.

To Find an In-Network Dentist:

1. **Go to www.deltadentalco.com and use the find a dentist search tool**
2. **Download the free Delta Dental mobile app and create and account**
3. **Call or email customer service at customer_service@ddpco.com or 1-800-610-0201**

Remember that your dentist can pull up your dental plan by using both your social security number or you ID card.

DENTAL COVERAGE

Our PPO Dental Plan utilizes three network options: PPO, Premier, and Non-Network. Seeing a PPO dentist in Delta's network will always give you the best benefit, and lowest cost. Please review the example below to see how PPO dentists can save you money on your dental care.

DENTAL | Example Procedure Cost Analysis			
Network	**PPO**	**Premier**	**Non-Network**
	Protected from balance billing		**Not protected from balance billing**
Procedure Cost	$1,200	$1,200	$1,200
Maximum Provider Can Charge Patient	$850	$975	$700
Benefit Percentage	50%	50%	50%
Delta Dental Pays	$425	$487.50	$350
Amount Dentist Can Balance-Bill	$0	$0	$500
You Pay	**$425**	**$487.50**	**$850**
Your Total Cost Savings	**$350**	**$225**	**$0**

VISION COVERAGE

VISION

Whether it's a day in the life or a day to remember, you're covered. Coverage is available from VSP, and with them, you'll get the personalized eye care you deserve. VSP will help you see well, stay healthy, and get the most out of life.

Each covered employee and their dependents are eligible to obtain the benefits outlined below under the vision care plan. These services may be provided by a VSP provider or from a provider of your choice. If a VSP provider is used, your expenses are less.

VSP Vision	In-Network	Out-of-Network
Annual Exam	$20 annual deductible then covered 100%	Reimbursed up to $45
Lenses (single vision, lined bifocal, lined trifocal)	$20 copay (every 12 months from the last date of service)	Reimbursed up to $30 single vision Reimbursed up to $50 lined bifocal Reimbursed up to $65 lined trifocal
Standard Retail Frame Allowance	$20 copay (every 24 months from the last date of service) $180 allowance	Reimbursed up to $210
Contacts Lens Allowance Medically Necessary / Elective	$20 copay then covered 100% $20 copay then $180 allowance	Reimbursed up to $105
Lens and Contact Frequency	Eligible for either 2 pairs of lenses or contacts per year, or one of each!	

This is a brief description of your vision plan. Please refer to the actual plan documents or your plan administrator for more information.

www.vsp.com. VSP customer service: 800-877-7195

***Note: Special Coatings, Progressive lenses and laminating of lenses are not covered benefits. These would be at additional cost to the member.**

2025 PER PAY PERIOD PRICING SCHEDULE

PPO Pricing Schedule				
	PPO Medical	Dental	Vision	Combined PPO/Dental/Vision Cost
Employee	$34.00	$0.00	$0.00	$34.00
Employee + Spouse	$148.00	$6.00	$2.00	$156.00
Employee + Child(ren)	$92.00	$8.00	$2.00	$102.00
Employee + Family	$160.00	$12.00	$4.00	$176.00

HDHP w/ HSA Pricing Schedule				
	HDHP w/ HSA Medical	Dental	Vision	Combined HDHP/Dental/Vision Cost
Employee	$0.00	$0.00	$0.00	$0.00
Employee + Spouse	$72.00	$6.00	$2.00	$80.00
Employee + Child(ren)	$34.00	$8.00	$2.00	$44.00
Employee + Family	$88.00	$12.00	$4.00	$104.00

The pricing schedule reflects the per pay period costs. If you decide to add dependents to your plan, you may add them to any combination of the insurance plans.

Because your medical, dental and vision benefits are paid on a pre-tax basis there are restrictions limiting the timing of your enrollment. Any change to your insurance will be restricted to making your changes at Open Enrollment or if you have a qualifying event. A qualifying event is a major life change, such as a change in marital status, birth, adoption, or employment status (full time to part time or part time to full time). Any change made due to a qualifying event must be done within 31 days of the event. If you ever have a need to make changes to your insurance plans, please contact HR

PATIENT ADVOCACY

Let us handle the healthcare stuff.

Health benefits can be confusing, medical costs are rising, and finding the right care for you and your family can be frustrating and time consuming. We are here to simplify your healthcare experience and help you take control of healthcare costs. Your personal Health Pro® consultant will take care of you, so you can spend more time on what matters most. We can help you…

- **Understand your benefits**
  Clear up any confusion about your health plan.
- **Find great doctors**
  Locate highly-rated doctors, dentists and eye care professionals.
- **Save money on healthcare**
  Compare prices and choose more cost-effective options.
- **Pay less for prescriptions**
  Get recommendations for lower-cost medications.
- **Resolve billing errors**
  Over 30% of medical bills are wrong. Don't get overcharged.
- **Schedule appointments**
  Have your appointments scheduled at times most convenient for you.

Get started.

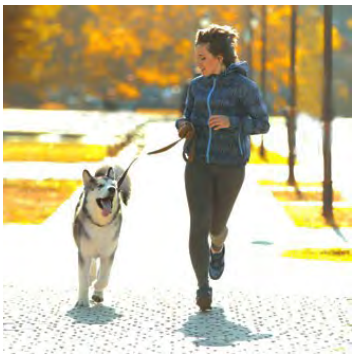
Member Portal: **Member.alight.com**
Health Pro: **Sunny.Mistry@alight.com | 800.513.1667 x3036**

alight

Alpine Bank employees have a dedicated Personal Health Pro, Sunny Mistry. Sunny is the main contact for Alpine Bank, however, you may speak to any Alight team member to ensure expedient service. Sunny may be reached at: 800.513.1667 ext. 3036 or via email at Sunny. Mistry@alight.com

Alpine Fit Wellness Program

Alpine Bank is continually looking for ways to help you improve and maintain your health. As a wise person once said, “An ounce of prevention is worth a pound of cure.” Plus, we think it’s the right thing to do. The Alpine Fit Wellness Program allows employees to earn up to $1,400 in 2025!



If you participate in our yearly blood screenings you are eligible for $200 just for participating. Eligibility for the remaining $600 in wellness, is based on your biometrics. Critical levels will not be eligible for reimbursement right away. If you are identified through the screening results as having a critical risk in any of the four categories outlined below, you still have an opportunity to receive the additional Wellness Dollars.

If you have not maintained your goal (same or improved biometric levels as last year), $150 will be deducted from the $600 total for each category you have a critical level.

Category	Amount
Blood Screening Participation	$200
Blood Pressure	$150
Cholesterol	$150
Glucose	$150
Triglycerides	$150
Total	$800

Spouses and dependents who are covered under our insurance, and 18 years of age or older, are also eligible to participate in the Blood Screening. No extra wellness dollars will be provided for spouse and dependent participation.

March 31st is the deadline for all Blood Screenings. If you are out of the office during the blood screenings provided by Alpine Bank you may get one from your physician. If this is the case, please contact Jazmine Vogel for further instruction.

Please note that non-benefitted employees can participate in Alpine Fit activities but do not receive any wellness dollars.

