2022-2023 BENEFITS GUIDE

SUMMIT SCHOOL DISTRICT

BENEFITS OVERVIEW

Summit School District RE-1 is proud to offer a comprehensive benefits package to eligible, full-time employees who work 30+ hours per week. The complete benefits package is briefly summarized in this booklet. In iVisions, you will have access to plan coverage documents which give you more detailed information about each of these programs.

You share the costs of some benefits (medical and dental), and Summit School District RE-1 provides other benefits at no cost to you (life, accidental death & dismemberment (AD&D)). In addition, there are voluntary benefits with reasonable group rates that you can purchase through payroll deductions.

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ELIGIBILITY

Eligible Employees and their dependents are eligible for Summit School District RE-1 benefits on the first day of the month following your date of hire by the District.

Eligible dependents are your legal spouse (including domestic partners), and children under age 26 (including disabled dependents of any age).

Elections made at the time of hire or during open enrollment will remain until the next open enrollment unless you or your family members experience a qualifying event. If you experience a qualifying event, you must contact HR within 31 days of the event.

2022-23 Health Benefit Plan Changes

Plan changes will be effective September 1, 2022 through August 31, 2023

OPEN ENROLLMENT 2022-2023

- Employees working 30+ hours per week are eligible for benefits
- Open enrollment will occur July 25, 2022 – August 15, 2022
- Any Open Enrollment changes for our 2022-23 benefits will again be processed through your iVisions Employee portal
- This will be an **ACTIVE** open enrollment year – so, you will need to go into iVisions to review your plan options and make your benefit elections. Examples:
    - Enroll in or Waive each benefit
    - Add or Remove Dependents
    - Update your beneficiaries

Please note: You must take action in iVisions during open enrollment as your current elections will not roll-over. If you do not complete your elections in iVisions, your benefit coverage will end August 31, 2022.

MEDICAL BENEFITS - UPDATES

- Beginning 9/1/22, we will offer two medical plan options:
    - Healthy Measures OAP PPO; and
    - High Deductible Health Plan (HDHP) with HSA
- The HDHP Plan offering will be equal to the HDHP Plus plan offered for the 2021/2022 plan year. The deductible is an "aggregate" deductible. That means that if you enroll with ANY dependents on your plan, you will need to reach the full $2,800 family deductible by one member or collectively before benefits are payable.
- The Healthy Measures plan is the same as it has been. The Healthy Measures Plus plan has been eliminated.

BENEFIT PLAN FEATURES:

Telemedicine (MDLive)

- 24/7 Medical and Mental Health Consultations – Access to Board Certified, U.S. Physicians, Licensed Counselors and Psychiatrists by Phone, Email or Live Online Chat
- **No Charge** through December 31, 2022 then a fee of $59 will apply (due at the time of service) if you are an HDHP plan member, beginning January 1, 2023 (unless extended by law).

Patient Advocacy (Cigna One Guide)

- Your support and guidance on how your coverage works including, education on health plan features and finding the right doctor

Patient Assurance Program (Diabetes Management)

- This program controls the cost of **eligible** insulin products
- A 30-day (or one month) supply costs no more than $25
- A 90-day (or three month) supply costs no more than $75
- Covered insulin products are Basaglar, Humalog, Humulin, and Levemir

2022-23 Health Benefit Plan Changes Cont.

Plan changes will be effective September 1, 2022 through August 31, 2023

HEALTH FLEXIBLE SPENDING ACCOUNT (FSA)

- $2,850 annual limit on salary reduction contributions to health flexible spending accounts (FSA's)
- There are no changes to the dependent care FSA annual maximum limit of $5,000 (or $2,500 if married and filing separately)

HEALTH SAVINGS ACCOUNT (HSA) LIMITS

- **NEW!** – Beginning September 1, 2022, the District will **match** your HSA contribution up to $300. This will be a one-time contribution to your HSA on the first payroll after 9/1/22.
- Per IRS Regulations, the maximum HSA contribution levels (including District contribution) for Calendar Year 2022 are as follows:
  - Individual: $3,650
  - Family: $7,300
  - Catch-Up (Over age 55): +$1,000

DENTAL and VISION BENEFITS

- The District will continue to offer you a choice of **TWO** different dental plans with Cigna
- In the buy-up plan, orthodontia is covered for dependent children **up to age 19**
- Vision benefits are with Cigna and will still utilize the VSP network of providers

VOLUNTARY BENEFITS

- Voluntary Benefit Options – If you are interested in adding any of these benefits, please log into iVisions for additional information, including costs. Benefits available include:
  - Voluntary Life and AD&D - Cigna
  - Accident Benefit - Cigna
  - Critical Illness (with Cancer) Benefit - Cigna
  - Hospital Indemnity Benefits - Cigna
  - Life Insurance with Long Term Care - Trustmark
  - Short-Term Disability - Cigna
  - Pet Insurance - ASPCA
  - ID Theft - Identity Guard

MONTHLY PREMIUMS

Health, Dental & Vision

- The District has restructured employee contributions due to the change to two medical plan offerings, please refer to page 17 of this summary for contributions effective 9/1/22.
- There will be no increase in cost for the dental plans and a small increase for the vision plan.

