ADAMS 14

Inspire. Educate. Empower. Inspira. Educa. Fortalece.

2023 - 24

BENEFITS

ENROLL FOR 2023 - 24 BENEFITS

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 41 for more details.

TABLE OF CONTENTS

Benefits Overview	2
Eligibility and What's in 2023-2024	3
Medical Benefits	4
Dental Benefits	18
Vision Insurance	22
Life and Accidental Death & Dismemberment Insurance	26
Supplemental Life and AD&D Insurance	26
Long Term Disability	26
Flexible Spending Account	27
Retirement - Tax Shelter Annuities	30
Employee Contributions for Benefits	31
Contacts	32
How to Enroll	33
Legal Notices	34

BENEFITS OVERVIEW

Adams 14 is proud to offer a comprehensive benefits package to eligible employees who work 20 hours per week or more. The complete benefits package is briefly summarized in this booklet.

You share the costs of some benefits (medical, dental and vision), and Adams 14 provides other benefits at no cost to you (life, accidental death & dismemberment insurance, and employee assistance program). In addition, there are voluntary benefits with reasonable group rates that you can purchase through payroll deductions.

BENEFITS OFFERED

- Medical Insurance
- Dental Insurance
- Vision Insurance
- Life Insurance and Accidental Death & Dismemberment (AD&D) Insurance
- Voluntary Life and AD&D Insurance
- Long Term Disability
- Flexible Spending Account (FSA)
- Employee Assistance Program (EAP)

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

ELIGIBILITY

Employees who are regularly schedule to work 20 hours or more per week are eligible for the Adams 14 benefits package. Certified staff are not eligible for long term disability through Adams 14. Variable hour employees who have worked an average of at least 30 hours per week over a designated lookback period are eligible for medical insurance only.

You and your dependents are eligible for Adams 14 benefits on the first of the month following your date of hire.

Eligible dependents may include:

- Your legal spouse, including domestic partner (both same and opposite sex)*
- Your child who is less than 26 years of age. Children include natural or legally adopted child, a stepchild, the child of your domestic partner, or a child who is less than 26 and has been placed under your legal guardianship.
- Your child, who satisfies the above definition of child, age 26 or older, and who is mentally or physically incapable of earning a living, and primarily supported by you.

*If you are enrolling a domestic partner, please see HR for requirements and important information about possible tax consequences.

Elections made now 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 30 days.

WHAT'S NEW IN 2023-2024

- Per Colorado law, Medical coverage now includes infertility. Details are on page 17.
- Dental rates have decreased with no change to coverage.
- The frame allowance and contact lens allowance on the Vision plans have increased to $200 and $180, respectively, with no change to rates. Walmart and Sam's Club are now in-network (effective February 2023).
- Life and Disability coverage is now insured by Lincoln Financial Group. Most rates for supplemental coverage have decreased. Please note small differences in supplemental coverage for children.
- The Employee Assistance Program, CareNow, and travel assistance with MetLife are ending, and they are being replaced by similar programs through Lincoln. More information will be coming on these programs.

MEDICAL BENEFITS

Insured by Kaiser Permanente

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost.

	KAISER HMO	KAISER DHMO
	In-Network	In-Network
Lifetime Benefit Maximum	Unlimited	Unlimited
Annual Deductible (Individual/Family)	None	$300 / $600
Annual Out-of-Pocket Maximum (Individual/ Family) (includes deductible)	$2,000 / $4,500	$3,300 / $6,600
Coinsurance	0%	10%
DOCTOR'S OFFICE		
Primary Care Office Visit	$30 Copay	Office visit: $30 Copay; Others: 10% Coinsurance
Specialist Office Visit	$50 Copay	Office visit: $50 Copay; Others: 10% Coinsurance
Wellness Care (routine exams, x-rays/tests, immunizations, well baby care and mammograms)	No Charge	No Charge
E-Visits, Chat Visits and Video Visits	No Charge	No Charge
PRESCRIPTION DRUGS		
Generic Drug	$15 Copay	$15 Copay
Brand Drug	$30 Copay	$30 Copay
Non-formulary Drug	$50 copay	$50 copay
Specialty Drug	20% Coinsurance to $250 Max	20% Coinsurance to $250 Max
HOSPITAL SERVICES		
Emergency Room	$250 Copay (Copay waived if admitted)	10% Coinsurance
Urgent Care	$75 Copay	$50 Copay
DispatchHealth	$75 Copay	$75 Copay
Ambulance	20% Coinsurance to $500	20% Coinsurance to $500
Inpatient Surgery	$500 Copay per Admission	$500 Copay per Admission
Outpatient Surgery - Ambulatory	Ambulatory surgical center: $500 Copay; Outpatient hospital: 10% Coinsurance	Ambulatory surgical center: $500 Copay; Outpatient hospital: 10% Coinsurance
Hospitalization	$500 Copay	10% Coinsurance
Diagnostic Laboratory / X-Ray	No Charge	X-ray: 10% Coinsurance; Lab: No Charge
Advanced Imaging (MRI/CAT/PET)	$100 Copay (Inpatient Copay waived if admitted)	10% Coinsurance

HOW TO BE A GOOD HEALTH CONSUMER

From strains to pains, you never know when you might need treatment. But when that time comes, you can get the care that's right for you by choosing from a number of options that meet your care and financial needs.

For minor illness or injury at times when you can't see your doctor, a call to a nurse helpline or your telemedicine advocate or a visit to a retail clinic may be able to provide the care you need, saving you time and the high costs of an urgent care or an emergency room visit.

Virtual Care (Phone, Email, E-Visit, Video Chat, Chat Online)

Access a doctor by video or phone when, where, and how it works best for you. Get treatment for minor conditions like allergies, cold/flu, and rashes at your fingertips.

- Sinus infections
- Allergies
- Rashes
- Cold/Flu symptoms
- Diarrhea
- UTI

Primary Care

Your best place to go for routine or preventive care, medication tracking, or getting a referral for unique services e.g. durable medical equipment etc. Expanded hours of care are 7 AM to 7 PM.

- Immunizations/ Preventive care
- Lab services
- Medication concerns
- Lingering pain
- Minor to moderate illnesses
- Non-urgent treatment

DispatchHealth

DispatchHealth brings comfortable healthcare to your home or location convenient to you. They treat everything an urgent care center can, plus more! Hours of care are 8 AM to 10 PM*. Visit www.dispatchhealth.com or download the phone app.
*Hours are subject to change without advance notice.

- Cold/flu symptoms
- Asthma & respiratory
- Nausea, vomiting, diarrhea
- UTI
- Ear, nose & throat
- Stitches & minor fractures
- Back, neck & joint pain

Urgent Care

Sometimes you need medical care fast but a trip to the emergency room may not be necessary. Visit a Kaiser Urgent Care center when you can't get in to see your primary doctor and are in need of after-hours care. Kaiser Urgent Care centers can generally treat many minor illnesses and injuries while saving you the time and expenses of an emergency room visit. Expanded hours of care are 9 AM to 9 PM*.

- Sprains, dislocations, fractures
- Concussions
- Minor allergic reactions
- Minor to moderate asthma attacks
- Sore throats, ear pain
- Small cuts

Emergency Room

When you feel you need immediate treatment for critical injuries or illnesses that may result in serious injury or are life threatening. If you believe you are experiencing a medical emergency, go to the nearest emergency room or call 911.

- Heavy bleeding
- Heart attack/chest pain
- Stroke
- Spinal injuries
- Difficulty breathing
- Risk of losing life or limb

KP.ORG

Get started!
Register on **kp.org**

Have your health record number handy – it's on your member ID card.
If you haven't received your member ID card in the mail, call New Member Connect at **303-338-3361** or **1-844-639-8657** (TTY **771**), Monday-Friday, 7 a.m.-6 p.m.