WELLNESS

Employees may choose four of the activities identified here to earn up to $400. Each item you complete is worth $100 up to a total of $400. Programs & Services available to you include:

PREVENTATIVE CARE COMPLIANCE (COMPLETE 4)
Annual Physical
Dental Exam
Vision Exam
Hearing Exam
Skin Exam
Mammogram
Pap Smear
Well Woman Exam
Testicular Exam
Prostate Exam
Colonoscopy
Other Cancer Screening
Flu Shot
COVID vaccine

Alpine Bank Wellness Rewards

Wellness Reimbursement Type	Wellness Dollar Amount
Blood Screening Participation	$200.00
Biometric Results	$600.00
Preventative Care Exams	$400.00
Alpine Fit Online Activities	$200.00
Total Amount Eligible in Wellness Dollars	**$1,400.00**

Well-Health Coaching

PATH TO WELLNESS PROGRAM

Offering personalized support and guidance on you path to wellness, this program is an interactive resource designed to guide your journey, helping you improve your health, overall well-being, and prevent/manage chronic conditions.

PROGRAM INCLUDES:

- One-on-one access to our highly qualified health coach
- One in-depth 40-minute virtual coaching session
- Six bi-weekly 20-minute virtual coaching sessions
- Online health assessment and customized wellness plan
- Accountability trackers to monitor your progress
- Weekly online support and useful tips to keep you engaged

HEALTH COACHING OFFERS SUPPORT IN AREAS SUCH AS:

LIFESTYLE MANAGEMENT

- Managing weight
- Eating healthy
- Physical activity
- Sleeping well
- Reducing stress
- Building resilience

HEALTH CONDITIONS

- High cholesterol
- Overweight
- Pre-diabetes
- Hypertension
- Mental Health
- Insomnia and sleep

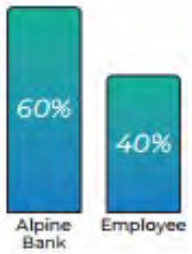
Well-Health Coaching

HEALTH COACHING OFFERS A RANGE OF BENEFITS, SUCH AS:

- Inner strength and balanced emotions
- Less fatigue and more energy
- Improvements in mood and mindset
- Reduced chronic pain, including joints
- Enhanced work-life balance
- A healthier, more enjoyable life

COST OF THE PROGRAM:

The cost of the Path to Wellness Program is $750. Alpine Bank covers 60%, leaving the participating employee responsible for the remaining 40%.



Participants may use their HSA or FSA funds cover their share of the cost.

INCENTIVE TO EARN WELLNESS POINTS:

Earn 1,000 wellness points upon completion of the program. These points go directly toward your wellness dollars.

To learn more details about the program or if you're ready to join, please reach out to our Wellness Program Coordinator, **Jazmine Vogel.**

GROUP LONG TERM DISABILITY INSURANCE – EMPLOYER PAID

What happens if you get sick or seriously hurt?

What would happen if you were seriously injured in a car accident or were diagnosed with cancer? You may eventually get better, but it may take a long time. And it is possible you might never be able to return to work.

In addition to dealing with health issues, how would you make your house and car payments, buy food, clothing and other essentials? A lot depends on our paycheck—that's why Alpine Bank provides long term disability (LTD) insurance.

If you are an active employee working 20 hours a week or more, you have long term disability insurance provided by Alpine Bank.

What kind of coverage is provided?

Once you are disabled for 180 days as defined by the plan, the benefit can pay 66 2/3% of your pre-disability monthly earnings, to a maximum of
$10,000 per month.

The amount of benefit you receive from the plan may be reduced or offset by income from other sources such as legal judgments, certain retirement plans and the amounts you receive or are entitled to receive as disability income from workers' compensation, a state compulsory benefit plan, and the amount you (and your family, if applicable) receive or are entitled to receive as disability payments under Social Security disability.

How long do payments last?

Your LTD benefits are payable for the period during which you continue to meet the definition of disability. Payments continue based on how old you are when your disability occurs. If your disability occurs before age 60, benefits will be payable to age 65 but not less than five years. If your disability occurs at or after age 60, benefits would be paid to the benefit duration schedule.

Additional features included in your LTD policy:

- **Rehabilitation and return-to-work assistance**—If you are deemed eligible and are participating in the program, the plan will pay an additional percentage of your gross disability payment for rehabilitation / work assistance.

- **Dependent care expense benefit—**If you are disabled and participating in the rehabilitation and return-to-work assistance program and have dependent care expenses, you may receive the dependent care expense benefit.

- **Survivor benefit—**Your eligible survivor will receive a lump sum benefit equal to three months of your gross disability payment if, on the date of your death, your disability had continued for 180 or more consecutive days, and you were receiving or were entitled to payments under the plan.

- **Conversion—**If you are terminating employment, you can convert your coverage to an individually paid plan without the evidence of insurability.

GROUP LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) – EMPLOYER PAID

We've got the basics covered!

If you are a new benefitted employee who works 20 hours a week or more, you have term life insurance equal to your annual salary rounded to the next highest $1,000 to a maximum of $400,000, minimum of $20,000, paid for by Alpine Bank. In addition, you have an equal amount of accidental death and dismemberment (AD&D) insurance.

If you are an active benefitted employee working 20 hours a week or more, and have been employed with Alpine Bank a year or more, you have term life insurance equal to your prior year W-2 wages. In addition, you have an equal amount of accidental death and dismemberment (AD&D) insurance.

What features are included?

Accelerated benefit — If you become terminally ill and are not expected to live more than 12 months, you may request a certain percentage of your life insurance amount up to the plan maximum without fees or present value adjustments. A doctor must certify your condition. Upon your death, any remaining benefit will be paid to your designated beneficiaries.

Portability /conversion — If you retire, reduce your hours or leave Alpine Bank, you can take this coverage with you, unless you have a medical condition which could shorten your life expectancy. In that case, you may be able to convert your term life policy to an individual life insurance policy.

Included with your AD&D plan

Education benefit — If you die within 365 days of a covered accident, this benefit can help defray the cost of tuition for your children if they are in college or other post-secondary school training.

Seat belt and airbag benefit — Pays an additional benefit if you die in a covered private passenger car accident while wearing a seat belt. An extra benefit is paid if the seat is protected by an airbag and seat belt and your seat belt is properly fastened.

Need to Change Your Beneficiary?

You may view or edit your beneficiary information at https://ew42.ultipro.com.

Go to: https://ew42.ultipro.com
Log into the system
Go to Benefits link
Choose Beneficiaries/Dependents

**NOTE: To update your 401K beneficiary, please contact Gena Cooper.

Coverage amount for life and AD&D insurance will reduce to 65% of original coverage and 50% of original coverage when you reach age 70. Coverage may not be increased after a reduction.

TRAVEL ASSISTANCE

Worldwide emergency travel assistance

Voya Travel Assistance offers you enhanced security whether you are traveling for business or personal reasons. With one phone call anytime of the day or night, you, your spouse* and dependent children can get immediate assistance anywhere in the world. Emergency travel assistance is available to you when you travel to any foreign country, including neighboring Canada or Mexico. It is also available anywhere in the United States for those traveling 100 or more miles from home.

At any time before or during a trip, you may contact Voya Travel Assistance for assistance services including: pre-trip information, emergency personal services, medical assistance services, and emergency transportation services.

Contact Voya Travel Assistance at: 800-859-2821 or ops@europassistance-usa.com
Online Portal: https://esirvices.europassistance-usa.com/sites/voya Group ID: N1VOY
Activation code: 140623

**A spouse traveling on business for his or her employer is not covered by the program.*

Funeral Planning Services

Included with your Basic Life insurance is a value-added service provided by Everest, for individuals who are dealing with funeral related issues. Everest, an independent, nationwide funeral planning and concierge service, is an independent consumer advocate who works on your behalf. Everest's sole purpose is to provide the information you need to make the most informed decisions about all funeral related issues, and then put those wishes into action.