MEDICAL BENEFITS

Administered by Cigna

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury.

Note: Your out-of-pocket costs will be less when using facilities within the Cigna PPO OAP network and can be significantly less by using Summit St. Anthony and PeakOne Surgery Center (Centura).

	CIGNA HDHP/HSA OAP PLAN	CIGNA HEALTHY MEASURES OAP PPO
	In-Network	In-Network
Lifetime Benefit Maximum	Unlimited	Unlimited
Annual Deductible (Single/Family)	$1,400 / $2,800	$2,500 / $5,000
Annual Out-of-Pocket Maximum (Single/Family – Includes Deductible And Copays)	$5,600 / $11,200	$5,000 / $10,000
Deductible/Out of Pocket Type	Aggregate / Embedded	Embedded / Embedded
Coinsurance	You Pay 20% / Plan Pays 80%	You Pay 20% / Plan Pays 80%
DOCTOR'S OFFICE		
Primary Care Office Visit	20% After Deductible	$35 Copay
Specialist Office Visit	20% After Deductible	$35 Copay
Preventive Care	Plan Pays 100%, No Deductible	Plan Pays 100%
Cigna Telehealth Connection	20% After Deductible	Plan Pays 100%
Urgent Care (Includes Lab/X-Ray)	20% After Deductible	$50 Copay
PRESCRIPTION DRUGS		
Retail—**Generic**	20% After Deductible	$10 Copay
Retail—**Preferred Brand**		You Pay 30%
Retail—**Non-Preferred Brand**		You Pay 50%
Retail and Mail Order-**Specialty**		You Pay 30% to $250 Max
Mail Order—**Generic**		$25 Copay
Mail Order—**Preferred Brand**		You Pay 25%
Mail Order—**Non-Preferred Brand**		You Pay 45%
HOSPITAL SERVICES		
Emergency Room	You Pay 20%; After In-Network Deductible	You Pay 20%; After In-Network Deductible
Inpatient Hospitalization	20% After Deductible	20% After Deductible
Inpatient Professional Services	20% After Deductible	20% After Deductible
Outpatient Surgery	20% After Deductible	20% After Deductible
Ambulance Service	You Pay 20%; After In-Network Deductible	You Pay 20%; After In-Network Deductible

Please note that out-of-network benefits are available, please refer to the plan documents posted in iVisions for details.

	CIGNA HDHP/HSA OAP PLAN	CIGNA HEALTHY MEASURES OAP PPO
	In-Network	In-Network
MENTAL HEALTH SERVICES		
Inpatient Services	20% After Deductible	20% After Deductible
Outpatient Services	20% After Deductible	$35 Copay
SUBSTANCE ABUSE SERVICES		
Inpatient Services	20% After Deductible	20% After Deductible
Outpatient Services	20% After Deductible	$35 Copay
OTHER SERVICES– SERVICES LIMITATIONS ARE COMBINED IN AND OUT OF NETWORK UNLESS OTHERWISE SPECIFIED		
Chiropractic Services (Limited to 20 Visits Per Plan Year)	20% After Deductible	$35 Copay
Outpatient Physical Therapy (Limited to 25 Visits Per Plan Year)	20% After Deductible	$35 Copay
Outpatient Speech Therapy (Limited to 20 Visits Per Plan Year)	20% After Deductible	$35 Copay
Outpatient Occupational Therapy (Limited to 20 Visits Per Plan Year)	20% After Deductible	$35 Copay
Outpatient Pulmonary Rehab And Cognitive Therapy (Limited to 20 Visits Per Plan Year)	20% After Deductible	$35 Copay
Outpatient Cardiac Rehabilitation (Limited to 36 Visits Per Plan Year)	20% After Deductible	$35 Copay
Lab & X-Ray in Physician's Office	20% After Deductible	Covered under Office Visit Copay
Radiology And Advanced Radiology Imaging At Outpatient Facility	20% After Deductible	20% After Deductible
Lab Tests at Independent Lab	20% After Deductible	20% After Deductible
Outpatient Advanced Radiology Imaging Services (Includes MRI, MRA, PET, CT & Nuclear Medicine)	20% After Deductible	20% After Deductible

Summit School District RE-1 and St. Anthony Summit Medical Center (Centura)

SUMMIT SCHOOL DISTRICT RE-1 AND ST. ANTHONY SUMMIT MEDICAL CENTER (CENTURA) PARTNERSHIP

If you are enrolled in the Summit School District Medical Benefit Plans - your Out-of-Pocket expenses for facility charges incurred at select facilities are greatly discounted (see HR for a complete list of those facilities).