STEP 1

Go to kp.org/registernow

- Select your language preference
- Choose "I have a Kaiser Permanente plan and want to use online services"
- Click "Continue"

STEP 2

Create your user account

On the following screens you will:

- Enter your name, date of birth, preferred language, area, and health record number
- Accept the terms and conditions
- Create a user ID and provide your email address

STEP 3

Get your password and sign in to your account

- Get your password immediately by confirming your personal information, such as current or past address or the last 4 digits of your social security number[1]
- Once your password is set up, you can sign on to your account
- You may also choose to have a password sent to you by mail, but you won't be able to access online services immediately

- ☑ Get lab results
- ☑ Email your doctor[2]
- ☑ Refill prescriptions[2]
- ☑ Make or cancel appointments[2]
- ☑ Chat with a doctor, pharmacist, or financial counselor

All online, easier than ever

1. These questions are asked from a third-party security company that won't share your information.
2. These services are available when you receive services from Kaiser Permanente.

KAISER
E-VISITS

E-VISITS

Get advice for nonurgent medical needs

If you're short on time and need nonurgent medical care, an e-visit might be right for you. Fill out a short questionnaire about your symptoms and a registered nurse will get back to you with a care plan – usually within 4 hours. E-visits are available 24 hours a day, 7 days a week.

E-visits can be used for issues like:

- coughs and colds
- nausea and vomiting
- hay fever
- sinus problems
- back pain
- flu symptoms
- pink eye

Complete an e-visit in 3 simple steps

1. Log on to **kp.org/appointments**, then click on "E-visit" in the list of care options provided.
2. From there, choose the appropriate medical condition that best describes your symptoms.
3. Complete and submit the series of questions, and a registered nurse will respond within 4 hours of receiving your questionnaire.

For your safety, some answers during your e-visit may prompt you to call the Appointment and Advice Contact Center directly to expedite your care. If this happens, call for medical advice immediately at **303-338-4545** or **1-800-218-1059** (TTY **711**).

Not registered on kp.org yet?

Go to **kp.org/register** and follow the prompts. Once registered, you'll be able to e-mail your doctor's office, complete an e-visit, pay medical bills, view lab results, and more!*

*Some services only available when you receive care at Kaiser Permanente medical offices.

KAISER CHATS

CHAT ONLINE

Connect with a doctor without leaving your home.

Kaiser Permanente has made it easier for you to get the care you need. Chat with a Doctor allows you to connect online, in real time, for medical advice with a Kaiser Permanente doctor. For your convenience, you can send pictures securely through the chat.

You can also chat online with a pharmacist or financial counselor.

Get fast answers to urgent questions about:

- Fevers, coughs, and colds
- Vomiting, diarrhea, and constipation
- Cuts and stitches
- Pink eye
- Rashes and skin concerns
- Minor injuries or trauma
- Sinus infections

Are you unsure about whether you just need advice or if you need to come in for an appointment? Are you wondering if you should be seen in our medical offices or if you need urgent care? Chat with a Doctor to get answers to these questions quickly!

How do I chat with a doctor?

If you are registered on **kp.org**, simply log on, click the chat button, and a doctor will help you in a timely manner. You can also chat with a doctor on the Kaiser Permanente mobile app.

When can I chat with a doctor?

Online chat is available 7 a.m. to 10 p.m., 7 days a week.

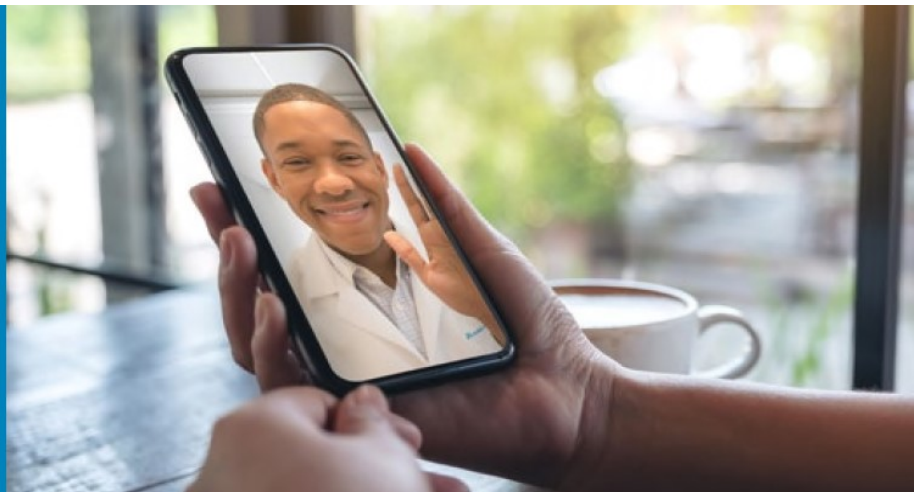
Our physicians are board certified and have access to your electronic medical record.

Explore your care options at **kp.org/getcare**

PHONE | EMAIL | E-VISITS | VIDEO VISIT | CHAT ONLINE | IN-PERSON

KAISER VIDEO

VIDEO VISITS



Online consultations with **your provider** from anywhere.

What is a video visit?

A video visit with your Kaiser Permanente provider is easy. You may be anywhere—at home, work, or on the go!

Simply log on to your **kp.org** account on your mobile device or computer. If you're not yet registered, visit **kp.org/registernow** to get started.

Is a video visit right for my care?

Video visits are a great option for many conditions. Having the option for a provider and a patient to speak face-to-face without coming into a medical office offers a level of comfort and convenience.

How do I schedule a video visit with my provider?

There are multiple ways to schedule a video visit:

- Book directly with your care team
- Log on to **kp.org/appointments**
- Call the Appointment and Advice Contact Center anytime, day or night at **303-338-4545** or **1-800-218-1059** (TTY **711**).

If I schedule a video visit and need technical support, who should I contact?

If you need technical support for your video visit, please contact the Virtual Care Support Team, Monday through Friday, 7 a.m. to 8 p.m. at **1-844-800-0821**. Check out the next page for instructions and technical support information for your video visit.

How much does a video visit cost?

No cost for most health plans. HSA-qualified high deductible health plan (HDHP) members must meet your deductible first before video visits are provided at no cost. For benefit information, review your Evidence of Coverage or Certificate of Insurance, or contact Member Services.

Explore your care options at **kp.org/getcare**

CHAT ONLINE · PHONE · EMAIL · VIDEO VISIT · E-VISITS · IN-PERSON

DISPATCHHEALTH

dispatch HEALTH | KAISER PERMANENTE®

BRINGING BACK THE HOUSE CALL

DISPATCHHEALTH BRINGS COMFORTABLE HEALTHCARE TO YOUR HOME.

WHAT WE TREAT

COMMON AILMENTS
- Fever - Flu - Nausea
- Headaches - Migraines
- Urinary tract infection

+ More

SKIN
- Hives - Allergic reactions
- Skin abscess (boil)
- Cuts that need stitches
- Rashes

+ More

GASTROINTESTINAL
- Diarrhea
- Heartburn
- Constipation
- Nausea and vomiting

+ More

EAR, NOSE & THROAT
- Sore throat
- Ear infection or pain
- Sinus infection
- Nosebleeds

+ More

EYE
- Eye infection
- Object in the eye

+ More

NEUROLOGICAL
- Vertigo (dizziness)
- Weakness

+ More

MUSCULOSKELETAL
- Joint or back pain
- Strains or sprains
- Minor bone breaks

+ More

RESPIRATORY
- Asthma attacks
- Bronchitis

+ More

PROCEDURES WE PERFORM
- IV placement
- IV fluids
- Stitches
- Splinting
- Advanced on-site blood testing
- Lancing of abscess (boil)
- Urinary catheter insertion
- Infectious disease testing (flu, strep, mono)

+ More

Billed as an Urgent Care visits.