Everest's services include:

- 24/7 Advisor Assistance — to discuss funeral planning issues
- PriceFinder Research Reports — nationwide database of funeral home prices with detailed comparisons
- Online Planning Tools
- At-Need Family Support — communicate the funeral plan to the funeral home, expedited life insurance claim assistance
- Negotiation Assistance — gather pricing information, negotiate funeral pricing with funeral home, help family compare prices of caskets and other products

For more information visit: www.everestfuneral.com/voya or call **800-913-8318**

TRAVELERS

Identity Fraud Expense Reimbursement Coverage

This document is a summary only and is intended to provide important information about the protection available to an Insured Person under the Identity Fraud Expense Reimbursement Policy (the "Policy"). Keep this coverage description for your records. This summary is not an insurance policy and does not amend, extend or alter the coverage afforded by the Policy described herein.

ALPINE BANKS OF COLORADO
has purchased the Identity Fraud Expense Reimbursement policy from Travelers Casualty and Surety Company of America in order to provide you, your spouse, qualified domestic partner, children under 18 and parents* with this valuable coverage.

Your Policy Number is: 105974635

Your Coverage Limit is: $20,000

Your Deductible is: $0

If you are a victim of Identity Fraud, please call Travelers to report your claim: 800.842.8496 or email at bfpclaims@travelers.com

The coverage reimburses identity fraud victims for the following:

- Lost wages as a result of time taken off from work to meet with, or talk to, law enforcement agencies, credit agencies and/or legal counsel, to complete fraud affidavits, or due to wrongful incarceration arising solely from someone having committed a crime in the insured person's name, up to $1,000 per week for five weeks up to the policy limit.
- Notary and certified mail charges for completing and delivering fraud affidavits.
- Fees to re-apply for loans that were denied because of erroneous credit information due to the identity fraud.
- Long distance telephone charges for calling merchants, law enforcement agencies or credit grantors to discuss an actual identity fraud.
- Attorney fees incurred, with Travelers' prior consent, for:
  - Defending suits brought incorrectly by merchants or their collection agencies
  - Removing criminal or civil judgments wrongly entered against the victim
  - Challenging information in a credit report
  - Release of medical records in cases of medical identity fraud
  - Contesting wrongfully incurred tax liability
  - Contesting the wrongful transfer of ownership of an insured person's tangible property
- Costs for daycare and eldercare coverage, if that coverage is necessary for an insured person to attend meetings or otherwise have the ability to restore financial health and credit history as a result of identity fraud.
- Travel and accommodations expense up to $1,000 per week up to five weeks which are incurred in the process of resolving fraud.
- Expenses and fees for new government issued identification such as passports, drivers license and social security cards.
- Expense and fees for copies of health records for purpose of investigating medical identity fraud.

*Unless modified by endorsement. Children and Parents must reside in your household in order to qualify for coverage.

VOLUNTARY LIFE INSURANCE– EMPLOYEE PAID

Why consider group voluntary termlife?

Group voluntary term life provides additional term life insurance at affordable group rates. And you get to choose the amount of coverage that is just right for you.

Who is eligible?

If you are an active employee (see next page) and work at least 20 hours each week, you may apply for coverage for yourself, your spouse and eligible children to age 26.

How much life insurance coverage can I get?

Employee — Up to $320,000 or 3 times your annual salary guarantee issue amount (see next page).

Spouse — Up to $30,000 guarantee issue amount
Children — $10,000 guarantee issue amount.
Note: Children age 1 day to 6 months have a $1,000 benefit.

Once you are enrolled in the plan, you and your spouse may purchase additional life insurance coverage up to the guarantee issue amounts without evidence of insurability.

Can I apply for more coverage?

Employee – Up to five times your annual salary in increments of $10,000, to a maximum of $500,000. Amounts over the guarantee issue limit will require evidence of insurability (*see next page*).

Spouse – Up to 100% of your coverage in increments of $5,000, to a maximum of $500,000. Amounts over the guarantee issue limit will require evidence of insurability.

In order to purchase life insurance and AD&D coverage for your spouse and eligible children, you must buy coverage for yourself. They cannot have more coverage than you do.

Spouse and Child(ren) are also eligible for voluntary AD&D coverage under the same parameters and plan design as the voluntary life insurance. Employee must be covered under the voluntary AD&D to cover spouse and children.

Coverage amounts for life insurance for you and your spouse will reduce to 65% of the original amount when you reach age 65, and will reduce to 50% when you reach age 70. Coverage may not be increased after reduction.

What other features are included?

Accelerated benefit – If you become terminally ill and are not expected to live more than 12 months, you may request a certain percentage of your life insurance amount up to the plan maximum. A doctor must certify your condition. Upon your death, any remaining benefit will be paid to your designated beneficiaries.

Portability / Conversion – If you retire, reduce your hours or leave Alpine Bank, you can take this coverage with you, unless you have a medical condition which could shorten your life expectancy. In that case, you may be able to convert your term life policy to an individual life insurance policy.

Waiver of premium — If you become disabled (as defined by your plan) and are no longer able to work, your life premium payments will be waived during the period of disability.

Included with your AD&D plan

Education benefit – If you or your insured spouse dies within 365 days of a covered accident, this benefit can help defray the cost of tuition for your children if they are in college or other post-secondary school training.

Seat belt and airbag benefit – Pays an additional benefit if you die in a covered private passenger car accident while wearing a seat belt. An extra benefit is paid if the seat is protected by an airbag and seat belt **and** your seat belt is properly fastened.

VOLUNTARY LIFE AND AD&D RATE CALCULATION

Insurance terms explained

Guarantee issue — Newly hired or newly eligible employees may apply for up to $320,000 of term life insurance for yourself and up to $30,000 for your spouse without answering any health questions or taking a physical exam. *That's what is meant by guarantee issue.*

Evidence of insurability— If you did not enroll when you were originally eligible or elect coverage amounts above the guarantee issue for yourself or your spouse, you will need to fill out and sign a medical history form. You may also be asked to take a health exam. *That's what is meant by providing evidence of insurability*.

Active employment — You are considered in active employment, if on the day you apply for coverage, you are being paid regularly by Alpine Bank for working at least 20 hours each week, and you are performing the material and substantial duties of your regular occupation.

Voluntary Term Life and AD&D coverage monthly rates

Rates shown are your monthly deduction. Your rate will increase as you move to the next age group. A tobacco user is defined as anyone who currently uses or has used a tobacco product within the last 12 months.

	Employee rate per $10,000		Spouse rate per $5,000	
	Non-tobacco	Tobacco	Non-tobacco	Tobacco
<25	$.26	$.39	$.13	$.20
25-29	$.30	$.44	$.15	$.22
30-34	$.39	$.58	$.20	$.29
35-39	$.56	$.90	$.28	$.45
40-44	$.78	$1.38	$.39	$.69
45-49	$1.25	$2.19	$.63	$1.10
50-54	$1.90	$3.66	$.95	$1.83
55-59	$3.06	$5.10	$1.53	$2.55
60-64	$4.78	$7.45	$2.39	$3.73
65-69	$5.38	$7.98	$2.69	$3.99
70-74	$7.45	$10.76	$3.73	$5.38
75+	$15.41	$19.89	$7.70	$9.94

Child life monthly rate is $2.00. One life premium covers all children.