HOSPITAL AND OUTPATIENT SURGERY DISCOUNTS

Summit School District RE-1 **Employees and Dependents** will have access to an **Increased Discount** of Billed Charges for inpatient and outpatient services provided at St. Anthony Summit Medical Center (SASMC) **and PeakOne Surgery Center**. This results in a lower out-of-pocket expense!

OUTPATIENT PRICING

Additionally, Summit School District RE-1 Employees and Dependents will receive specific fixed pricing for the following procedures performed at St. Anthony Summit Medical Center:

FIXED PRICING FOR HIGH TECH. DIAGNOSTIC AT SASMC:

- MRI/MRA Services
- CT Scan Services
- Mammograms
- Diagnostic Imaging Services including Colonoscopies

FIXED PRICING FOR EMERGENCY ROOM SERVICES AT SASMC:

- Level 1-5
- Critical Care

SPECIFIC PRICING FOR CENTURA OWNED URGENT CARE:

- Centura owned Urgent Care facilities – See HR for listing

SUMMIT SCHOOL DISTRICT

St. Anthony Summit Medical Center
Centura Health

DENTAL BENEFITS

Administered by Cigna

Good oral care enhances overall physical health, appearance and mental well-being. Problems with the teeth and gums are common and easily treated health problems. Keep your teeth healthy and your smile bright with the District dental benefit plans. Your benefit dollars go further when using a Cigna in-network dental provider.

SERVICES	BASE PLAN	BUY-UP PLAN
Plan Year Deductible (Single / Family)	$50 / $150	$50 / $150
Deductible Applies To	Basic & Major Services Only	Basic & Major Services Only
Plan Year Benefit Maximum Per Covered Person	$1,500	$1,500
Preventive Dental Services (Cleanings, Exams, X-Rays)	Plan Pays 100%	Plan Pays 100%
Basic Dental Services (Fillings, Extractions, Periodontics, Endodontics, Oral Surgery)	Plan Pays 80%	Plan Pays 80%
Major Dental Services (Crowns, Bridges, Dentures, Implants)	Plan Pays 50%	Plan Pays 50%
Orthodontia Services (Child(ren) Only to Age 19)	Not Covered	Plan Pays 50% to Maximum Lifetime Benefit of $1,500

LIFE INSURANCE BENEFITS

DISTRICT PAID LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

Insured by Cigna

Be sure to keep your beneficiary(ies) up-to-date in iVisions. This can be changed at any point during the year.

Life Insurance

Life insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump sum payment if you die while employed by Summit School District RE-1. The District provides you basic life insurance of $20,000 at no cost to you regardless of whether or not you participate in the medical plans offered by Summit School District RE-1.

Accidental Death and Dismemberment (AD&D) Insurance

Accidental Death and Dismemberment (AD&D) insurance provides payment to you or your beneficiaries if you lose a limb or die in an accident. Summit School District RE-1 provides AD&D coverage of $20,000 at no cost to you. This coverage is in addition to your district-paid life insurance described above.

VOLUNTARY LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

Insured by Cigna

You may purchase voluntary life and AD&D insurance in addition to the company provided coverage. You may also purchase voluntary Life and AD&D insurance for your dependents if you purchase additional coverage for yourself. You are guaranteed coverage without answering medical questions if you enroll when you are **first eligible**. Coverage is not effective until evidence of insurability is approved by Cigna.