A TEAM YOU CAN TRUST

For every house call we send a physician assistant or nurse practitioner along with a medical technician. An on-call physician is also available at all times via phone.

WE'VE GOT YOU COVERED

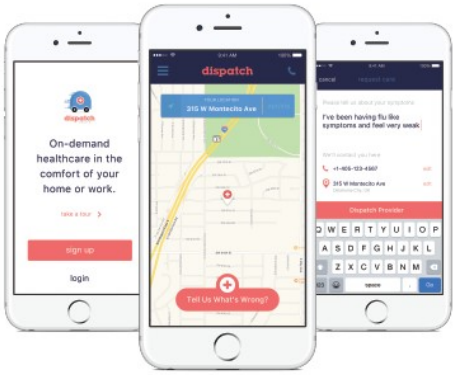
QUICK. EFFICIENT. AFFORDABLE.

We are in-network with Kaiser Permanente. Please contact DispatchHealth for more information about your specific plan.

We accept credit card, debit card, health savings account (HSA), health reimbursement account (HRA) and flexible spending account (FSA) payments.

ON-DEMAND HEALTHCARE 7 DAYS A WEEK 365 DAYS A YEAR | **8AM-10PM**

DISPATCHHEALTH.COM OR **303-500-1518**



Download on the App Store | ANDROID APP ON Google Play

FOLLOW US FOR UPDATES:

dispatch HEALTH | KAISER PERMANENTE®

MENTAL HEALTH

Start a conversation about mental health and wellness—anytime, anywhere.

Your thoughts and feelings affect your overall well-being

We're committed to helping you be mentally, physically, and emotionally healthy.

That's why we make it easy to connect with care—or start a conversation about your mental health and wellness.

kp.org/mentalhealth

KAISER PERMANENTE®

MENTAL HEALTH

Explore self-care resources

Find a range of resources – including tools, tips, audio activities, and more – designed to help you thrive in mind, body, and spirit. Visit **kp.org/selfcare.**

Try self-care apps

Download self-care apps like Calm and myStrength, for help with sleep, stress, anxiety, depression, meditation, resilience, and more, at no cost.[1] Visit **kp.org/selfcareapps**.

Text with an emotional support coach

The Ginger app offers 1-on-1 support for many common challenges – from anxiety, stress, grief, and low mood to issues with work, relationships, and more. Kaiser Permanente members can use the app for 90 days per year at no cost. Visit **kp.org/coachingapps/co**.[2,3]

Talk to a wellness coach

Partner with a wellness coach to put a personalized plan in place to eat healthier, quit smoking, or manage your weight. Visit **kp.org/wellnesscoach.**

Get 24/7 medical advice by phone

Call **303-338-4545** or **1-800-218-1059** (TTY **711**), for 24/7 for medical advice and care guidance.

Talk to your primary care provider

Your doctor can assess your needs and connect you with the right care, which may include an immediate consultation with a behavioral medicine specialist during your office visit.[4]

Call **303-338-4545** or **1-800-218-1059** (TTY **711**) or visit **kp.org/appointments** to schedule an in-person, phone or video visit.[5,6]

Chat online with a Kaiser Permanente mental health specialist

Connect online, in real time for assistance with mental health concerns or conditions.[4]

- Log on to **kp.org,** and click "Chat with KP"
- Sign on to the mobile app, choose "Online Care," then select "Chat with KP"

Meet with a mental health therapist or psychiatrist

Get care for a wide range of mental health and addiction services, including treatment for depression, substance use, eating disorders, medication evaluation and management, and more.

Visit **kp.org/getcare** to:

- Schedule a phone, video, or in-person visit with a Kaiser Permanente mental health provider.[6]
- Schedule a one-on-one video counseling session with an Amwell mental health therapist.[6]

You can also call **303-471-7700** (TTY **711**), or toll free at **1-866-359-8299** (TTY **711**). In Southern Colorado, call **1-866-702-9026** (TTY **1-866-835-2755**).

Get urgent mental health care

Call **303-338-3900** (TTY **711**), Monday through Friday, from 7 a.m. to 7 p.m. to speak to our crisis team. Outside these hours, please call **303-338-4545** (TTY **711**) to speak with a member of your Kaiser Permanente care team. In Southern Colorado, call **1-866-702-9026** (TTY **1-866-835-2755**).

Get emergency care

If you're having a medical or mental health emergency, call **911** or go to the nearest emergency department.

1. myStrength® is a trademark of Livongo Health, Inc., a wholly owned subsidiary of Teladoc Health, Inc.
2. The Ginger coaching services described above are not covered under your health plan benefits, are not a Medicare-covered benefit, and are not subject to the terms set forth in your Evidence of Coverage or other plan documents. These services may be discontinued at any time without notice.
3. The coaching services are not available to any members under 18 years old. The coaching services are neither offered nor guaranteed under contract with the FEHB Program, but are made available to enrollees and family members, aged 18 and older, who become members of Kaiser Permanente. The coaching services are available to members enrolled in the Child Health Plan Plus (CHP+) program who are aged 18 and older. The coaching services are not available to anyone enrolled in the State of Colorado's Fee-for-Service Medicaid program and receiving primary care medical provider services from Kaiser Permanente.
4. Where available and appropriate.
5. These features are available when you receive care at Kaiser Permanente medical offices.
6. Chat with a mental health specialist, video, and phone services are offered at no additional cost for most health plans. For these services, some PPO or high deductible health plans are subject to a copayment, coinsurance or deductible first before being provided at no additional cost. Review your Evidence of Coverage, Membership Agreement, or Certificate of Insurance, or call Member Services at **303-338-3800** or **1-800-632-9700** (TTY **711**), Monday through Friday, from 8 a.m. to 6 p.m., for your plan details.

KP
TRAVEL BENEFIT

KAISER PERMANENTE®

TRAVELING? YOU'RE COVERED!

Anytime, anywhere,
Kaiser Permanente has you covered.