AD&D coverage rates - Monthly

		AD&D	Cost
	Employee	Per $10,000	$.24
	Spouse	Per $5,000	$.12
	Children	Per $2,000	$.07

Cost Calculation

To calculate your cost, select your coverage amount and rate based on your insurance age. To calculate your insurance age, subtract your year of birth from the year your coverage becomes effective.

For example: Let's say you are 38 and a non-tobacco user who would like to apply for $50,000 of voluntary term life. Take $50,000 and divide it by $10,000. Multiply that number by $.56 (your rate based on your insurance age) and you get a monthly cost of $2.80.

Voluntary term life calculation worksheet

Coverage amount			Increment		Rate	Monthly Cost
Employee	$_____	÷	$10,000	x	$_____	$_____
Spouse	$_____	÷	$5,000	x	$_____	$_____
Children	$_____	÷	$2,000	x	$_____	$_____
			TOTAL MONTHLY COST			$_____

AD&D calculation worksheet

Coverage amount			Increment		Rate	Monthly Cost
Employee	$_____	÷	$10,000	x	$_____	$_____
Spouse	$_____	÷	$5,000	x	$_____	$_____
Children	$_____	÷	$2,000	x	$_____	$_____
			TOTAL MONTHLY COST			$_____

Discover which benefits are right for you - at Youville®!

Few things are more important than knowing what benefits you need in each stage of your life. After all, the right benefits can help protect you financially during unexpected times of need.

Fortunately, understanding your benefits is not nearly as difficult as you may think.

An educational website called Youville is here to help you quickly become more knowledgeable about employee benefits.

The site offers:

- Information on financial protection.
- Personalized benefit recommendations.
- Insurance terms to know.
- Guidance around changing needs at different life stages.

A visit to Youville better prepares you for your counseling session.

- ✓ Go to the Youville website.
- ✓ Complete the brief questionnaire.
- ✓ Print out your personal benefit recommendations and summary showing the benefits your employer offers.
- ✓ Take the printout with you to a 1-to-1 session with your Colonial Life benefits counselor.

You'll be more informed about the benefit options that can help protect you and your family.

So what are you waiting for?
Visit us at

http://visityouville.com/AlpineBank

While you're there, be sure to subscribe to *The Youville Reporter* for tips about health and financial protection.

Colonial Life.
Making benefits count.

Colonial Life
1200 Colonial Life Boulevard
Columbia, South Carolina 29210
colonialife.com

1/13

100990

COLONIAL ACCIDENT INSURANCE – EMPLOYEE PAID

Hearing the word "oops" is never a good thing

Maybe your spouse fell off the ladder while cleaning the gutters, or your child tripped and broke a tooth playing outside, or you threw out your back while cleaning the garage.

Unexpected accidents always have lousy timing, especially when you are responsible for insurance deductibles and out- of-pocket costs. You need a plan that helps you protect your family and your wallet. Voluntary accident insurance from Colonial can help with:

- Hospitalization deductibles and copays
- Doctor visit copays
- Visits to the emergency room
- Physical therapy
- Transportation and lodging

Colonial Basic Accident Rates (no health screening)	
Coverage	**Semi-monthly premium**
Individual	$7.22
Individual and Spouse	$9.82
One-parent family	$11.53
Two-parent family	$14.13

Features you'll appreciate:

Accident insurance can help cover the extra costs that can occur when you, your spouse or your children suffer a covered injury—like those that can happen during a game of pick-up basketball or when your kids go rollerblading. It also covers on-the-job accidents.

- **No health questions to answer**—You will automatically receive the base plan if you apply.
- **Guaranteed renewable**—As long as you pay the premiums on time, your base coverage is guaranteed renewable for life— policy provisions cannot be changed.
- **Lump sum benefit**—You will receive a predefined benefit based on the injury or qualifying event.
- **Family coverage**:
  - Employees age 17-80 who are actively at work for a minimum of 20 hours per week are eligible to apply.
  - Spouses age 17 to 80 are eligible to apply if they arenot disabled.
  - Dependent children who are between 14 days through 24 years old are eligible.

Other important information

- Premiums are automatically deducted from your paycheck
- Coverage becomes effective the first day of the month in which payroll deductionsbegin.
- You own the policy and can take it with you if you leave the company or retire. Colonial will bill youat home for the same premiumamount.

Colonial Schedule of Benefits

Colonial Schedule of Benefits	
Base Accident / Injury	**Benefit amount**
Accidental death	
Employee	$40,000
Spouse	$40,000
Child	$8,000
The accidental death benefit doubles if the insured individual is injured as a fare-paying passenger on a common carrier.	
Ambulance	$120
Air ambulance	$1,200
Appliance	$75
Blood, plasma and platelets	$300
Burns	
Based on degree and size	Up to $12,000
Skin Graft	50% of burn benefit
Catastrophic accident: loss of use of sight in both eyes, hearing both ears, speech, arms or legs*	
Employee <65	$50,000
Amounts reduced for covered persons over age 65	Reduced by 50%
Over age 70	Reduced by 50% of the already reduced amount
Concussion	$60
Dental work, emergency	
Extraction	**$50**
Crown	$200
Dislocations	
Based on joint and if repaired by open or closed reduction	$90-$3,600
Emergency room treatment (includes x-rays)	$75
Eye injury – requires surgery or removal of foreign body	$200
Follow-up treatment for accident – initial follow-up visit	$50
Fractures	
Based on joint and if repaired by open or closed reduction	$90-$4,500
Health Screening Benefit	$50
Hospital admission * (per admission)	$750/Accident
Hospital confinement (per day up to 365 days)	$175
Hospital ICU Admission*	$1,500/Accident
Hospital intensive care unit (per day up to 15 days)	$350
Knee cartilage (torn)	$500
Laceration	$30-$500
Lodging (per night up to 30 days)	$100
Loss of finger, toe, hand, foot or sight	$600-$12,000
Physical Therapy (10 visits/accident)	$25 per day
Prosthetic device or artificial limb	
One	$500
More than one	$1,000
Ruptured disc	$500
Surgery benefit (Cranial, open abdominal, thoracic)	$1,000
Exploratory or Arthroscopic	$150
Tendon/ligament and rotator cuff	
Repair of one	$500
Repair of more than one	$1,000
Transportation (up to 3 trips per accident)	$400

*Colonial will pay either the Hospital Admission or Hospital ICU Admission benefit, not both.
Please see the policy provisions for complete details about these covered benefits. Accident coverage is a limited policy.

Group critical illness with wellness, recurrence and cancer benefit

Employee-paid

Could your bank account survive a serious illness?

Thanks to modern medicine, more people are surviving heart attacks, strokes and other critical health problems. But the "cure" often comes at a high price. Even with medical insurance, you could face thousands of dollars in out-of-pocket costs such as:

- Copays and deductibles
- Prescriptions
- Rehabilitation
- Transportation to a health facility outside your city
- Family travel for visits
- Child or elder care

How does it work?

Critical illness insurance can pay a lump sum benefit at the diagnosis of a covered illness. You choose the level of coverage-from $5,000 to $100,000.

The money is paid to you, not to the medical provider, such as a doctor or hospital. You can use the money any way you see fit, so you can stay focused on getting well, rather than on your bills. And the amount you receive is not reduced if your health insurance pays for some of your treatment.

Who can apply for coverage?