Employee— $10,000 increments up to a maximum of five times your salary or $500,000, whichever is less

Guarantee Issue— $80,000

Spouse— $5,000 increments up to minimum of $250,000, not to exceed 50% of employees benefit amount

Guarantee Issue— $25,000

Children (until age 26)— $1,000 increments up to $10,000

Guarantee Issue— up to $10,000

Age	Employee Per Month	Spouse Per Month
Voluntary Life – Cigna (rate per $1,000 of coverage)		
0 – 19	$0.700	$0.350
20 – 24	$0.700	$0.350
25 – 29	$0.800	$0.400
30 – 34	$1.000	$0.500
35 – 39	$1.100	$0.550
40 – 44	$1.200	$0.600
45 – 49	$1.700	$0.850
50 – 54	$2.500	$1.250
55 – 59	$4.500	$2.250
60 – 64	$6.800	$3.400
65 – 69	$12.90	$6.450
70 – 99	$20.80	~

- If you did not enroll in the benefit when you were first eligible (i.e. within 31 days after being hired) you will be required to submit Evidence of Insurability (EOI) for all benefits requested.
- If you enrolled in benefits when you were first eligible and want to increase your benefit above the Guaranteed Issue limit, you will be required to submit an Evidence of Insurability (EOI).
- If you enrolled in benefits when you were first eligible and want to increase your coverage during subsequent Open Enrollment, you may do so by up to 2 increments up to the Guaranteed Issued Amount without providing Evidence of Insurability (EOI).

VISION BENEFITS

Insured by Cigna

Regular eye examinations can not only determine your need for corrective eyewear but also may detect general health problems in their earliest stages. Protection for the eyes should be a major concern to everyone.

SERVICE	IN-NETWORK (USING CIGNA VISION PROVIDER)	OUT-OF-NETWORK (ANY QUALIFIED NON-NETWORK PROVIDER OF YOUR CHOICE)
Eye Exam — once every 12 months	$10 copay; covered in full	Reimbursed Up to $60 Allowance
LENSES — ONCE EVERY 12 MONTHS		
Single Vision Lenses	$30 copay	Reimbursed Up To $40 Allowance
Lined Bifocal Lenses	$30 copay	Reimbursed Up To $65 Allowance
Lined Trifocal Lenses	$30 copay	Reimbursed Up To $75 Allowance
Lenticular Lenses	$30 copay	Reimbursed Up To $100 Allowance
Progressive Lenses	$30 copay	Reimbursed Up To $75 Allowance
Frames — once every 24 months	$150 Allowance	Reimbursed Up To $83 Allowance
Contact Lenses — once every 12 months in lieu of lenses/frames	$130 Allowance	Reimbursed Up To $105 Allowance

To take advantage of your Cigna vision benefit, simply contact a Cigna provider and let them know you have Cigna Vision coverage.

Flexible Spending Accounts (FSA) & Health Savings Accounts (HSA)

Flexible Spending Accounts (FSA)

Administered by Rocky Mountain Reserve

Summit School District RE-1 provides you the opportunity to fund out-of-pocket medical, dental, vision and dependent care expenses with pre-tax dollars through Flexible Spending Accounts. You must enroll/re-enroll in the plan to participate for the plan year September 1, 2022 through August 31, 2023. You can save approximately 25% of each dollar spent on these expenses when you participate in a FSA.

A health care FSA is used to reimburse out-of-pocket medical, dental and vision expenses incurred by you and your dependents. A dependent care FSA is used to reimburse expenses related to care of eligible dependents while you and your spouse work.

IMPORTANT: If you are enrolled in the District's HDHP plan with HSA (or another High Deductible Health Plan with HSA), you are ONLY eligible to enroll in the limited purpose FSA (dental and vision expenses ONLY). If you are not enrolled in our medical plan or are enrolled in your spouses or another PPO plan (non-HDHP), then you are able to enroll in the full FSA plan at the District.

Contributions to your FSA come out of your paycheck before any taxes are taken out. This means that you don't pay federal income tax, Social Security taxes, or state and local income taxes on the portion of your paycheck you contribute to your FSA. You should contribute the amount of money you expect to pay out of pocket for eligible expenses for the plan period. If you do not use the money you contributed, with the exception of $500 which can be rolled over to the new plan year, it will not be refunded to you or carried forward to a future plan year. This is the use-it-or-lose-it rule.

- The maximum that you can contribute to the Health Care Flexible Spending Account is $2,850.
- The maximum that you can contribute to the Dependent Care Flexible Spending Account is $5,000 if you are a single employee or married filing jointly, or $2,500 if you are married and filing separately.

The following example shows how you can save money with a flexible spending account.

Bob and Jane's combined gross income is $30,000. They have two children and file their income taxes jointly. Since Bob and Jane expect to spend $2,000 in adult orthodontia and $3,300 for day care next plan year, they decide to direct a total of $5,300 into their FSAs.

	Without FSAs	With FSAs
Gross income:	$30,000	$30,000
FSA contributions:	0	-5,000
Gross income:	30,000	25,000
Estimated taxes:		
Federal	-2,550*	-1,776*
State	-900**	-750**
FICA	-2,295	-1,913
After-tax earnings:	24,255	20,314
Eligible out-of-pocket		
Medical and dependent care expenses:	-5,000	0
Remaining spendable income:	$19,255	$20,561
Spendable income increase:	N/A	$1,306

The example above is for illustrative purposes only. Every situation varies and we recommend that you consult a tax advisor for all tax advice.
Assumes standard deductions and four exemptions. ** Varies, assumes 3 percent.