CONNECT 24/7 with a licensed care provider for medical advice

TALK with your primary care physician via phone or video

EMAIL your doctor with nonurgent questions

CALL our Away from Home Travel Line at **951-268-3900**

VISIT kp.org/travel

BEST OPTIONS FOR NON-EMERGENCY URGENT CARE AWAY FROM HOME

DOMESTIC TRAVEL (USA) WITHIN A KP SERVICE AREA/REGION*

- Nearest KP urgent care

DOMESTIC TRAVEL (USA) IN A STATE WITHOUT KP

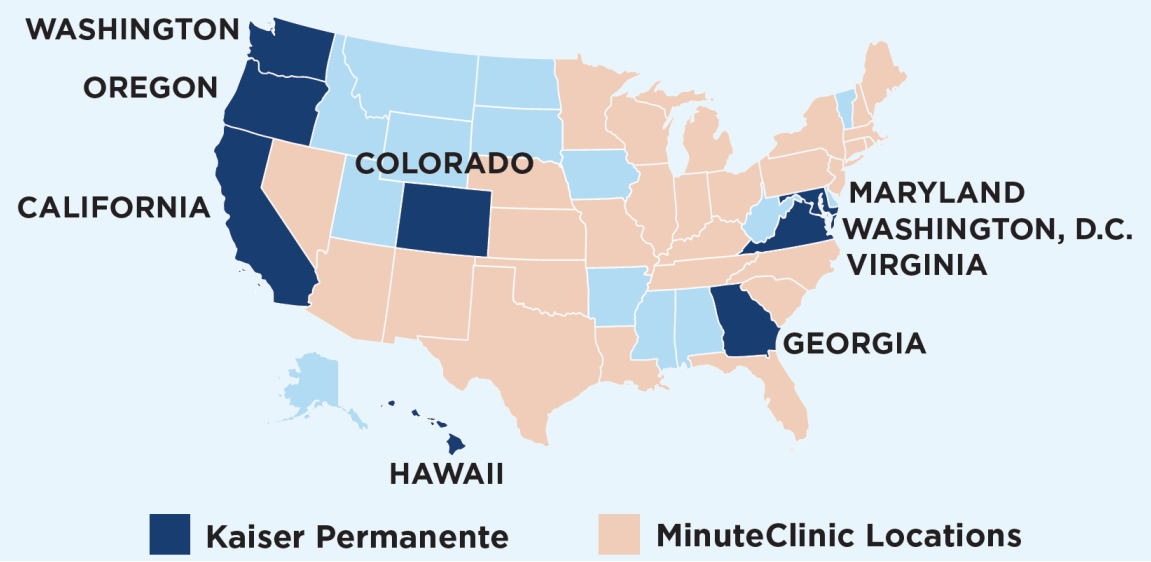
- Nearest MinuteClinic**
- Nearest urgent care facility

INTERNATIONAL TRAVEL***

- Nearest urgent care facility
- Nearest hospital

EMERGENCY CARE AWAY FROM HOME

- Nearest hospital
- Call 911 (USA)



SUPPORT FOR SOCIAL HEALTH

Here for your total health

Find community resources near you

If you ever need help with your daily needs, it's good to know where you can turn. Kaiser Permanente's community resource directory is a convenient online tool to help you find services for healthy food, housing, child care, financial assistance, transportation, and more.

Food Housing Child care Financial assistance

To get started, visit **kp.org/communityresources** or scan the QR code.

To speak to a resource specialist, call **1-800-443-6328** (TTY **711**), Monday through Friday, 8 a.m. to 5 p.m.

You deserve to thrive in mind, body, and spirit. Our community resource directory brings you closer to what you need to live well and thrive.

The services described above are not covered under your health plan benefits and are not subject to the terms set forth in your *Evidence of Coverage* or other plan documents. These services may be discontinued at any time without notice.

Learn more at **kp.org/communityresources**

KAISER PERMANENTE®

KP INFERTILITY BENEFIT

Infertility Benefit[1,2]

Begin your journey to parenthood.

Take your health beyond checkups with a partner who provides the information and support you need to live life to the fullest.

Find more information at **kp.org**, or call Member Services at **303-338-3800** or toll-free **1-800-632-9700**, 8 a.m. to 6 p.m., weekdays, to learn more.

TTY users may call **711** for assistance with any phone number above.

Supplement your health care coverage

Sometimes starting a family requires a little help. If you're struggling with infertility, you're not alone. According to the World Health Organization, infertility affects up to 15% of reproductive-aged couples worldwide. But there's good news. Modern medicine can significantly improve your chances of getting pregnant. And, with our newest coverage for infertility tests and treatments, you have additional benefit options.

Beginning January 1, 2023, upon renewal, covered services include:

- Up to three (3) completed egg retrievals and unlimited embryo transfers in accordance with the guidelines of the American Society for Reproductive Medicine (ASRM), using single embryo transfer when recommended and medically appropriate.
- Coverage for IUI, IVF, GIFT, and ZIFT with no dollar limits or other limitations, consistent with the guidelines of the American College of Obstetricians and Gynecologists (ACOG) or ASRM.
- Coverage for infertility drugs at the same cost share as other prescription medication. Drug coverage applies only if the group purchases a prescription drug rider.
- Coverage for cryopreservation consistent with the guidelines of the American Society of Clinical Oncology (ASCO) or ASRM.

1. Colorado state law requires that an Access Plan be available that describes Kaiser Foundation Health Plan of Colorado's network provider services. To obtain a copy, please call Member Services or visit **kp.org**.
2. The information provided here is a summary only. For a list of services available with your plan, see your Summary of Benefits and Coverage. Upon enrollment, your Evidence of Coverage will contain a description of your coverage, including benefits, exclusions, and limitations. Your Evidence of Coverage will prevail over this or any other plan summary.

Kaiser Foundation Health Plan of Colorado, 10350 E. Dakota Ave., Denver, CO 80247
917021966_22_OE_Infertility-Flyer_CO

kp.org/thrive

KAISER PERMANENTE®

DENTAL BENEFITS

Insured by Delta Dental of Colorado

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 Adams 14 dental benefit plan.

SERVICES	PPO NETWORK	PREMIER NETWORK	OUT-OF-NETWORK
Annual Deductible	$25 per person; $75 family limit	$50 per person; $150 family limit	$50 per person; $150 family limit
Annual Benefit Maximum		$1,500	
Preventive Services (cleanings, exams, x-rays)	0%; no deductible	0%; no deductible	0%; no deductible
Basic Services - Level 1 (fillings)	20%	30%	30%
Basic Services - Level 2 (Endodontics, Periodontics and oral surgery)	20%	60%	60%
Major Services (extractions, crowns, inlays, onlays, bridges, dentures, repairs)	50%	60%	60%
Orthodontia Services (Children and Adults)		50% to $1,500 lifetime maximum	

DENTAL
NETWORK COMPARISON

With the Delta Dental PPO plus Premier plan, you and your family members may visit any licensed dentist. **You will receive the greatest out-of-pocket savings if you see a Delta Dental PPO provider.** PPO and Premier providers file claims directly with Delta Dental and accept Delta Dental's reimbursement in full. You are responsible only for your deductible and coinsurance (as determined by your plan), as well as any charges for non-covered services. If you choose to see an out-of-network provider, you will incur additional out-of-pocket expenses, and you will be billed the total amount the provider charges beyond what Delta Dental pays (called balance-billing). When you see a Delta Dental PPO or Premier® provider, you are protected from balance-billing for covered services.

Advantages of the Delta Dental PPO plus Premier plan:

▶ **SAVINGS:** Delta Dental PPO providers offer our members the greatest savings.

▶ **CHOICE:** If you choose to visit a Premier provider, you will still save money because Premier providers also accept discounted fees (however, discounts are not as great as if you see a PPO provider).

▶ **NETWORK:** Delta Dental's dual network has nearly 102,000 PPO providers and an additional 50,000 Premier providers, for a total of 152,000 participating providers nationwide.

To find a participating provider or to see if your current provider is in the network, visit our website at **deltadentalco.com** and click on the **Find a Dentist** search tool. Or use our free mobile app for iPhone and Android. You may even be able to schedule an appointment online or on the app if your provider has Brighter Schedule.

You can also contact our customer relations department, Monday–Friday 8 a.m. to 6 p.m. Mountain Time, at 1-800-610-0201 (toll-free) or **customer_service@ddpco.com**.

Looking for a dentist? Concerned about costs? PPO providers offer you the greatest savings.

Service: Porcelain Crown (*Benefit illustration only.* Example assumes deductible has been met.)

	Greatest Savings ◄		► Least Savings
	Protected from balance-billing (for covered services)		Not protected from balance-billing
Network	Delta Dental PPO Provider	Delta Dental Premier Provider	Out-of-Network Provider
Procedure Cost	$1,000	$1,000	$1,000
Maximum Provider Can Charge Patient	$700	$850	$1,000+*
Benefit Percentage (you pay)	50%	60%	60%**
Delta Dental Pays	$350	$340	$400
You Pay	**$350**	$510	**$600+**

* Please note that an out-of-network provider is not bound by Delta Dental's in-network contractual obligations and may bill patients for the remaining balance, called balance-billing. The practice of balance-billing refers to a provider's ability to bill patients for outstanding balances after the insurance company pays the required portion of the bill (coinsurance percentage).