Who can have it?	Benefit
Employees who are permanent and actively working 20 hours or more per week	$5,000 to $100,000 in $1,000 increments. (Amounts over $75,000 require underwriting approval)
Child(ren) newborn through age 24 and unmarried	Automatically covered at 25% of employee benefit amount.
Spouse ages 17 to 70 with purchase of employee coverage	From $5,000 to $40,000 in $1,000 increments. If spouse is covered under the employee's plan, their face amount is 50% of the employee's coverage.

What's Covered?

Covered Conditions	
Heart Attack	Blindness
Major organ failure	End-stage renal (kidney) failure
Occupation HIV	Coronary artery bypass surgery; pays 25% of lump sum benefit
Cancer	

Covered Conditions with time limitations	
Stroke	The date a Stroke occurring based on neuroimaging or other neuro-diagnostic study consistent with an acute or subacute infarction, hemorrhage, embolism, thrombosis and presence of neurological deficits persisting for a period of 30 days or greater
Coma	Coma resulting from a Covered Accident or a Covered Sickness has lasted seven or more consecutive days
Permanent paralysis	Complete and permanent loss of the use of two or more limbs through paralysis as a result of a Covered Accident as defined in the policy for a continuous period or 180 days, as confirmed by a Doctor. Loss of use of two or more limbs through paralysis as the result of a Stroke will not be construed as Permanent Paralysis due to a Covered Accident for purposed of the policy.

Optimal cancer conditions
If selected by your employer, you may choose to select this benefit for an additional premium.
Cancer
Carcinoma in situ*
Please see policy definitions for complete details about these covered conditions. *Cancer that involves only cells in the tissue in which it began and that has not spread to nearby tissues. See you certificate for details

Key advantage

You can use this coverage more than once. If you receive a full benefit payout for a covered illness, your coverage can be continued for the remaining covered conditions. The diagnosis of a new covered illness must occur at least 90 days after the most recent diagnosis. Each condition is payable once per lifetime.

A wellness benefit is also included

This benefit can pay $50 per calendar year per insured individual if a covered health screening test is performed, including:

- Blood tests
- Chest x-rays
- Stress tests
- Mammograms
- Colonoscopies

A full list of covered tests will be provided in your certificate.

A recurrence benefit is also included

This benefit can provide an additional payout for a second occurrence of:

- Benign brain tumor
- Coma
- Heart attack
- Stroke
- 12 months must elapse between occurrences of the same condition
- A benefit payout of 25% is available, based on the plan selected by your employer

Group

Semi-monthly premium for				
Age	Without cancer coverage		With cancer coverage	
	Non-tobacco	Tobac-co	Non-tobacco	Tobac-co
17-24	$0.12	$0.16	$0.20	$0.28
25-29	$0.15	$0.23	$0.29	$0.44
30-34	$0.20	$0.33	$0.40	$0.65
35-39	$0.34	$0.52	$0.57	$.91
40-44	$0.42	$0.70	$0.70	$1.17
45-49	$0.58	$.93	$0.96	$1.53
50-54	$0.79	$1.24	$1.38	$2.15
55-59	$1.01	$1.62	$1.73	$2.78
60-64	$1.31	$2.01	$2.34	$3.60
65-70	$1.50	$2.31	$2.61	$4.04
Semi-monthly wellness premium				
Employee and Children				$1.00
Employee, children and				$1.55

Group critical illness insurance is a limited policy.

Why should I buy at work?

- You get affordable rates when you buy this coverage through your employer, and the premiums are conveniently deducted from your paycheck.
- Coverage is portable. You may take the coverage with you if you leave the company or retire without having to answer new health questions. Colonial will bill you directly for the same premium amount.

More about cancer coverage

- Your policy also contains optional cancer coverage
- Upon first diagnosis of cancer, as defined by the policy, you will be paid up to 100% of the benefit amount.
- Upon first diagnosis of carcinoma in situ,* as defined in the policy, you will be paid 25% of the benefit amount.

Individual Short Term Disability Insurance

Being unable to work shouldn't hurt your bank account

It's not life-threatening—a broken arm, hysterectomy, or maybe you're going to have knee surgery—but you're going to miss work for several weeks, even a month or two. How are you going to pay the bills? Maybe you have a week or two of sick leave or earned time off, but after that, what happens?

Fortunately, Alpine Bank provides you an opportunity to purchase individual short term disability insurance from Colonial. It can pay you a percentage of your income if you become disabled due to a covered illness or off-the-job accident.

- During this enrollment period, if you are actively at work and work a minimum of 20 hours per week, you can apply for coverage of up to 60% of your gross monthly salary to a maximum of $6,500 by answering a few health questions.
- Because you pay your premium with post-tax dollars, your benefit will not be taxed, under current tax laws.

SAMPLE individual short term disabiltiy rates

Semi-Monthly Premium

7 days injury/7 days illness/3 month benefit period

Annual Salary	60% Monthly Benefit	Issue age 17 - 49	Issue age 50 - 64	Issue age 65 - 74
$25,000	$1,200	$16.86	$19.32	$23.46
$30,000	$1,500	$21.08	$24.15	$29.33
$35,000	$1,700	$23.89	$27.37	$33.24
$40,000	$2,000	$28.10	$32.20	$39.10
$45,000	$2,200	$30.91	$35.42	$43.01
$50,000	$2,500	$35.13	$40.25	$48.88
$55,000	$2,700	$37.94	$43.47	$52.79
$60,000	$3,000	$42.15	$48.30	$58.65
$65,000	$3,200	$44.96	$51.52	$62.56
$70,000	$3,500	$49.18	$56.35	$68.43
$80,000	$4,000	$56.20	$64.40	$78.20
$90,000	$4,500	$63.23	$72.45	$87.98
$100,000	$5,000	$70.25	$80.50	$97.75
$130,000	$6,500	$91.33	$104.65	$127.08

Choose the coverage that best suits your needs.

- The following plans are available: 7/7/3, 14/14/6 and 30/30/6. The first number is the elimination period for an accident. The second number is the elimination period of sickness. This is the number of days of continuous disability due to a covered off-the-job injury or illness which must be satisfied before you are eligible to receive your benefit.
- The third number refers to the benefit duration or benefit period, the number of months you may be eligible to receive benefits.

Features you'll appreciate:

- **Affordable coverage**—Your premiums are based on your age when you buy the insurance and will not increase when you move into the next age band.†
- **Guaranteed renewable**—You own the policy and can take it with you if you leave Alpine Bank. As long as you pay your premiums on time, your coverage is guaranteed renewable until age 70.
- **Payroll deduction**—Your premiums are automatically deducted from your paycheck.
- **Maternity coverage**—Pregnancy is covered nine months after coverage becomes effective. Medical complications due to pregnancy are considered the same as any other covered illness, subject to pre-existing condition limitations. Monthly benefits are payable when the elimination period is satisfied.

Contact HR to Enroll in:

- **Individual Short Term Disability**
- **Critical Illness**
- **Accident**

The above rates are based on coverage of 66 2/3% of gross monthly salary.

†Premiums can be changed only if they are changed on all polices of this kind inforce in the state where the policy is issues

CONTACT INFORMATION

Refer to this list when you need to contact one of your benefit vendors. For general information contact Human Resources.