Health Savings Accounts (HSA)

Health Savings Accounts (HSA)

Administered by Health Equity

A Health Savings Account (HSA) is an individually-owned, tax-advantaged account that you can use to pay for current or future IRS-qualified medical, dental and vision expenses. With an HSA, you'll have the potential to build more savings for healthcare expenses or additional retirement savings through self-directed investment options.

Advantages of the High Deductible Health Plan (HDHP) with an HSA

The HDHP option is designed to encourage you to be more conscientious of your healthcare expenditures. It also offers a number of special features, for example:

- It has a lower monthly payroll contribution
- You have access to a Health Savings Account (HSA) that allows you to put aside money, tax-free, to pay for eligible medical expenses. You choose when to use the money in your HSA account. It rolls over from year to year, allowing the balance to increase.

Setting Up an HSA Account

Your HSA is administered through Health Equity. You can open and contribute to an HSA if you:

1. Are covered by an HSA-qualified health plan (HDHP);
2. Are not covered by other health insurance (with some exceptions);
3. Are not enrolled in Medicare;
4. Are not eligible to be claimed as a dependent on another person's tax return;
5. Have not received health benefits from the Veterans Administration with the exception of services for a "service related disability" or an Indian Health Services facility within the last three months; and
6. Are not covered by your own or your spouse's Healthcare FSA.

Contributing to Your HSA

Health Savings Accounts have a triple tax advantage:

- Contribute tax-free
- Invest tax-free
- Make withdrawals for eligible medical expenses, or for any use after age 65 tax-free
- **NEW! Summit School District will match your annual contribution election up to $300.**

Using Your HSA Funds

Money you use from your HSA to pay for qualified medical expenses is federally tax-free. If you use money for reasons other than qualified medical expenses before age 65, that money is taxable and subject to a 20% penalty. This isn't a complete list of rules and requirements for HSAs. More info can be found in the publication 969 of the IRS, at www.irs.gov.

2022 ANNUAL HSA CONTRIBUTION LIMITS	
Single Coverage	$3,650
Family Coverage	$7,300
If age 55 or older you may contribute an additional $1,000	

Special Considerations

You CANNOT use HSA dollars on Domestic Partners unless they are your legal tax dependent.

Your adult children 19-26 MUST be a tax dependent to be eligible to use your HSA dollars for their expenses. If they are not tax dependents, they may open their own HSA and contribute up to the full family maximum.

Employee Assistance Plan (EAP)

As an employee of Summit School District RE-1 you have access to our valuable Employee Assistance Program (EAP) at no cost to you.

EAP personal advocates will work with you and your household family members to help you resolve issues you may be facing, connect you with the right mental health professionals, direct you to a variety of helpful resources in your community and more.

Take advantage of a wide range of services offered at no cost to you

⇒ **6** face-to-face counseling sessions with a counselor in your area, as well as video-based sessions.

⇒ **Legal assistance:** 30-minute consultation with an attorney, face-to-face or by phone.*

⇒ **Financial:** 30-minute telephone consultation with a qualified specialist on topics such as debt counseling or planning for retirement.

⇒ **Parenting:** Resources and referrals for childcare providers, before and after school programs, camps, adoption organizations, child development, prenatal care and more.

⇒ **Eldercare:** Resources and referrals for home health agencies, assisted living facilities, social and recreational programs and long-distance caregiving.

⇒ **Pet care:** Resources and referrals for pet sitting, obedience training, veterinarians and pet stores.

⇒ **Identity theft:** 60-minute consultation with a fraud resolution specialist.

We're here to listen. Contact us any day, anytime.

Call 1.877.622.4327
Or log in to myCigna.com.
Employer ID: summitschooldistrict
(Needed for initial registration only)
If already registered on myCigna.com, simply log in and go to the EAP link under the Review My Coverage tab.

VOLUNTARY BENEFITS

ACCIDENTAL INJURY INSURANCE

Insured by Cigna

Accidental Injury Insurance

An accident can happen to anyone at any time. Even with medical coverage, out-of-pocket expenses can quickly add up. That's why having Cigna Accidental Injury Insurance is important. Cigna Accidental Injury Insurance pays you (or whoever you designate) for treatments or injuries resulting from a covered accident. It can help you pay for expenses such as rehabilitation, transportation, child care, travel or other out-of-pocket expenses. What you do with the money is all up to you. Coverage continues after your first covered accident and can help provide protection for future covered accidents. Choose the coverage that works best for you and your family. Your monthly cost will depend on the level of coverage you choose.