** Check your specific plan to see what the coinsurance rate is as they differ from plan to plan.

deltadentalco.com

DENTAL
USING YOUR BENEFITS

DELTA DENTAL®

Using Your Benefits

Congratulations! You have a dental plan from Delta Dental of Colorado. It's so important to use your dental benefits because your oral health is connected to your overall health. Your dentist can spot the early signs of some systemic diseases and can help you avoid painful and costly dental procedures in the future. So make dental care a priority.

Create a subscriber account on deltadentalco.com

You can check the specifics of your plan, the status of claims, and much more. To create a secure account, go to our homepage and click on the Members link and follow the prompts. If you need help setting this up, you can contact our customer service team.

Download our free mobile app

Once you've created an account online, you can access all of the same information within the app. To download our app on your device, visit the App Store (Apple) or Google Play (Android) and search for Delta Dental. You will need an internet connection in order to download and use most features of our free app.

Find a dentist near you

Go to our website or use the mobile app and choose either a Delta Dental PPO™ or a Delta Dental Premier® provider based on the plan you have. A Delta Dental PPO provider will always cost you less out of pocket, so search for one near you to get the greatest savings.

Make an appointment....and smile!

You're taking steps to protect your oral health and your overall health! Plus, preventive services — like cleanings and exams — are usually at no cost to you, so there's no reason to wait.*

Contact Us

Toll-free: 1-800-610-0201 | Monday–Friday 8 a.m. to 5 p.m.
Email: customer_service@ddpco.com

DENTAL
PRE-DETERMINATION ESTIMATES

DELTA DENTAL®

Pre-Determination Estimates

Estimating your dental care costs is simple. Asking your dentist for a pre-determination estimate* from Delta Dental before you agree to receive any recommended major treatment, lets you know up front what the plan will pay, and the difference you will be responsible for.

A pre-determination estimate is useful for costlier procedures such as:

- Crowns
- Wisdom-tooth extractions
- Bridges
- Dentures
- Periodontal surgery

When your dentist submits a pre-determination estimate to Delta Dental, Delta Dental sends them an estimate of your share of the cost and how much Delta Dental will pay.

Dental care cost estimator

Our dental care cost estimator provides estimated cost ranges for common dental care needs. Our cost estimates reflect the range of fees charged by dentists in your area, both in and out of our dental networks. **Remember you will receive the greatest out-of-pocket savings if you see a Delta Dental PPO™ provider.**

Using the dental care cost estimator*

1. Log in to your member account at deltadentalco.com or the Delta Dental mobile app.
2. Click on the **Cost Estimator** tab.
3. Enter the required information: Zip code, treatment category, and dentist last name.
4. To obtain cost information for a specific procedure, contact your dentist directly for a pre-determination estimate.

*The cost estimator or pre-determination estimate are not a guarantee of payment. When the services are complete and a claim is received for payment, Delta Dental will calculate its payment based on your current eligibility, amount remaining in your annual maximum, and any deductible requirements.

deltadentalco.com

VISION BENEFITS

Insured by VSP

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.

Higher allowances for Frames and Contacts at no additional cost!

SERVICE	IN-NETWORK (ANY VSP PROVIDER)	OUT-OF-NETWORK (ANY QUALIFIED NON-NETWORK PROVIDER OF YOUR CHOICE)
EXAMS— ONCE EVERY PLAN YEAR		
Eye Exam	$5 Copay	Reimbursed up to $50, less $5 copay
Contact Lens Exam (Fitting and Evaluation)	Up to $60 Copay	NA
LENSES — ONCE EVERY PLAN YEAR		
Single Vision Lenses	$0 copay; covered in full	Reimbursed up to $50
Lined Bifocal Lenses	$0 copay; covered in full	Reimbursed up to $75
Lined Trifocal Lenses	$0 copay; covered in full	Reimbursed up to $100
Lens Enhancements - Standard Progressive Premium Progressive Custom Progressive	$0 copay; covered in full Up to $90 allowance Up to $160 allowance	Reimbursed up to $75
FRAMES — ONCE EVERY OTHER PLAN YEAR		
Based on frame selection	$200 allowance plus 20% off	Reimbursed up to $70
CONTACT LENSES — ONCE EVERY PLAN YEAR		
If you elect contacts instead of lenses/frames	Up to $180 allowance	Reimbursed up to $105

No need for an ID card. To take advantage of your VSP vision benefit, simply contact a VSP provider and let them know you have VSP coverage—they handle the paperwork for you.

VISION
NETWORK COMPARISON

Your VSP benefits include more than an eye exam and glasses. Consider this your guide to help you understand all that VSP has to offer.

VSP® Vision care for life

1 Create an account.

Get started by creating a **vsp.com** account and opting in to receive information about your benefits. ***Already have an account?*** Log in to review your coverage before your eye exam.

2 Schedule an eye exam.

Find the eye care provider who's right for you at **vsp.com**. We recommend you get an eye exam once a year. And don't forget to check out the featured frame brands to find your perfect style.

3 See your savings.

Log in to your account on **vsp.com** to view your personalized Savings Statement to see how much you saved.

4 Re-enroll in VSP.

Vision insurance is a simple benefit option to review and select. Still on the fence? Here's one more reason—**members save an average of $362** when they select VSP.

GET THE MOST OUT OF YOUR BENEFITS

DID YOU KNOW?

You have access to more than **30,000 network doctors**.

9 out of 10 members reported satisfaction over the past 5 years.*

As a member you'll get Exclusive Member Extras that you won't find anywhere else.

Visit **vsp.com/memberjourney**

TRUHEARING
VSP HEARING BENEFIT

VSP EXCLUSIVE MEMBER EXTRAS

TruHearing® Hearing Aid Discount Program

VSP® Vision Care members can save up to 60% on the latest brand-name hearing aids. Dependents and even extended family members are eligible for exclusive savings, too.

Hearing loss is growing in the workplace.

Like vision loss, hearing loss can have a huge impact on productivity and overall quality of life. Unfortunately, of the over 38 million people who need hearing aids, only one in five has them. And the high cost of hearing aids is a major factor keeping people from addressing their hearing loss.

*96% of customers surveyed would recommend TruHearing to their friends and family.**

More Than Just Great Pricing

TruHearing also provides members with:

- Three provider visits for fitting and adjustments
- A 45-day trial
- Three-year manufacturer warranty for repairs and one-time loss and damage replacement
- 48 free batteries per hearing aid

Plus, members get:

- Access to a national network of more than 3,800 hearing healthcare providers
- Straight-forward, nationally-fixed pricing on a wide selection of the latest brand-name hearing aids
- Deep discounts on batteries shipped directly to their door

Best of all, if your organization already offers a hearing aid benefit, members can combine it with TruHearing prices to reduce their out-of-pocket expense even more!

TruHearing™

Here's how it works:

1. **Members call TruHearing.** Members and their family call **877.396.7194** and mention VSP.
2. **Schedule exam.** TruHearing will answer questions and schedule a hearing exam with a local provider.
3. **Attend appointment.** The provider will perform a hearing exam, make a recommendation, order the hearing aids through TruHearing, and fit them for the member.

Learn more about this VSP Exclusive Member Extra at truhearing.com/vsp or, call 877.396.7194 with questions.

*Based on a 2013 satisfaction study of VSP members.

VSP
SIMPLE VALUES

Enjoy VSP® Simple Values—an exclusive member extra that gives you and your family access to valuable discounts and everyday savings.