MEDICAL	
Provider Name:	UMR
Funding	Shared Funding
Provider Phone Number:	Customer Care – 800-826-9781
Provider Web Address:	www.umr.com

DENTAL	
Provider Name:	Delta Dental
Funding	Shared Funding
Provider Phone Number:	1-800-610-0201
Provider Web Address:	www.deltadentalco.com

VISION	
Provider Name:	VSP
Funding	Shared Funding
Provider Phone Number:	VSP Customer Services - 800-877-7195
Provider Web Address:	www.vsp.com

FLEXIBLE SPENDING ACCOUNTS (FSA)	
Provider Name:	TASC
Funding	Employee Contributions
Provider Phone Number:	800-422-4661
Provider Web Address:	uba.tasconline.com

PROVIDER NETWORK

Provider Name:	UnitedHealthcare Choice Plus
Funding	Shared Funding
Provider Phone Number:	800-826-9781
Provider Web Address:	www.umr.com

PHARMACY

Provider Name:	Express Scripts By RxBenefits
Funding	Shared Funding
Provider Phone Number:	800-334-8134; RxHelp@rxbenefits.com
Provider Web Address:	www.express-scripts.com

ESOP & 401(k)

Provider Name:	Newport
Funding	Employer Paid - ESOP/Employee Paid - 401(k)
Provider Phone Number:	844-749-9981
Provider Web Address:	newportgroup.com

LIFE/AD&D & LONG TERM DISABILITY

Provider Name:	Voya
Funding	Employer Paid
Provider Phone Number:	Life/AD&D - 800-955-7736 / LTD - 800-328-4090
Provider Web Address:	claimscenter.voya.com

VOLUNTARY LIFE/AD&D

Provider Name:	Voya
Funding	Employee Paid
Provider Phone Number:	800-955-7736
Provider Web Address:	claimscenter.voya.com

ACCIDENT/CRITICAL ILLNESS/SHORT TERM DISABILITY

Provider Name:	Colonial
Funding	Employee Paid
Provider Phone Number:	Customer Service – 800-325-4368 Decrease or Cancel Benefits – 800-635-5597

CONCIERGE MEDICAL

Provider Name:	Alight
Funding	Employer Paid
Provider Phone Number:	1-800-513-1667 x3036 Sunny.Mistry@alight.com

INSURANCE CONSULTANT

Provider Name:	IMA
Provider Phone Number:	Erik Johnson – 1-303-615-7543 Lindsay Powers– 1-720-994-4801

Annual Notices

Alpine Banks of Colorado
50891 Hwy 6
Glenwood Springs, CO 81601
970-384-4309

The following pages provide employee benefit plan notices. Please read them carefully as we generally provide these once a year during annual open enrollment. You may see some of these notices in other documents as well, but we consolidate the following notices here for your convenience:

If you (and/or your dependents) have Medicare or will be eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 2 for more details.

Throughout these pages you are invited to "contact HR" for assistance. For any questions or requests you may have about the pages below, including a request for a paper copy of this notice packet, contact Kris Erpestad in human resources at 970-384-4309

Before we get into the notices, some basic rules governing our plan are summarized below:

- You may only enroll when first eligible or during our annual open enrollment each November.
- **Your election is locked** for the entire plan year, January 1 to December 31.
- You can generally submit an election change form **within 30 days of a qualifying life event** to request a benefit change during the plan year. We may require substantiating documentation of the event, and we may determine the event does not qualify to make the requested change.
- At any time, we may audit dependent status and require current substantiating documentation.
- Declining to enroll in coverage will require your signature each year.
- **Please keep us informed of address or beneficiary changes**.
- When first enrolling in health coverage, a **general notice of rights and responsibilities to continue health coverage under COBRA** is mailed to the home. It explains that when certain life events make an enrolled individual no longer eligible to stay on the plan, coverage might be able

to continue for a limited time under COBRA so long as you or your spouse follow our procedures to notify us within 30 days of the qualifying life event.

- Your rights and responsibilities under the FMLA and our company-specific FMLA policies are discussed in our employee handbook.

MEDICARE PART D PRESCRIPTION DRUG CREDITABILITY/NON-CREDITABILITY

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

Below are highlights to note:

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

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

Creditable Coverage	Non-Creditable Coverage
Alpine Bank PPO **Alpine Bank HDHP**	**None (all plans are creditable)**

Anyone needing to learn more about Medicare should contact a Medicare-approved counselor in their state at https://www.medicare.gov/Contacts/#resources/ships.

OUR PLAN PAYS SECONDARY TO DISABILITY-BASED MEDICARE AFTER BEING SOCIAL SECURITY DISABLED FOR 24 MONTHS

When you or a dependent are determined disabled by the Social Security Administration, it is imperative such individual have Medicare begin immediately after 24 months of Social Security disability.

Regardless whether the individual is enrolled in Medicare or not, our plan will calculate how much Medicare would have paid and then pay secondary (meaning it will pay very little or nothing).

If we employ 100 or more full- and part-time employees during 50% or more of business days during the previous calendar year, then we will give everyone an update that our plan will begin paying primary (not secondary) to disability-based Medicare.

Anyone needing to learn more about Medicare should contact a Medicare-approved counselor in their state at https://www.medicare.gov/Contacts/#resources/ships.

NON-GRANDFATHERED MEDICAL PLAN APPEALS PROCESSES

Your medical plan booklet will explain how to appeal a claim denial through the plan, through a government-authorized third party, and with the help of a consumer assistance office.

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

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

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

These benefits will be provided subject to the same deductibles and co-insurance applicable to other medical and surgical benefits provided under the medical plan. If you would like more information on WHCRA benefits, please contact HR.

PUBLIC HEALTH INSURANCE MARKETPLACE

For individuals needing to purchase health insurance on their own, the Affordable Care Act (ACA) created a new public health insurance Marketplace. This website and call center helps individuals shop for private health insurance, helps individuals enroll in Medicaid or the Children's Health Insurance Program (CHIP), and evaluates eligibility for new tax credits. Open enrollment for public Marketplace coverage occurs each fall for coverage starting January 1, but special enrollment periods may be available for certain life events. Learn more or request assistance at www.healthcare.gov.

Please note that insurance companies are not required to participate in the public Marketplace, so you are unlikely to see all plans available in the community when shopping the public Marketplace.

The public Marketplace can help you determine whether you may be eligible for tax credits under section 36B of the Internal Revenue Code for Marketplace coverage. One tax credit can lower your monthly premium, and the other can lower your cost sharing (such as your deductible). Since tax credits are based on your projected household income and typically paid in advance to the insurance company, there is a chance you may have to repay some or all tax credits on your tax return if your income for the year ends up higher than anticipated.

Tax credits are not available to those eligible for "affordable, minimum value" medical coverage. "Minimum value" means our plan is intended to pay, on average, at least 60% of the costs of medical care received. "Affordable" means our lowest-cost minimum value plan costs you no more than 9.5% (indexed annually) of your household income to be enrolled in single (not family) coverage.

Our plan is intended to be affordable and minimum value. As a result, if you or someone in your family wanted to compare your health insurance options in the public Marketplace to the insurance offered through us, you'll need to remember that:

- You might pay full retail price for public Marketplace insurance (without the new tax credits)
    a) You would no longer be paying for insurance on a pre-tax basis
    b) You would no longer have an employer contribution toward your insurance (note that employer contributions are typically excludable from income for federal income tax)
- You would navigate any questions you have directly with the insurance company you choose…HR will not be able to assist you with your public Marketplace plan
- Should you desire to come back to our plan in the future, you will either need to:
    a) experience a "qualifying event" recognized by our plan as a mid-year election change, or
    b) wait until our next annual open enrollment

SPECIAL MEDICAL ENROLLMENT RIGHTS AND RESPONSIBILITIES UNDER HIPAA

When you are eligible to participate in our group medical plan, you may have to enroll and agree to pay part of the premium through payroll deduction in order to actually participate.

A federal law called the Health Insurance Portability and Accountability Act (HIPAA) requires that we notify you of your right to enroll in the plan under its "special enrollment provision" if you acquire a new

dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

SPECIAL ENROLLMENT PROVISION

- **Loss of Eligibility under Medicaid or a State Children's Health Insurance Program (CHIP).** If you decline enrollment for yourself or for an eligible dependent (including your spouse) while coverage under Medicaid or CHIP is in effect, you may be able to enroll yourself and your dependents in this plan **if eligibility is lost for the other coverage**. However, **you must request enrollment within 60 days** after the other coverage ends.
- **Loss of Eligibility for Other Coverage.** If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other medical coverage is in effect, you may be able to enroll yourself and your dependents in this plan **if eligibility is lost for the other coverage (or if the employer stops contributing toward it)**. However, **you must request enrollment within 30 days** after the other coverage ends (or after the employer stops contributing toward it).
- **New Dependent by Marriage, Birth, Adoption, or Placement for Adoption.** If you have a new dependent as a result of marriage, birth, adoption, or placement with you for adoption, you may be able to enroll yourself, your spouse, and your new dependents. However, **you must request enrollment within 30 days** after the marriage, birth, adoption, or placement for adoption.
- **Eligibility for Medicaid or CHIP State Premium Assistance Subsidy.** If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through CHIP with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, **you must request enrollment within 60 days** after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact HR.

If You Decline Coverage, You Must Complete a "Form for Employee to Decline Coverage"

- If you decline enrollment for yourself or for an eligible dependent, you must complete a "Form for Employee to Decline Coverage."
- On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or CHIP) is the reason for declining enrollment, and you are asked to identify that coverage.

- If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or CHIP with respect to coverage under this plan, as described above.
- If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or CHIP with respect to coverage under this plan.

Notice of Privacy Practices

Our Company's Pledge to You
This notice is intended to inform you of the privacy practices followed by the Alpine Bank Group Employee Health Plan (the Plan) and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan. It is effective on **1/1/2025.**

The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the plan participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy.

Protected Health Information
Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

How We May Use Your Protected Health Information
Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

Payment. We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

Health Care Operations. We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.

Treatment. Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

***As permitted or required by law*.** We may also use or disclose your protected health information without your written authorization for other reasons as *permitted* by law. We are *permitted* by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when *required* by law, for example, in order to prevent serious harm to you or others.

Pursuant to your Authorization. When required by law, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

To Business Associates. We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

To the Plan Sponsor. We may disclose protected health information to certain employees of the Alpine Bank Group Employee Health Plan for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for reemployment purposes without your specific authorization.

Your Rights

Right to Inspect and Copy. In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to amend your health information. If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.

Right to an Accounting of Disclosures. You have the right to receive an accounting of certain disclosures of your protected health information. The accounting will not include disclosures that were made (1) for purposes of treatment, payment or health care operations; (2) to you; (3) pursuant to your authorization; (4) to your friends or family in your presence or because of an emergency; (5) for national security purposes; or (6) incidental to otherwise permissible disclosures. Your request to for an accounting must be submitted in writing to the person listed below. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a12-month period.

Right to Request Restrictions. You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend.
Your request for restrictions must be submitted in writing to the person listed below. We will consider your request, but in most cases are not legally obligated to agree to those restrictions. However, we will comply with any restriction request if the disclosure is to a health plan for purposes of payment or health care operations (not for treatment) and the protected health information pertains solely to a health care item or service that has been paid for out-of-pocket and in full.

Right to Request Confidential Communications. You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to the person listed below. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Our Legal Responsibilities We are required by law to protect the privacy of your protected health information, provide you with certain rights with respect to your protected health information, provide you with this notice about our privacy practices, and follow the information practices that are described in this notice.

We may change our policies at any time. In the event that we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

If you have any questions or complaints regarding the following employee group health plans:
Health PPO Plan, Rx Plan, Dental Plan, Vision Plan, Health FSA, please contact:
Alpine Bank
Kris Erpestad
Benefits Coordinator
970-384-4309
kriserpestad@alpinebank.com

Women's Health And Cancer Rights Act (WHCRA)

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections 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 lymphedemas.

The Alpine Bank Group Health PPO and HDHP Plans provide coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on the WHCRA benefits, please refer to your employee health care plan document summary, or contact:

ALPINE BANK
Kris Erpestad
Benefits Coordinator
970-384-4309
kriserpestad@alpinebank.com

HIPAA Notice of Special Enrollment Rights

You should read this notice even if you plan to waive coverage at this time.
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 [insert "30 days" or any longer period that applies under the plan] 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 [insert "30 days" or any longer period that applies under the plan] after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:
Alpine Bank
Kris Erpestad
Benefits Coordinator
970-384-4309
kriserpestad@alpinebank.com

PREMIUM ASSISTANCE UNDER MEDICAID OR 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 with us**, 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 at 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 (1-877-543-7669)** or visit 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 HIPAA "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 us at [HR phone] or the Department of Labor at **www.askebsa.dol.gov** or **1-866-444-EBSA (1-866-444-3272)**.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2024. Contact your State for more information on eligibility –

Medicaid Premium Assistance		CHIP Premium Assistance
ALABAMA – Medicaid		
Web:	myALhipp.com	
Phone:	1-855-MyALHIPP (1-855-692-5447)	
ALASKA – Medicaid		
Web:	myAKhipp.com Eligibility: health.alaska.gov/dpa/Pages/medicaid Email: CustomerService@myAKhipp.com	
Phone:	1-866-251-4861	

	Medicaid Premium Assistance	CHIP Premium Assistance
ARKANSAS – Medicaid		
Web:	myARhipp.com	
Phone:	1-855-MyARHIPP (1-855-692-7447)	
CALIFORNIA – Medicaid		
Web:	dhcs.ca.gov/hipp Email: hipp@dhcs.ca.gov	
Phone:	916-445-8322	
COLORADO – Medicaid (Health First CO Health Insurance Buy-In) and **CHIP** (Child Health Plan Plus, or CHP+)		
Web:	healthfirstcolorado.com and mycohibi.com	colorado.gov/HCPF/Child-Health-Plan-Plus
Phone:	1-800-221-3943, State Relay 711, or HIBI 1-855-692-6442	1-800-359-1991 or State Relay 711
FLORIDA – Medicaid		
Web:	FLmedicaidTPLrecovery.com/FLmedicaidTPLrecovery.com/hipp	
Phone:	1-877-357-3268	
GEORGIA – Medicaid		
Web:	medicaid.georgia.gov/health-insurance-premium-payment-program-hipp	medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone:	678-564-1162 press 1	678-564-1162 press 2
INDIANA – Medicaid		
Web: Phone:	in.gov/fssa/hip (Healthy Indiana Plan for low-income adults age 19-64) 1-877-GET-HIP9 (1-877-438-4479)	
Web: Phone:	All other Medicaid: in.gov/medicaid 1-800-457-4584	
IOWA – Medicaid and **CHIP** (Hawki)		
Web:	dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp	dhs.iowa.gov/hawki
Phone:	1-888-346-9562	1-800-257-8563
KANSAS – Medicaid		
Web:	kancare.ks.gov HIPP: http://content.dcf.ks.gov/ees/KEESM/Miscform/MS-2504HEALTH_INSURANCE_PREMIUM_PAYMENT_INFORMATION_FORM1-05.pdf	
Phone:	1-800-792-4884	
KENTUCKY – Medicaid		
Web:	chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Email: kihipp.program@ky.gov	kidshealth.ky.gov
Phone:	1-855-459-6328	1-877-524-4718
LOUISIANA – Medicaid		
Web:	ldh.la.gov/lahipp	
Phone:	1-855-618-5488	
MAINE – Medicaid		
Web:	maine.gov/dhhs/ofi/applications-forms (PHIP application)	
Phone:	1-800-977-6740 or TTY: Maine Relay 711	

	Medicaid Premium Assistance	CHIP Premium Assistance
MASSACHUSETTS – Medicaid and **CHIP**		
Web:	mass.gov/masshealth/pa	<– Same as Medicaid website
Phone:	1-800-862-4840 or TTY: 617-886-8102	<– Same as Medicaid phone
MINNESOTA – Medicaid		
Web:	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 or 651-431-2670	
MISSOURI – Medicaid		
Web:	dss.mo.gov/mhd/participants/pages/hipp.htm	
Phone:	573-751-2005	
MONTANA – Medicaid		
Web:	dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Email: HHSHIPPprogram@mt.gov	
Phone:	1-800-694-3084	
NEBRASKA – Medicaid		
Web:	AccessNebraska.ne.gov	
Phone:	1-855-632-7633, Lincoln 402-473-7000, Omaha 402-595-1178	
NEVADA – Medicaid		
Web:	dhcfp.nv.gov/Pgms/CPT/HIPP	
Phone:	1-800-992-0900	
NEW HAMPSHIRE – Medicaid		
Web:	dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program	
Phone:	603-271-5218 or 1-800-852-3345 ext 5218	
NEW JERSEY – Medicaid and **CHIP**		
Web:	www.state.nj.us/humanservices/dmahs/clients/medicaid	njfamilycare.org
Phone:	609-631-2392	1-800-701-0710
NEW YORK – Medicaid		
Web:	health.ny.gov/health_care/medicaid	
Phone:	1-800-541-2831	
NORTH CAROLINA – Medicaid		
Web:	medicaid.ncdhhs.gov/medicaid/get-started/find-programs-and-services/health-insurance-premium-payment-program	
Phone:	1-855-696-2447 or 919-855-4100	
NORTH DAKOTA – Medicaid		
Web:	nd.gov/dhs/services/medicalserv/medicaid	
Phone:	1-844-854-4825	
OKLAHOMA – Medicaid and **CHIP**		
Web:	insureoklahoma.org	<– Same as Medicaid website
Phone:	1-888-365-3742	<– Same as Medicaid phone

	Medicaid Premium Assistance	CHIP Premium Assistance
OREGON – Medicaid		
Web:	healthcare.oregon.gov or oregonhealthcare.gov (same website)	
Phone:	1-800-699-9075	
PENNSYLVANIA – Medicaid		
Web:	dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx	
Phone:	1-800-692-7462	
RHODE ISLAND – Medicaid and **CHIP**		
Web:	www.eohhs.ri.gov	<– Same as Medicaid website
Phone:	1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	<– Same as Medicaid phone
SOUTH CAROLINA – Medicaid		
Web:	www.scdhhs.gov	
Phone:	1-888-549-0820	
SOUTH DAKOTA - Medicaid		
Web:	dss.sd.gov	
Phone:	1-888-828-0059	
TEXAS – Medicaid		
Web:	gethipptexas.com	
Phone:	1-800-440-0493	
UTAH – Medicaid and **CHIP**		
Web:	medicaid.utah.gov	health.utah.gov/chip
Phone:	1-877-543-7669	<– Same as Medicaid phone
VERMONT– Medicaid		
Web:	greenmountaincare.org	
Phone:	1-800-250-8427	
VIRGINIA – Medicaid and **CHIP**		
Web:	CoverVA.org/hipp	<– Same as Medicaid website
Phone:	1-800-432-5924	1-855-242-8282
WASHINGTON – Medicaid		
Web:	hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program	
Phone:	1-800-562-3022 ext. 15473	
WEST VIRGINIA – Medicaid		
Web:	myWVhipp.com	
Phone:	1-855-myWVhipp (1-855-699-8447); TTY 1-855-888-3003	
WISCONSIN – Medicaid and **CHIP**		
Web:	dhs.wisconsin.gov/badgercareplus/p-10095.htm	<– Same as Medicaid website
Phone:	1-800-362-3002	<– Same as Medicaid phone

Medicaid Premium Assistance		CHIP Premium Assistance
WYOMING – Medicaid		
Web:	health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility	
Phone:	1-800-251-1269 or 307-777-7531	

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

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

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

General Notice of COBRA Continuation Coverage Rights

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Kris Erpestad, Benefits Coordinator, (970) 384-4309.

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. In order to determine if you or a covered member of your family qualify for the disability extension, you must send documentation received from SSA verifying the disability determination to Kris Erpestad – Benefits Coordinator at (970) 384-4309.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Alpine Bank Kris
Erpestad
Benefits Coordinator
970-384-4309
kriserpestad@alpinebank.com

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job

Military Family Leave Entitlements

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings. FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period.

A covered service member is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the service member medically unfit to perform his or her duties for which the service member is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.
Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:
- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or related to FMLA

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.
FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information: 1-866-4US-WAGE
(1-866-487-9243) TTY: 1-877-889-5627 **WWW.WAGEHOUR.DOL.GOV**

Beginning in 2024, Colorado's paid family and medical leave insurance (FAMLI) program will provide paid time off when you face life circumstances that pull you away from your job — like growing your family or caring for a loved one with a serious health condition.

How does it work?

Beginning on January 1, 2024, nearly every Colorado worker who earns at least $2,500 in yearly wages within the state will be eligible to take paid family and medical leave during covered circumstances:

- To care for a new child, including adopted and fostered children
- To care for themselves, if they have a serious health condition
- To care for a family member with a serious health condition
- To make arrangements for a family member's military deployment
- To address the immediate safety needs and impact of domestic violence and/or sexual assault.

Depending on your income, when using paid leave, you will receive between 37% and 90% of your normal weekly wages. Benefits are capped at $1,100 per week.

Most workers are eligible to receive up to 12 weeks of paid family and medical leave. Those who experience pregnancy or childbirth complications may receive an additional four weeks.

Who pays for FAMLI?

Contributions to Colorado's FAMLI program will be shared between employers and workers. Beginning on January 1, 2023, your employer may begin deducting up to 0.45% of your pay to cover your portion of the FAMLI premium.

What are my rights?

Eligible Colorado workers have the right to take paid family and medical leave for covered circumstances.

Once you have served in your job for at least 180 days (about six months), your job is protected under the law. As long as you are eligible and qualify to use paid leave, your employer cannot prevent you from taking it, and cannot penalize or fire you for taking paid leave.

COLORADO
Family and Medical Leave Insurance Program (FAMLI)
Department of Labor and Employment

This poster is a summary and cannot be relied on as complete labor law information. For more information, or to estimate your premiums or benefits, please visit famli.colorado.gov.