CRITICAL CARE ILLNESS INSURANCE

Insured by Cigna

Critical Care Illness Insurance

Being diagnosed with a critical illness can happen to anyone at any time. Even with medical coverage, out-of-pocket expenses can quickly add up. That's why Cigna Critical Illness Insurance is important. Cigna's Critical Illness Insurance can help provide you and your family with the additional financial protection you may need for expenses associated with an unexpected coverage critical illness-so you can focus on getting better. Cigna Critical Illness insurance pays you (or whoever you designate) a lump-sum benefit for diagnosis of a covered critical illness or specified event like a heart attack or stroke. It can help pay for expenses such as travel, room and board, transportation, child care or treatment options not covered by traditional insurance. Choose the coverage that works best for you and your family. Your monthly cost will depend on the level of coverage you choose.

HOSPITAL CARE COVERAGE

Insured by Cigna

Hospital Care Coverage

A hospital stay can happen at any time, and it can be costly. Cigna Hospital Care can help you and your loved ones have additional financial protection. We can help cover these unexpected events-so you can focus on getting better. With Cigna Hospital Care, you receive a check after a qualified hospitalization resulting from a covered injury or illness. You can use the money however you like. There are no copays, deductibles, coinsurance or network requirements. And benefits aren't reduced because you receive a payment from any other coverage you have such as medical, accidental injury or critical insurance. Your monthly cost will depend on the level of coverage you choose.

How to file a claim for Accident, Critical Illness or Hospital Care

You can find claim forms in the "Find Forms" section on Cigna.com. If you need help or have questions, call Cigna at 800.754.3207. Please remember to always seek appropriate medical attention immediately and call Cigna to start your claim.

To file a claim, make sure you have personal information (date of hire and SSN), employer information (name, address and phone number), and doctor information (name, address and phone number).

VOLUNTARY BENEFITS

LONG TERM CARE BENEFITS

Administered by Trustmark Universal Life Insurance

Long Term Care

At any point in your life, you may need long term care services, which could cost hundred of dollars per day. Universal Life includes a long-term care benefit that can pay for these services at any age. Visit www.trustmarksolutions.com for more information.

IDENTITY THEFT

Administered by Identify Guard with Watson

Identify Theft

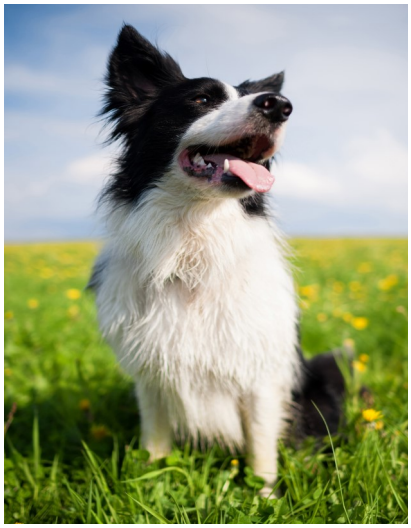
Identity Guard combines the best of traditional identify theft monitoring solutions, with the powerful processing of IBM Watson technology. The personal cybersecurity is there to alert you to personal habits that put you at greater risk than the average person; inform you of threats due to companies getting hacks and losing your personal information, phishing scams, and more; as well as your personal information being used to open new access and access existing accounts. To learn more, go to identityguard.com, pricing will depend on your plan section.

PET INSURANCE

Administered by ASPCA® Pet Health Insurance

Pet Insurance

There are many reasons why more pet parents today are covering their pets with ASPCA® Pet Health Insurance. Most of all, they want to make sure they'll have financial support if their pet is sick or hurt. That way, they can give their pets the best care possible without worrying about the costs. With the insurance you can customize your annual limit, reimbursement percentage and deductible. Additionally, you will be able to add preventive care reimbursement option or select accident-only coverage. To get your customized quote and enroll, visit www.aspcapetinsurance.com/summit or call 1-877-343-5314.



EMPLOYEE CONTRIBUTIONS

EMPLOYEE CONTRIBUTIONS FOR MEDICAL BENEFITS

BENEFIT PLAN	PER MONTH
Medical/RX—Cigna **HDHP/HSA** OAP	
Employee Only	$66.00
Employee / Spouse	$429.00
Employee / Employee	$138.00
Employee / Child(ren)	$347.00
Employee / Family	$710.00
Employee / Employee / Family	$420.00

BENEFIT PLAN	PER MONTH
Medical RX—Cigna **Healthy Measures** OAP PPO	
Employee Only	$218.00
Employee / Spouse	$749.00
Employee / Employee	$458.00
Employee / Child(ren)	$628.00
Employee / Family	$1,159.00
Employee / Employee / Family	$869.00

EMPLOYEE CONTRIBUTIONS FOR DENTAL AND VISION BENEFITS

BENEFIT PLAN	PER MONTH
Dental - Cigna - **Base Plan**	
Employee Only	$5.00
Employee / Spouse	$39.00
Employee / Employee	$8.00
Employee / Child(ren)	$35.00
Employee / Family	$67.00
Employee / Employee / Family	$36.00

BENEFIT PLAN	PER MONTH
Dental - Cigna - **Buy-Up Plan**	
Employee Only	$5.00
Employee / Spouse	$39.00
Employee / Employee	$8.00
Employee / Child(ren)	$45.00
Employee / Family	$77.00
Employee / Employee / Family	$46.00

BENEFIT PLAN	PER MONTH
Vision - Cigna	
Employee Only	$6.85
Employee + 1 (Spouse or Child)	$13.70
Employee / Children	$13.83
Family	$22.09

BENEFIT PLAN	PER MONTH
Life & AD&D - Cigna	
Employee Only	$0.00

Contact Information

If you have specific questions about a benefit plan, please contact the administrator listed below, or your local human resources department.

BENEFIT	ADMINISTRATOR	PHONE	WEBSITE/EMAIL
Medical/Prescription Drug	Cigna	800-244-6224	www.mycigna.com Group Number: 3340975
Dental			
Cigna Telehealth Services	MDLive	MDLive: 888-726-3171	
Cigna OneGuide (Member Advocacy Services)	Cigna	Pre-Enrollment Line: 888-806-5042 Cigna participants: 800-244-6224	
Employee Assistance Plan (EAP)	Cigna	800-622-4327	
Vision		877-478-7557	
District Paid Life and AD&D		800-362-4462	
Voluntary Life and AD&D			
Accident			
Critical Illness			
Hospital Indemnity			
Short-Term Disability			
Life with Long Term Care	Trustmark	800-918-8877	www.trustmarksolutions.com
Pet Insurance	ASPCA	877-343-5314	www.aspcapetinsurance.com/Summit
ID Theft	Identity Guard	855-443-7748	www.identityguard.com
COBRA Information	Rocky Mountain Reserve	888-722-1223	www.rockymountainreserve.com
Flexible Spending Accounts (FSA)			
Health Savings Accounts (HSA)	Health Equity	866-346-5800	www.healthyequity.com

To participate in the District sponsored benefit programs, employees must meet **BOTH** of the following eligibility requirements:

You must be a Full-Time Employee who is regularly employed 30 or more hours per week during the regularly scheduled work week for the position; AND your normal monthly District net pay must be sufficient to pay the costs for the coverage you select (net pay equals gross pay minus PERA and state/federal/Medicare taxes).

Pre-tax OR Post-tax contributions? All contributions will be made on a pre-tax basis, unless otherwise elected in writing and submitted to Payroll. If your contributions are made on a pre-tax basis, the IRS does not permit mid-plan year election changes unless they are due to qualified change of status events such as marriage, divorce, birth/adoption, etc. However, if you elect your contributions to be made on a post-tax basis, you may drop (not add) coverage for yourself and your dependents without a qualified change in status event during the Plan Year by notifying Payroll in writing. Subsequent re-enrollment in the plan under this circumstance is only permitted at open enrollment.

You must take action in iVisions during open enrollment as your current elections will not roll-over. If you do not complete your elections in iVisions, your benefit coverage will end August 31, 2022.

Enrollment changes must be submitted no later than August 15, 2022.

HEALTH PLAN LEGAL NOTICES

Health Plan Annual Notices for

SUMMIT SCHOOL DISTRICT
educate • elevate • empower

For the Plan Year: September 1, 2022– August 31, 2023

Summit School District Re-1

Cigna Medical Benefit Plans

Enclosed are our health plan's Annual Notices. You and your dependents should read each notice very carefully as they outline important benefits, terms and limitations that apply to our health plan. Should you have any questions after reviewing each notice, you should contact your Human Resources Department.

Notice # 1: Annual Health Plan Notices

Notice # 2: Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

Notice # 3: COBRA Continuation Coverage Rights

HIPAA NOTICE OF PRIVACY PRACTICES REMINDER

Protecting Your Health Information Privacy Rights

Summit School District is committed to the privacy of your health information. The administrators of the Summit School District Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Human Resources.

HIPAA SPECIAL ENROLLMENT RIGHTS

Summit School District Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Summit School District Health Plan (to actually participate, you must complete the online open enrollment process and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - 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.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

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 for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program 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 Human Resources at 970-368-1006.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete the enrollment process to decline coverage. During the process, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete enrollment, 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 through a state children's health insurance program 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 through a state children's health insurance program with respect to coverage under this plan.

INITIAL NOTICE OF THE PLAN'S PREEXISTING CONDITION LIMITATION AND PROCEDURE TO REQUEST CERTIFICATE OF CREDITABLE COVERAGE

Preexisting Condition Limitations do not apply under these Plans.

WOMEN'S HEALTH & CANCER RIGHTS ACT

The Women's Health Act of 1998 requires us to notify you that our plans provide benefits for certain breast reconstruction procedures related to a mastectomy. If you elect coverage under the medical plan and you or any covered family member require breast reconstruction related to a mastectomy, benefits will be provided for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.
- Any deductible, copayments or other plan requirements that normally apply to surgical procedures covered by your health plan will also apply to these procedures.

If you have questions pertaining to this notice, please feel free to contact Human Resources.

UNIFORMED SERVICES EMPLOYMENT & REEMPLOYMENT RIGHTS ACT (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) was enacted in 1994 following U.S. military action in the Persian Gulf. USERRA prohibits discrimination against individuals on the basis of membership in the uniformed services with regard to any aspect of employment. Since its enactment, USERRA has been modified and expanded by additional federal laws, such as the Veterans Benefits Improvement Act of 2008 (2008 Act). Please contact Human Resources for additional details about USERRA.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 "WELLSTONE ACT"

Under the Wellstone Act, large group health plans (i.e., employers who employ 51 or more employees) that choose to offer mental health and substance abuse benefits under their health plan are not allowed to set annual or lifetime dollar limits, nor office visit or inpatient day limits on mental health and substance abuse benefits that are lower than any other limits imposed by the medical plan for other medical and surgical benefits. In addition, the group health plan must provide the same out-of-network coverage for mental health and substance abuse coverage that is available for out-of-network medical and surgical benefits.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 (NEWBORNS' ACT)

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

NOTICE OF CREDITABLE COVERAGE

Important Notice from Summit School District

About Your Prescription Drug Coverage and Medicare

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

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

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **Summit School District has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

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

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

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Summit School District coverage will be affected.

If you do decide to join a Medicare drug plan and drop your current Summit School District coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Summit School District and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Summit School District changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

Date:	**September 1, 2022**
Name of Entity/Sender:	**Summit School District Re-1**
Contact—Position/Office:	**Human Resources**
Office Address:	**150 School Road** **Frisco, Colorado 80443** **United States**
Phone Number:	**(970) 368-1006**

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2022. Contact your State for more information on eligibility –

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

GEORGIA – Medicaid	MAINE – Medicaid
A HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711
INDIANA – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840
IOWA – Medicaid and CHIP (Hawki)	**MINNESOTA – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
KANSAS – Medicaid	**MISSOURI – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KENTUCKY – Medicaid	**MONTANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
LOUISIANA – Medicaid	**NEBRASKA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEW HAMPSHIRE – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218	Website: http://dss.sd.gov Phone: 1-888-828-0059

NEW JERSEY – Medicaid and CHIP	TEXAS – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW YORK – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH CAROLINA – Medicaid	**VERMONT– Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH DAKOTA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OKLAHOMA – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
OREGON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
PENNSYLVANIA – Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
RHODE ISLAND – Medicaid and CHIP	**WYOMING – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2022, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

COBRA GENERAL NOTICE

Model General Notice of COBRA Continuation Coverage Rights

(For use by single-employer group health plans)

** Continuation Coverage Rights Under COBRA**

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- 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: Human Resources.

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated;

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, Medicare, Medicaid, Children's Health Insurance Program (CHIP), 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/**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or

- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

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

Date:	**September 1, 2022**
Name of Entity/Sender:	**Summit School District Re-1**
Contact—Position/Office:	**Human Resources**
Office Address:	**150 School Road** **Frisco, Colorado 80443** **United States**
Phone Number:	**(970) 368-1006**

https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

Protecting Your Health Information Privacy Rights

Summit School District is committed to the privacy of your health information. The administrators of the Summit School District Health Plan use strict privacy standards to protect your health information from unauthorized us or disclosure.

This benefit summary prepared by:

Gallagher

Insurance | Risk Management | Consulting

For:

SUMMIT SCHOOL DISTRICT

150 School Road | Frisco, CO 80443 | www.summitk12.org

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