VSP SIMPLE VALUES

Health and Wellness:

- Prescription Drugs – **save up to 85%**
  Accepted at CVS Pharmacy, COSTCO Wholesale, Walmart, Target, Walgreens, and others.
- Doctor Visits – **save up to 25%**
  Includes 24/7 doctor access via phone or video visit
- Dental – **save up to 50%**
- Lab Work, MRI, and Imaging – **save up to 60%**
- Hearing – **save up to 60%**
- Diabetic Care Services – **save up to 75%**

Family Fun:

- Live Entertainment, Movie Tickets, and Theme Park Passes – **save up to 40%**
- Travel and Hotels – **save up to 60%**

Everyday Savings:

- Retail Rewards – **cash back**

FIND THE SAVINGS AVAILABLE TO YOU.

Visit **vsp.com/simplevalues** and sign up to download your card today!

EXCLUSIVE MEMBER EXTRAS

THESE DISCOUNT OFFERINGS ARE NOT INSURANCE, and are not intended to replace insurance. These discount offerings, powered by Competitive Health, Inc., are made by third parties, and are not made by VSP. These offerings are not a Qualified Health Plan under the Affordable Care Act. THIS IS NOT A MEDICARE PRESCRIPTION DRUG PLAN. The third-party discount offers may provide discounts on certain services or products. The range of discounts and the range of services and products to which they may apply may vary. VSP shall have no liability whatsoever for the services or products or the discounts that may be offered by third parties. These third-party offers are void where prohibited. The discount medical plan organization is AccessOne Consumer Health, Inc., 84 Villa Rd., Greenville, SC 29615, http://www.accessonedmpo.com.

LIFE & DISABILTY INSURANCE

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Insured by Lincoln Financial Group

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 Adams 14. The company provides basic life insurance at no cost to you as outlined below. Benefits reduce beginning at age 65.

- Administrators - 1.5 times your basic annual earnings, rounded to the next higher $1,000 ($125,000 maximum)
- Certified - 1 times your basic annual earnings, rounded to the next higher $1,000 ($50,000 maximum)
- Classified - 1 times your basic annual earnings, rounded to the next higher $1,000 ($25,000 maximum)

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. Adams 14 provides AD&D coverage equal to your Life Insurance benefit amount at no cost to you. This coverage is in addition to your company-paid life insurance.

SUPPLEMENTAL LIFE AND AD&D INSURANCE

Insured by Lincoln Financial Group

You may purchase life and AD&D insurance in addition to the company-provided coverage. You may also purchase life and AD&D insurance for your dependents if you purchase additional coverage for yourself. You are guaranteed coverage (up to $100,000 or five times your salary, and up to $25,000 for your spouse and up to $10,000 for your children) without answering medical questions if you enroll when you are first eligible. Benefits reduce beginning at age 65. To enroll or increase your coverage, please see HR.

Maximum Benefit Available (subject to medical questionnaire)

Employee— Up to five times your salary in increments of $10,000; $500,000 maximum amount

Spouse— Up to $100,000 in increments of $5,000 not to exceed 50% of EE's amount

Children— One day to age 26 (if unmarried and full time student): $2,000, $4,000, $5,000, or $10,000

LONG TERM DISABILTY INSURANCE

Insured by Lincoln Financial Group

Meeting your basic living expenses can be a real challenge if you become disabled. Your options may be limited to personal savings, spousal income and possibly Social Security. Long Term Disability (LTD) insurance provides protection for your most valuable asset — your ability to earn an income. LTD coverage provides income when you have been disabled for 90 days. This amount may be reduced by other deductible sources of income or disability earnings. Adams 14 provides LTD coverage to all regular full and part-time employees except Certified staff at no cost to you.

Elimination Period—90 Days

Monthly Benefit Amount— 60% of the first $6,000 of your pre-disability earnings, subject to reductions for certain other income

Benefit Duration — Until your normal retirement age (longer for those who are disabled after age 65)

FLEXIBLE SPENDING ACCOUNT

Administered by Wex (Discovery Benefits)

Flexible Spending Accounts (FSAs) allow employees to use pretax dollars for healthcare or child/dependent care expenses not covered by insurance plans. Employees contribute a portion of each paycheck to an FSA and save significantly on taxes. Money in an FSA can be used to pay for out-of-pocket medical, dental and vision expenses or dependent care expenses.

Employees do not need to be enrolled in the Employer's Health Plan to have an FSA. Adams 14 offers you a Healthcare Flexible Spending Account and a Dependent Care Flexible Spending Account.

Healthcare FSA

A Healthcare FSA is a pre-tax benefit account used to pay for eligible medical, dental, and vision care expenses that aren't covered by your insurance plan or elsewhere. It's a smart, simple way to save money while keeping you and your family healthy and protected. The IRS sets a limit on how much you can contribute to this account each year. **For 2023, the spending limit is $3,050.**

Dependent Care FSA

A Dependent care FSA is a pre-tax benefit account used to pay for dependent care services, such as preschool, summer day camp, before or after school programs, and child or elder daycare. A Dependent Care FSA is a smart, simple way to save money while taking care of your loved ones so that you can continue to work. The IRS sets a limit on how much you can contribute to this account each year. **For 2023, the spending limit is $5,000 if married and filing jointly or head of household or $2,500 if married and filing separately**.

Here's How an FSA Works

1. You decide the annual amount (up to the set limit for each account) you want to contribute to either or both FSAs based on your expected healthcare and/or dependent childcare/elder care expenses.
2. Your contributions are deducted from each paycheck before income and Social Security taxes, and deposited into your FSA.
3. You can pay with the Healthcare FSA debit card for eligible healthcare expenses. For dependent care, you pay for eligible expenses when incurred, and then submit a reimbursement claim form or file the claim online.
4. You are reimbursed from your FSA. So, you actually pay your expenses with tax-free dollars.
5. At the end of the plan year, any unused amount in your Healthcare FSA will be forfeited with the exception of a $610 rollover to be used for the next plan year. The $610 rollover does not apply to the Dependent Care FSA.
6. For the Dependent Care FSA, there is a 2 1/2 month grace period after the end of the plan year during which you may use remaining funds. Any funds remaining after the grace period will be forfeited.

IRS QUALIFIED EXPENSES

Below is a list of some of the common expenses claimed against Healthcare Flexible Spending Accounts (FSA). This is not a comprehensive list of the IRS qualified expenses. For more information, please refer to the IRS publication 502 title "Medical and Dental Expenses".

Newer Items added to Eligible Expenses that you might not be aware of:

The eligible expenses have been expanded to include:

- Feminine hygiene products
- Over-the counter (OTC) medications without a prescription.

Common IRS-Qualified Medical and Dental Expenses

Acupuncture
Ambulance service
Annual physical examination
Artificial limb or prosthesis
Birth control pills (by prescription)
Blood sugar test kits
Breast pumps and lactation supplies
Chiropractor
Childbirth/ delivery
Convalescent home
(medical treatment only)
Crutches
Doctor's fees (copay, etc.)
Dental treatments
(including x-rays, braces, dentures, fillings, oral surgery)
Dermatologist
Diagnostic services
Disabled dependent care
Drug addiction therapy
Feminine hygiene products
Fertility enhancement
(including in-vitro fertilization)
Guide dog (or other service animal)
Gynecologist
Hearing aids and batteries
Hospital bills
Infertility treatments
Insurance premiums**
Laboratory fees
Laser eye surgery
Lodging
(away from home for outpatient care)
Medical alert bracelet
Medical transportation expenses
Midwife
Obstetrician
Osteopath
Orthodontics
Orthotic Inserts (custom or off the shelf)
Over-the-counter medicines and drugs
Physical therapy
Pregnancy test kit
Podiatrist
Prenatal care & postpartum treatment
Psychiatrist
Psychologist
Smoking cessation programs
Special education tutoring
Surgery
Transplants
Vaccines
Vasectomy
Vision care
(including eyeglasses, contact lenses, Lasik surgery)
Walker, cane
Weight loss programs
(for a specific disease diagnosed by a physician, such as obesity, hypertension, or heart disease)
Wheelchair
X-rays

**Insurance premiums only qualify as an IRS qualified expenses while continuing coverage under COBRA; for long-term care coverage; coverage while receiving unemployment compensation; for any healthcare coverage for those age 65 including Medicare (except Medicare supplemental coverage).

IRS Publication 502

These are only examples and this is not all-inclusive. For more information, visits irs.gov/forms-pubs/about-publications-502 to view the IRS Publication 502.

WHY SHOULD I CHOOSE...

HEALTHCARE FLEXIBLE SPENDING ACCOUNT

A healthcare FSA is a benefit that allows you to choose how much of your paycheck you'd like to set aside, before taxes are taken out, for healthcare expenses. This saves you money by reducing your taxable income.

Funds on Day One

All the money you elect to set aside is available the first day of the plan year. Use your Discovery Benefits debit card at the point of purchase.

Plan Ahead

Think about the money you spent on your healthcare expenses last year. Plan ahead and set those funds aside in a medical FSA and save 30%.*

Don't know how much to elect? Determine how much you spent on healthcare expenses last year and estimate the amount you'll be spending this year. Do you have a planned surgery coming up? Do you need new glasses or contact lenses?

Any funds you contribute to the healthcare FSA must be spent by the end of the plan year, subject to the $610 carry over maximum.

What Does the Healthcare FSA Cover?

See page 27 for a list of IRS qualified eligible expenses under the Healthcare FSA. You may also visit www.DiscoveryBenefits.com/eligibleexpenses for an interactive eligible expense list.

Can I Enroll?

As long as you or your spouse aren't actively enrolled and contributing to a health savings account (HSA), you may enroll in the healthcare FSA.

DEPENDENT CARE SPENDING ACCOUNT

A dependent care FSA allows you to put aside a portion of your paycheck before taxes for eligible dependent care expenses each year.

Save Money

The dependent care FSA lets you pay for eligible dependent care expenses while you reap the benefits of additional tax savings. You're spending the money either way. This way, eligible childcare and other dependent care costs are a little less.

Save Strategically

Submit all of your dependent care expenses at the end of the plan year for a one lump sum reimbursement to give yourself a hard-earned "bonus".

TIP: For recurring costs, submit the Discovery Benefits Recurring Dependent Care Form. It makes claim filing simple. You only need to submit one form once in order to get reimbursed each pay period.

What Does the Dependent Care FSA Cover?

- Childcare center, babysitter, nanny (children birth through age 12)
- Summer day camp
- Before or after-school care
- Disabled dependent and/or spouse care
- Elder care

Visit www.DiscoveryBenefits.com/eligibleexpenses for an interactive eligible expense list.

Can I Enroll?

If you and/or your spouse (if applicable) are gainfully employed, looking for work, or are attending school on a full-time basis, you may enroll in a dependent care FSA.

Benefits Mobile App

Download the free Benefits Mobile App by Discovery Benefits on Apple and Android smartphone and tables, to access your FSA while on the go anytime, anywhere 24/7. With the Benefits Mobile App, you can:

- Access claims status updates instantly
- File a claim and upload supporting documentation
- Report a lost or stolen debit card
- Use your benefits debit card using Apple Pay or Samsung Pay
- Scan an item's bar code to determine if it's an IRS Qualified Eligible expenses.
- Rest your login credentials

The Benefits Mobile app uses secure encryption and won't store pictures on your phone, keeping your documents safe and secure.

RETIREMENT
TAX SHELTER ANNUITIES

ADAMS COUNTY SCHOOL DISTRICT 14
TAX SHELTER ANNUITY VENDORS (T.S.A.) PROVIDERS

SECURITY BENEFITS

COOPER PETERS
PETERS FINANCIAL LLC
7432 S Eudora Way
Centennial, Co 80122
720-244-4212
720-458-0258
www.petersfinancialllc.com
cpeters@lincolninvestments.com

PERA 401K

303-832-9550
1-800-759-7372
www.copera.org

VALIC FINANCIAL ADVISOR/ROCKY MTN DISTRICT

CRAIG FISCHER
AIG RETIRMENT SERVICES
165 S Union Blvd, Suite 600
Lakewood, Co 80228
720-288-2780
833-622-1290
Craig.Fischer@aig.com
www.aig.com/Retirement Services
720-962-8000

MATTHEW HOWARD
AIG RETIRMENT SERVICES
165 S Union Blvd, Suite 600
Lakewood, Co 80228
303-550-8440 (phone)
720-501-5605 (fax)
matthew.howard1@aig.com
www.aig.com/Retirement Services
720-962-8000

EQUITABLE ADVISORS LLC

GORDON SANDEMAN
14143 Denver West Parkway, Suite 520
Lakewood CO 80401
720-275-3237
720-946-4414
Gordon.Sandeman@equitable.com
www.equitable.com

HANNAH MOORE, Financial Advisor
ROCKY MOUNTAIN BRANCH
14143 Denver West Parkway, Suite 520
Lakewood CO 80401
970-260-3882
Hannah.Moore@equitable.com

HORACE MANN

KENDRA ROBINETTE, LUTCF, CLU, CHFC
720-269-4899
Kendra.Robinette@HoraceMann.com

VOYA-RELIASTAR LIFE INSURANCE CO

Appreciation Insurance & Financial Services, LLC

JOHN BECKER
REGIONAL VICE PRESIDENT
720-432-5887 (phone)
720-936-0507 (mobile)
jbecker@appreciationfinancial.com

DAVID GAGLIARDI
SENIOR FIELD MANAGER
720-772-1998
dgagliardi@appreciationfinancial

Employee CONTRIBUTIONS

EMPLOYEE CONTRIBUTIONS FOR BENEFITS

BENEFIT PLAN	MONTHLY
Kaiser HMO	
Employee	$95.76
Employee + One Dependent	$629.79
Employee + Family	$1,270.61
Kaiser DHMO	
Employee	$49.47
Employee + One Dependent	$537.20
Employee + Family	$1,122.47

BENEFIT PLAN	MONTHLY
Delta Dental	
Employee	$0.00
Employee + One Dependent	$35.66
Employee + Family	$83.88
VSP Vision	
Employee	$0.00
Employee + One Dependent	$9.17
Employee + Family	$18.22

SUPPLEMENTAL LIFE INSURANCE	
Age of Employee/ Spouse	Supplemental Life Rates (Per $1,000 per month)
0-24	$0.050
24-29	$0.060
30-34	$0.079
35-39	$0.090
40-44	$0.100
45-49	$0.150
50-54	$0.230
55-59	$0.413
60-64	$0.623
65-69	$1.191
70+	$1.928
Dependent Child	$0.240

SUPPLEMENTAL AD&D INSURANCE (Per $1,000 per month)	
Employee	$0.016
Spouse	$0.016
Child	$0.051

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	Kaiser Permanente	800.632.9700	www.kp.org
Mobile Urgent Care	DispatchHealth	303.500.1518	www.dispatchhealth.com
Dental	Delta Dental of Colorado	800.610.0201	www.deltadentalco.com
Vision	VSP	800.877.7195	www.vsp.com
Life/ AD&D	Lincoln Financial Group	800.423.2765	www.lfg.com
Supplemental Life/ AD&D	Lincoln Financial Group	800.423.2765	www.lfg.com
Long Term Disability	Lincoln Financial Group	800.423.2765	www.lfg.com
Employee Assistance Program	Lincoln Financial Group	800.423.2765	www.lfg.com
Flexible Spending Accounts	Wex (Discovery Benefits)	866.451.3399	www.wexinc.com

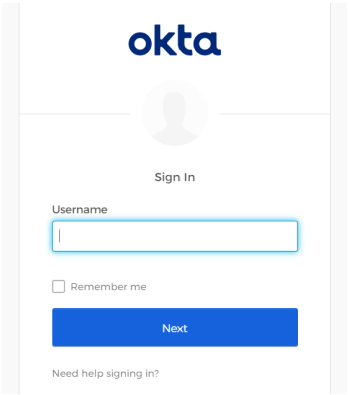
HOW TO ENROLL

Please follow these instructions when accessing the employee portal.

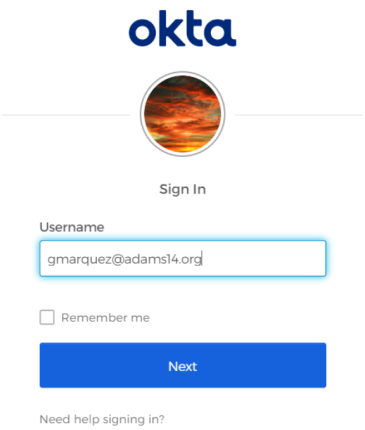
1. [Click here to access](https://tyler-adamsctsd14co.okta.com)

https://tyler-adamsctsd14co.okta.com

2. This is the screen you should see when clicking in the invisions icon

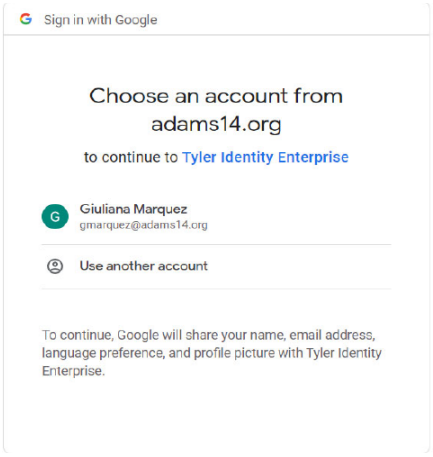


3. Enter your district email address

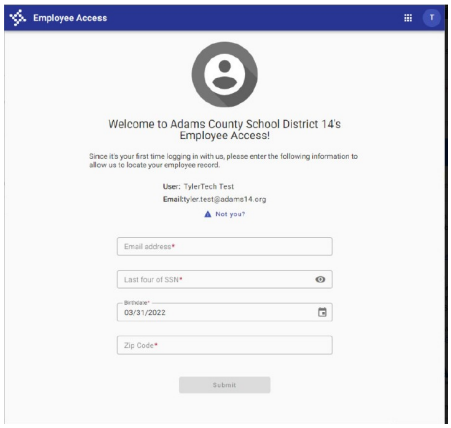


4. You'll be prompted to answer a few security questions

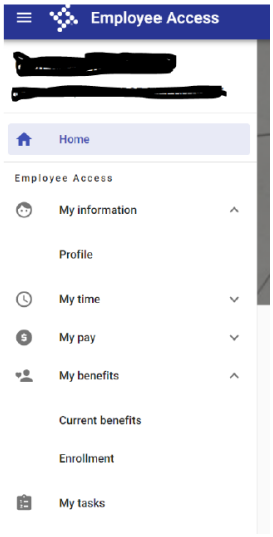
5. After proceeding, you should get a message from Google to enter your district email address



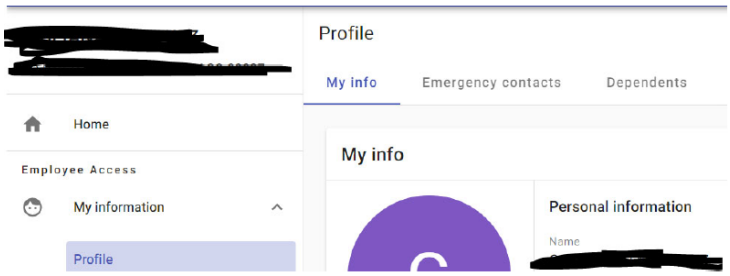
6. First time users will see this screen, you'll need to enter the information that was provided when you were originally hired



7. Once in the portal you'll see this information



If you need to add dependents you'll click on the information tab and add dependents under that tab



LEGAL NOTICES

Health Plan Annual Notices

For the Plan Year 2023-24

Adams 14

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 General Notice

PATIENT PROTECTIONS DISCLOSURE

The Adams 14 Health Plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Kaiser Permanente designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Kaiser Permanente at 800.632.9700 or www.kp.org.

For children, you may designate a pediatrician as the primary care provider.
You do not need prior authorization from Kaiser Permanente or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Kaiser Permanente at 800.632.9700 or www.kp.org.

WOMEN'S HEALTH & CANCER RIGHTS ACT

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

Plan 1: KAISER HMO (Individual: 20% coinsurance and None deductible; Family: 20% coinsurance and None deductible)
Plan 2: KAISER DHMO (Individual: 10% coinsurance and $300 deductible; Family: 10% coinsurance and $600 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 303.853.3260 or nboughton@adams14.org.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION 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).

Protecting Your Health Information Privacy Rights

HIPAA NOTICE OF PRIVACY PRACTICES REMINDER

Adams 14 is committed to the privacy of your health information. The administrators of the Adams 14 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 Nathan Boughton – Chief Human Resources Officer at 303.853.3260 or nboughton@adams14.org.

HIPAA SPECIAL ENROLLMENT RIGHTS

Adams 14 Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Adams 14 Health Plan (to actually participate, you must complete an enrollment form 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 Nathan Boughton – Chief Human Resources Officer at 303.853.3260 or nboughton@adams14.org.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form 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 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 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 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.

NOTICE OF CREDITABLE COVERAGE

Important Notice from Adams 14

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 Adams 14 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. **Adams 14 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 Kaiser coverage will not be affected. See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current Kaiser coverage, be aware that you and your dependents will 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 Adams 14 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 Adams 14 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:	**August 01, 2023**
Name of Entity/Sender:	**Adams 14**
Contact—Position/Office:	**Nathan Boughton – Chief Human Resources Officer**
Office Address:	**5291 East 60th Avenue** **Commerce City, Colorado 80022** **United States**
Phone Number:	**303-853-3260**

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

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

GEORGIA Medicaid	INDIANA Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	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
IOWA Medicaid and CHIP (Hawki)	**KANSAS 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://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012
KENTUCKY Medicaid	**LOUISIANA 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: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE Medicaid	**MASSACHUSETTS Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
MINNESOTA Medicaid	**MISSOURI Medicaid**
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	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA Medicaid	**NEBRASKA Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA Medicaid	NEW HAMPSHIRE Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY Medicaid and CHIP	**NEW YORK Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA Medicaid	**NORTH DAKOTA Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA Medicaid and CHIP	**OREGON Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA Medicaid and CHIP	**RHODE ISLAND Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA Medicaid	**SOUTH DAKOTA Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS Medicaid	**UTAH Medicaid and CHIP**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT Medicaid	**VIRGINIA Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON Medicaid	**WEST VIRGINIA Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN Medicaid and CHIP	**WYOMING Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

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

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

Paperwork Reduction Act Statement

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

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

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

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: Nathan Boughton.

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, 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

Adams 14
Nathan Boughton – Chief Human Resources Officer
5291 East 60th Avenue
Commerce City, Colorado 80022
United States
303-853-3260

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

MARKETPLACE NOTICE

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[2]

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Nathan Boughton.

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

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

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting