SUMMIT
SCHOOL DISTRICT

Benefit Guide
2024-2025

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If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 32-33 where Notice of Creditable Coverage begins for more details.

Benefits Overview

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

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

Benefits Offered

- Medical (2 plans)
- Prescription Drugs
- Regenexx
- Dental (2 plans)
- Voluntary Employee, Spouse, and Child(ren) Life and AD&D Insurance
- Vision
- District Paid Life and AD&D
- Telemedicine Services
- Plan Advisor
- Real Appeal
- Member Assistance Program (MAP)
- Flexible Spending Accounts (FSA) – Medical and Dependent Care
- Health Savings Account (HSA)
- Other Voluntary Benefits (Voluntary Accident, Critical Illness, STD, Life with Long Term Care, Hospital Indemnity)

Eligibility

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

- You must be a full-time employee who is regularly working 30 or more hours per week during the regularly scheduled work week AND;
- Your normal net pay must be sufficient to pay the costs for the coverage you select (net pay equals gross pay minus PERA and State / Federal / Medicare taxes)

Employees are eligible for benefits starting on the first day of the month following their date of full-time hire by the District. You may elect coverage for you and your dependents.

Dependents include:

- Your legal spouse (including domestic partners)
- Your child who is less than 26 years of age (disabled dependents of any age—requires carrier approval)

Elections made at the time of hire or during open enrollment will remain until the next open enrollment unless you or your family members experience a qualifying event. If you experience a qualifying event, you must contact HR **within 30 days of the event**.

Open Enrollment 2024 - 2025

- Employees working 30+ hours per week are eligible for benefits.
- Open enrollment will occur July 22-August 9, 2024
- Open enrollment for the 2024-2025 benefits will again be processed through the Employee Access Portal.
- **ALL** benefits eligible employees will need to go into the Employee Access Portal to review your plan options and make your benefit elections for the 2024-2025 plan year. Open enrollment examples:
  - Enroll in or waive each benefit;
  - Add or Remove Dependents;
  - Update your beneficiaries for the $25k District Paid Life Insurance benefit

Please note: You must take action in the Employee Portal during open enrollment as your current elections will not roll-over. If you do not complete your elections in the Employee Portal, your benefit coverage will end August 31, 2024.

What's New for 2024 - 2025?

Plan Changes will be effective September 1, 2024 through August 31, 2025

MEDICAL BENEFITS - UPDATES

- We will continue to offer the same two medical plan options with UMR/UnitedHealthcare of Colorado:
  - Healthy Measures PPO; and
  - High Deductible Health Plan (HDHP) with HSA
- The only change to either plan that will occur is with the High Deductible Health Plan (HDHP). This plan currently has a $1,500 deductible for single enrollment and a $3,000 deductible for family enrollment. **Due to IRS requirements,** this must be changed to $1,600 for single enrollment and $3,200 for family enrollment starting 9/1/24.
- **Regenxx** will continue to be offered— this is a great alternative to Orthopedic Surgery

BENEFIT PLAN FEATURES:

Telemedicine (CirrusMD)

- 24/7/365 Medical and Behavioral Health Consultations – Access to Board Certified, U.S. Physicians, Licensed Counselors and Psychiatrists by Phone, Email or Live Online Chat
- **No Charge** for these services through December 31, 2024 then a fee will apply (due at the time of service) if you are an HDHP plan member, beginning January 1, 2025 (unless extended by law).
- **Available to ALL employees regardless of eligibility for other benefits (includes part-time employees).**

Plan Advisor (Member Advocacy)

- A personal guide for all things healthcare
- Higher level of customer service
- CARE programs (complex condition assistance e.g., high risk pregnancy)

Prescription Benefit Value Adds (OptumRx)

- Pre-Check my script™
- DivvyDOSE (Multi-Dose Pill Packing)

Real Appeal – Healthier habits, healthier lifestyle

- Evidence based program supporting weight management and loss
- Customized plan for each individual
- Ongoing individual and group coaching support
- No cost to eligible members and dependents

UPDATED SPENDING LIMITS

Flexible Spending Account (FSA)

- $3,200 annual limit on salary reduction contributions to health flexible spending accounts (FSAs)
- There are no changes to the dependent care FSA calendar year maximum limit of $5,000/$2,500 if married and filing separately

Health Savings Account (HSA)

- Per IRS Regulations, the maximum HSA contribution levels for the calendar year 2024 are as follows:
  - Individual: $4,150
  - Family: $8,300
  - Catch-Up (Over age 55): +$1,000

DENTAL AND VISION BENEFITS

- The District will continue to offer you a choice of the same TWO dental plans, with **UHC**.
  - In the buy-up plan, orthodontia is covered for **dependent children to age 19.**
- Voluntary Vision benefits will continue with **UHC**.

VOLUNTARY BENEFITS

- Voluntary Benefit Options– If you are interested in adding any of these benefits, please review them in the Employee Portal for additional information, including costs. Benefits available include:
  - Voluntary Life and AD&D– UHC
  - Accident Benefit– UHC
  - Critical Illness Benefit– UHC
  - Hospital Indemnity Benefits– UHC
  - Life Insurance with Long Term Care– Trustmark
  - Voluntary Short-Term Disability– UHC
  - Pet Insurance– ASPCA
  - ID Theft– Identity Guard

Medical Benefits

Administered by UMR

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

In-Network Benefits Shown—Out-of-Network Benefits are available.	HDHP / HSA PLAN	HEALTHY MEASURES PPO
	UHC Choice Plus Network—In-Network Benefits	
Lifetime Benefit Maximum	Unlimited	Unlimited
Plan Year Deductible (Single/Family)	$1,600 / $3,200	$2,500 / $5,000
Plan Year Out-of-Pocket Maximum (Single/Family – Includes Deductible And Copays)	$5,600 / $11,200	$5,000 / $10,000
Deductible / Out-of-Pocket Type	**Aggregate** / Embedded	Embedded / Embedded
Coinsurance	You Pay 20% / Plan Pays 80%	You Pay 20% / Plan Pays 80%
DOCTORS OFFICE		
Office Visits (PCP/Specialists)	20% After Deductible	$35 Copay
Virtual Office Visits	20% After Deductible	$35 Copay
Preventive Care	Plan Pays 100%, No Deductible	Plan Pays 100%
Urgent Care (Includes Lab/X-Ray)	20% After Deductible	$50 Copay
PRESCRIPTION DRUGS		
Retail - **Generic**	20% After Deductible	$10 Copay
Retail - **Preferred Brand**	20% After Deductible	You Pay 30%
Retail - **Non-Preferred Brand**	20% After Deductible	You Pay 50%
Retail and Mail Order - **Specialty**	20% After Deductible	You Pay 30% to $250 Maximum per Rx
Mail Order - **Generic**	20% After Deductible	$25 Copay
Mail Order - **Preferred Brand**	20% After Deductible	You Pay 25%
Mail Order - **Non-Preferred Brand**	20% After Deductible	You Pay 45%
HOSPITAL SERVICES		
Emergency Room	You Pay 20%; After In-Network Deductible	You Pay 20%; After In-Network Deductible
Inpatient Hospitalization	20% After Deductible	20% After Deductible
Inpatient Professional Services	20% After Deductible	20% After Deductible
Outpatient Surgery	20% After Deductible	20% After Deductible
Ambulance Service	You Pay 20%; After In-Network Deductible	You Pay 20%; After In-Network Deductible

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

In-Network Benefits Shown—Non-Network Benefits are available.	HDHP/HSA PLAN	HEALTHY MEASURES PPO
	UHC Choice Plus Network—In-Network Benefits	
MENTAL HEALTH SERVICES		
Inpatient Services	20% After Deductible	20% After Deductible
Outpatient Services	20% After Deductible	$35 Copay
SUBSTANCE ABUSE SERVICES		
Inpatient Services	20% After Deductible	20% After Deductible
Outpatient Services	20% After Deductible	$35 Copay
OTHER SERVICES– Services limitations are combined in and out of network unless otherwise specified		
Chiropractic Services (Limited to 20 Visits Per Plan Year)	20% After Deductible	$35 Copay
Outpatient Physical Therapy (Limited to 25 Visits Per Plan Year)	20% After Deductible	$35 Copay
Outpatient Speech Therapy (Limited to 25 Visits Per Plan Year)	20% After Deductible	$35 Copay
Outpatient Occupational Therapy (Limited to 25 Visits Per Plan Year)	20% After Deductible	$35 Copay
Outpatient Pulmonary Rehab & Cognitive Therapy (Limited to 25 Visits Per Plan Year)	20% After Deductible	$35 Copay
Outpatient Cardiac Rehabilitation (Limited to 36 Visits Per Plan Year)	20% After Deductible	$35 Copay
Lab & X-Ray in Physician's Office	20% After Deductible	Covered under Office Visit Copay
Radiology And Advanced Radiology Imaging At Outpatient Facility	20% After Deductible	20% After Deductible
Lab Tests at Independent Lab	20% After Deductible	20% After Deductible
Outpatient Advanced Radiology Imaging Services (MRI, MRA, PET, CT & Nuclear Medicine)	20% After Deductible	20% After Deductible

UMR Member Portal

Make www.umr.com your first stop.

You want managing your healthcare to be fast and easy, right? You got it. At umr.com you'll find everything you want to know-and need to-as soon as you log in. No hassles. No waiting. Just the answers you're looking for anytime, night or day!

New and Re-Registration for Members

- Visit www.umr.com and click on the **Login/Register** button
- Click on **Register**
- Select **Member** from the list of the UMR user types and click **Next**
- Fill out the **we want to get to know you** section and click **Verify my account** (Note: have your member ID card handy)
- Enter account details
- Create a username and password for the account
- Create security questions and answers
- Select family member coverage, if applicable
- Select security settings for access to information
- Begin using the www.umr.com portal

Lost ID card?

No worries. It's easy to get a replacement online.

Just click **ID card** from **myMenu** to see a copy of your card. With a couple more clicks you can have a new card mailed to your home.

Can't wait? Print a temporary copy from our desktop site. Or, use your smart phone to view your ID card or fax a copy to your doctor's office.

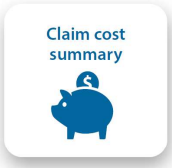
Don't be surprised by unexpected costs. Use the portal for the following features:

Know the price you'll pay ahead of time

Use the Health cost estimator to look up a treatment or procedure in your area.

Quickly see what you spent on health care this year

Get a breakdown by the types of services, so you can see where all your money went.



Make sure you get your in-network discount

Do a quick search for participating doctors and facilities near you.

The **UMR app** is another way we're reimagining health care to work for you.

We have a smarter, simpler, faster way to manage your health care benefits, right from the palm of your hand.

With just a tap, you can:

- Access your digital ID card
- View your plan details on-demand – anytime, anywhere
- Find out if there is a co-pay for your upcoming appointment
- Chat, call or message UMR's member support team

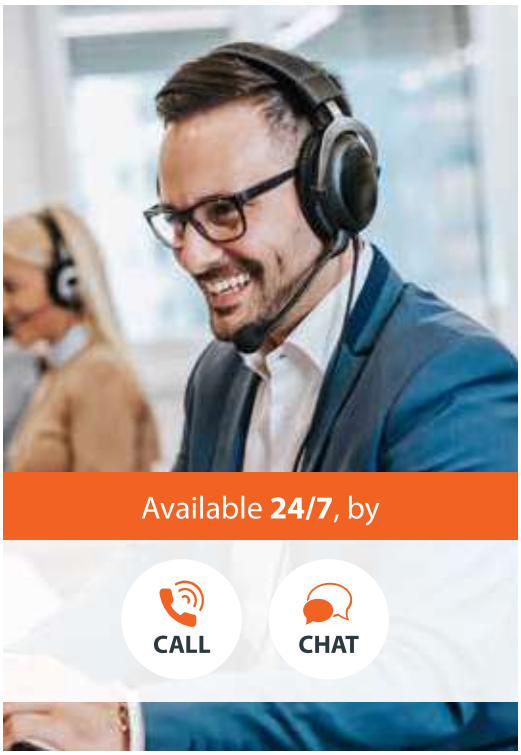
Stay connected to your health care and download the UMR app today!

Simply scan the QR code to the left or visit your app store to get started.

Plan Advisor: An advocacy focused service model

A UnitedHealthcare Company

Supporting employer priorities and specific plan objectives



Designated team, trained on plan,

UMR collaborates with customers to create a custom plan design, built from the ground up. Plan Advisor supports the initiatives of the plan while providing advocacy for members.

A personalized, member-oriented, relationship-based approach

Plan Advisors have a deep understanding of:

– Benefit plan details
– Employer culture
– Targeted goals

Receive **6 weeks of specific advocacy training** and ongoing continuing education on situational coaching

Plan Advisor dashboard — Advisors can quickly see:

- A comprehensive view of your member's health
- History of individual actions taken on behalf of the member
- Customer priorities and focus areas (captured at implementation/annually)

Plan Advisor redirect

Helping members navigate to the most optimal provider by intercepting and redirecting care opportunities.

- Research and identify more optimal places of service – review quality, cost, availability, location
- Contact member to promote redirection of care via phone, email, mail
- Help member successfully redirect care, schedule appointments, transfer medical records

One call. One advocate.

Guiding members to better health

Simplified health care experience

Members make better decisions about care, feel more confident in their decisions, and take ownership of their health

Single-entry point
for true member advocacy, 24/7

- **Educating** members on their health plan and benefits
- **Engaging** members with a simplified and streamlined experience
- **Connecting** members with higher quality, more efficient and cost-effective care
- **Informing** members about health and wellness opportunities

A closer look — What Plan Advisor delivers to members:

- Provide benefit and eligibility information
- Explain EOBs and benefit information
- Resolve claims and billing inquiries
- Help members find a provider and schedule appointments
- Promote preventive care and identify any gaps in care
- Ensure connection with primary care provider
- Deliver network guidance
- Guide members on using online tools
- Engage members in CARE opportunities with seamless transfers
- Coordinate with employer's external vendors
- Communicate health information, employer-specific events and reminders
- Redirecting care opportunities for better health outcomes and improved cost savings

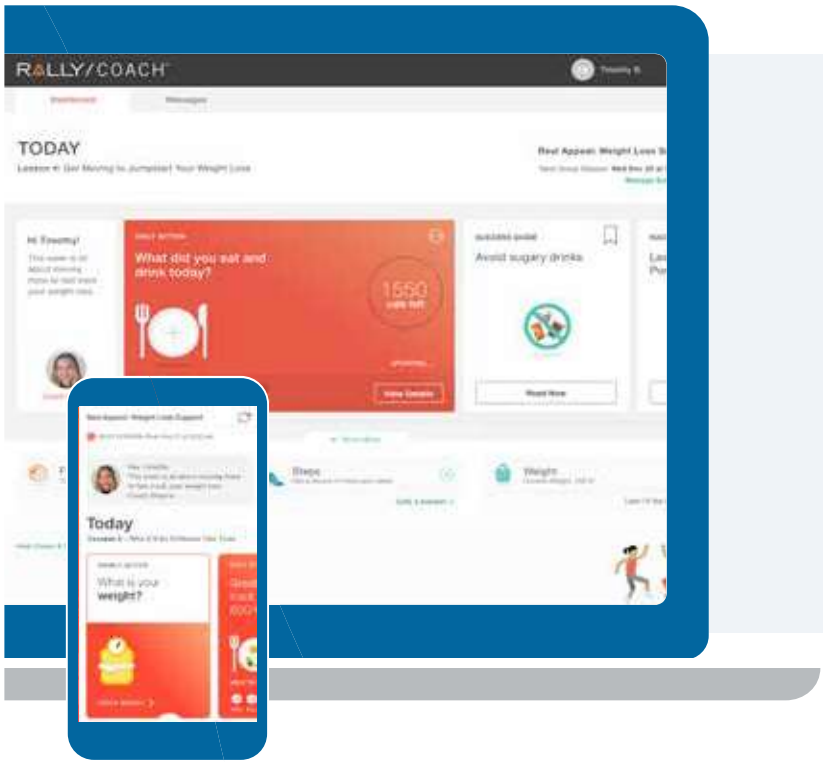
ADD-ON PROGRAM

Plan Advisor + CARE Connect

Integrating licensed nurses and social workers to serve as a connection point to other key clinical programs.

Real Appeal

Lose weight. Feel better. Be healthier.



Supports weight loss with an evidence-based approach:

- Reduces pre-diabetes and cardiovascular risk
- Entertaining, Hollywood quality videos
- Clinically sound guidance
- Direct-to-consumer strategies
- Aspirational messaging

How it works

Real Appeal helps people make small changes necessary for larger, long-term health results, based on weight-loss research studies commissioned by the National Institutes of Health. Real Appeal uses a highly interactive weekly internet show, videos and live online coaching to drive small behavior changes, week-by-week, over a full year.

The program is designed to support members with:

≥ 30 body mass index (BMI)

≥ 25 to ≤29.9 BMI with qualifying co-morbidity*

≥ 23 to ≤29.9 BMI with no co-morbidity

* Diabetes, dyslipidemia, high blood pressure, pre-diabetes, tobacco user

Members receives:

- Small, actionable changes
- Engaging, inspiring content
- Ongoing coaching support
- Customized plan

Customer receives:

- Improvement engagement
- Employee satisfaction
- Potential for reduced medical costs
- Pay-for-performance pricing

UMR℠

A UnitedHealthcare Company

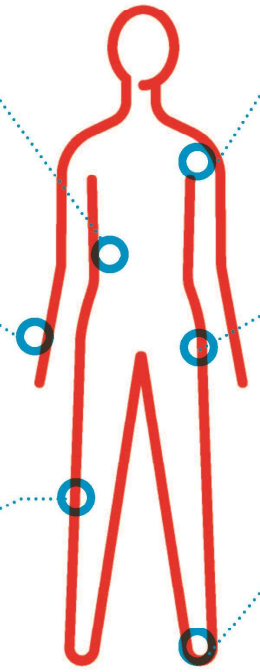
Regenexx®

SUMMIT SCHOOL DISTRICT

Summit School District now covers Regenexx under your health plan

Regenexx uses your body's natural healing agents to replace the need for up to 70% of elective orthopedic surgeries. Your stem cells and blood platelets are concentrated in our on-site orthobiologics lab and injected under image guidance into the precise area of your injury. With Regenexx, you can get back to doing what you love without invasive surgery and lengthy recovery.

Conditions Treated



Spine
- bulging, collapsed, or herniated disc
- ruptured or torn disc
- degenerative disc disease
- disc extrusion
- disc protrusion
- back or neck nerve pain

Hand/Wrist/Elbow
- arthritis
- tennis elbow
- ulnar nerve entrapment
- CMC joint arthritis (thumb)
- carpal tunnel
- trigger finger

Knee
- arthritis
- meniscus tear
- sprain or tear of ACL/PCL
- sprain or tear of the MCL/LCL
- tendinopathy
- joint replacement alternative

Shoulder
- arthritis
- rotator cuff tears
- labral tear
- rotator cuff tendinosis
- joint replacement alternative

Hip
- osteonecrosis
- bursitis
- labral/labrum tear
- tendinopathy
- joint replacement alternative
- arthritis

Ankle/Foot
- arthritis
- instability
- bunions
- ligament sprain or tear
- plantar fasciitis
- achilles tendinopathy

Learn more about Regenexx and your benefits

For an in-depth overview, **Regenexx** hosts weekly informational sessions where you can learn about **Regenexx** and how our procedures may be able to help treat your orthopedic pain. You'll also have the opportunity to ask questions about your benefits. Follow the QR code or visit the address below to register for a webinar. Scheduled dates and times are updated regularly.

regenexxbenefits.com/webinar?card

Contact us at 970-401-7523 or visit regenexxbenefits.com/summitk12.

Easy access to your prescription information

Through our partnership with OptumRx, we can help you manage your pharmacy benefits through **umr.com**.

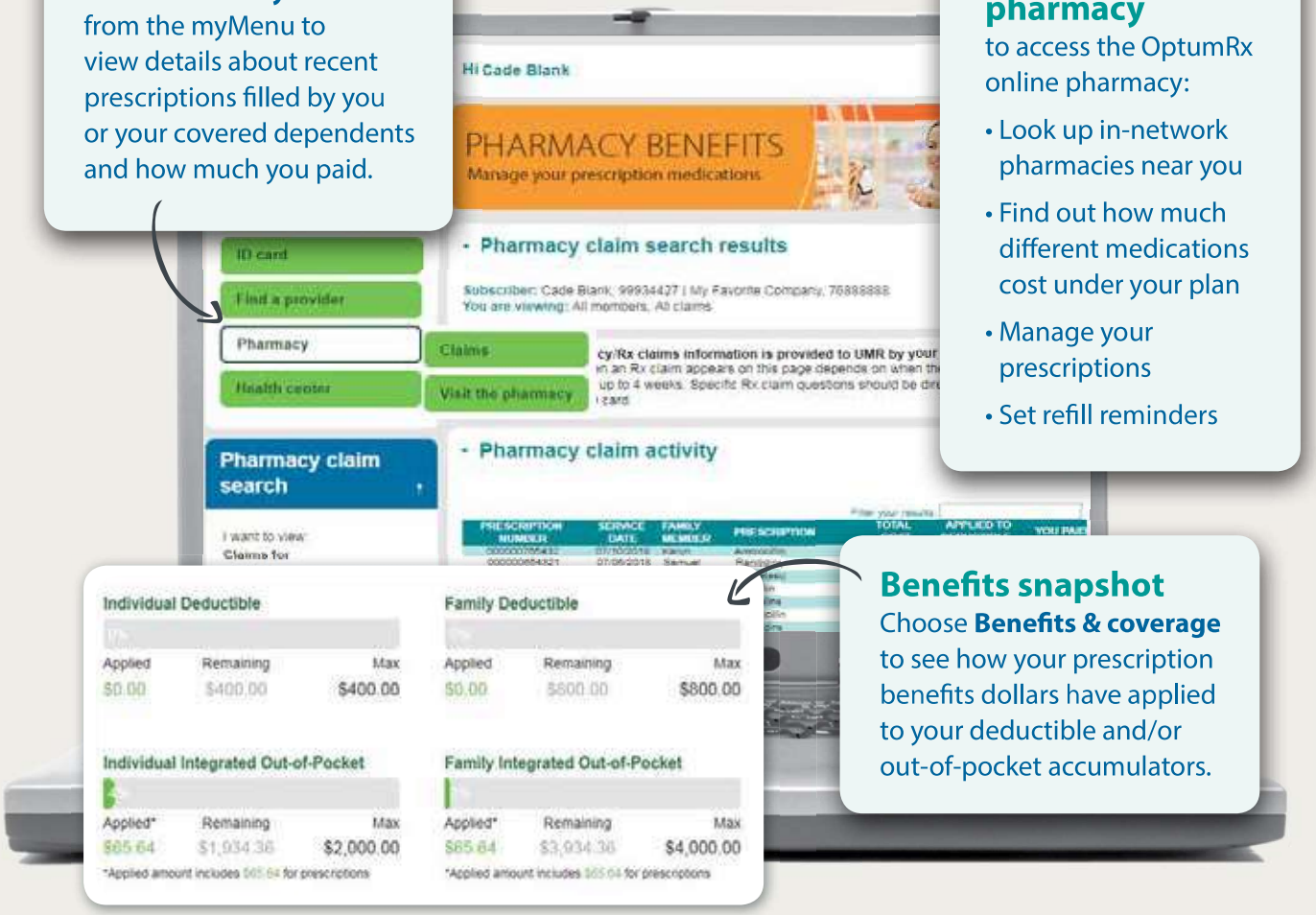
Claim information

Select **Pharmacy > Claims** from the myMenu to view details about recent prescriptions filled by you or your covered dependents and how much you paid.

Visit the pharmacy

to access the OptumRx online pharmacy:

- Look up in-network pharmacies near you
- Find out how much different medications cost under your plan
- Manage your prescriptions
- Set refill reminders



Benefits snapshot

Choose **Benefits & coverage** to see how your prescription benefits dollars have applied to your deductible and/or out-of-pocket accumulators.

NOTE: UMR receives OptumRx claims information and accumulator amounts in different ways, so you may see updates to your accumulators before the new claims details are viewable on **umr.com**.

UMR℠
A UnitedHealthcare Company

Telemedicine Services

Administered by CirrusMD

Get a jump-start on good health habits this year by chatting with a CirrusMD doctor today. CirrusMD can help by answering any medical questions you may have on your health and wellness journey. **CirrusMD is here to keep you healthy all year long.**

Just send a message with the CirrusMD app, and get a response from a doctor in less than a minute — it's that easy.

Chat with a doctor about any of the following:

- COVID-19
- Getting asthma under control
- How to lose weight
- Managing high blood pressure
- Clearing up acne
- General questions about overall wellness
- Help with quitting smoking

CirrusMD is available to ALL employees regardless of eligibility for other benefits (includes part-time employees)

- 24/7/365 Medical and Behavioral Health Consultations – Access to Board Certified, U.S. Physicians, Licensed Counselors and Psychiatrists by Phone, Email or Live Online Chat
- **No Charge** for these services through December 31, 2024 then a fee will apply (due at the time of service) if you are an HDHP plan member, beginning January 1, 2025 (unless extended by law).

Chat with a Doctor Now!

Flexible Spending Accounts (FSA)

Administered by Rocky Mountain Reserve

Summit School District provides you the opportunity to fund out-of-pocket medical, dental, vision and dependent care expenses with pre-tax dollars through Flexible Spending Accounts. You must enroll/re-enroll in the plan to participate for the plan year September 1, 2024 through August 31, 2025. You can save approximately 25% of each dollar spent on these expenses when you participate in a FSA.

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

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

Contributions to your FSA come out of your paycheck before any taxes are taken out. This means that you don't pay federal income tax, Social Security taxes, or state and local income taxes on the portion of your paycheck you contribute to your FSA. You should contribute the amount of money you expect to pay out of pocket for eligible expenses for the plan period. If you do not use the money you contributed, with the exception of $640 which can be rolled over to the new plan year, it will not be refunded to you or carried forward to a future plan year. This is the use -it-or-lose-it rule.

- The maximum that you can contribute to the Health Care Flexible Spending Account is $3,200.
- The maximum that you can contribute to the Dependent Care Flexible Spending Account is $5,000 if you are a single employee or married filing jointly, or $2,500 if you are married and filing separately.

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

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

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

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

Health Savings Accounts (HSA)

Administered by Health Equity

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

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

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

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

Setting Up an HSA Account

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

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

Contributing to Your HSA

Health Savings Accounts have a triple tax advantage:

- Contribute tax-free
- Invest tax-free
- Make withdrawals for eligible medical expenses, or for any use after age 65 tax-free

Using Your HSA Funds

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

2024 ANNUAL HSA CONTRIBUTION LIMITS	
Single Coverage	$4,150
Family Coverage	$8,300
If age 55 or older you may contribute an additional $1,000	

Special Considerations

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

Your adult children 19-26 MUST be a tax dependent to be eligible to use your HSA dollars for their expenses. If they are not tax dependent, and still covered under your Summit School District HDHP plan, they may open their own HSA and contribute up to the family maximum.

Dental Benefits

Administered by UMR

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

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

Voluntary Vision Benefits

Insured by UnitedHealthcare

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

	IN-NETWORK (USING UHC VISION PROVIDER)	OUT-OF-NETWORK (ANY QUALIFIED NON-NETWORK PROVIDER OF YOUR CHOICE)
Eye Exam — once every 12 months	$10 copay	Reimbursed Up to $45 Allowance
LENSES — ONCE EVERY 12 MONTHS		
Single Vision Lenses	$25 copay	Reimbursed Up To $40 Allowance
Lined Bifocal Lenses	$25 copay	Reimbursed Up To $65 Allowance
Lined Trifocal Lenses	$25 copay	Reimbursed Up To $75 Allowance
Lenticular Lenses	$25 copay	Reimbursed Up To $100 Allowance
Progressive Lenses	$25 copay	Reimbursed Up To $65 Allowance
Frames — once every 24 months	$150 allowance	Reimbursed Up To $83 Allowance
CONTACT LENSES — ONCE EVERY 12 MONTHS IN LIEU OF LENSES/FRAMES		
Formulary contact lenses	Up to 4 boxes	Reimbursed Up To $105
Non-Formulary contact lenses	$130 allowance	Reimbursed Up To $105
Medically Necessary	Covered in full	Reimbursed Up To $210

ExpressExam

As a United Healthcare Vision member, you can now renew your eyewear prescription virtually with ExpressExam. This is available at no additional cost and is a quick, simple way to ensure you're prioritizing your vision care.

How it works:

- **Take the exam:** Use your phone or computer to take an online vision exam. It only takes about 10 minutes.
- **Doctor review:** A certified ophthalmologist in your state reviews your exam results.
- **Get your prescription:** If approved, your renewed prescription will be ready to use within a few hours.

United Healthcare

1800contacts

EXPRESS exam

Life and Accidental Death & Dismemberment (AD&D) Insurance

Insured by UnitedHealthcare

DISTRICT PAID LIFE AND AD&D INSURANCE

Life Insurance

Life insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump sum payment if you die while employed by Summit School District. The District provides benefits eligible employees basic life insurance of $25,000 at no cost to you regardless of whether or not you participate in the medical plans offered by Summit School District.

Accidental Death and Dismemberment (AD&D) Insurance

Accidental Death and Dismemberment (AD&D) insurance provides payment to benefit eligible employees or your beneficiaries if you lose a limb or die in an accident. Summit School District provides AD&D coverage of $25,000 at no cost to you. This coverage is in addition to your district-paid life insurance described above.

VOLUNTARY LIFE WITH AD&D INSURANCE

You may purchase voluntary life and AD&D insurance in addition to the company provided coverage. You may also purchase voluntary Life and AD&D insurance for your dependents if you purchase additional coverage for yourself. You are guaranteed coverage without answering medical questions if you enroll when you are **first eligible.**

Be sure to keep your beneficiary information up-to-date in your employee portal. This can be changed at any point during the year.

Employee— $10,000 increments up to a maximum of five times your salary or not to exceed $500,000. NOTE: Employee age 42 can get the minimum $10,000 in coverage for just $1.20 per month!!!

Guarantee Issue— $80,000

Spouse— $5,000 increments up to maximum of $250,000, not to exceed 50% of employees benefit amount (spouse rate based on spouse's age)

Guarantee Issue— $25,000

Children (until age 26)— $1,000 increments up to $10,000, not to exceed 50% of employees benefit amount

Guarantee Issue— $10,000

Age	Employee Per Month	Spouse Per Month
Voluntary Life/AD&D – UHC (per $1,000 of coverage)		
0–25	$0.070	$0.070
25-29	$0.080	$0.080
30-34	$0.100	$0.100
35-39	$0.110	$0.110
40-44	$0.120	$0.120
45-49	$0.170	$0.170
50-54	$0.250	$0.250
55-59	$0.450	$0.450
60-64	$0.680	$0.680
65-69	$1.290	$1.290
70-74	$2.080	$2.080
75+	$2.080	$2.080

- If you enrolled in benefits when you were first eligible and want to increase your benefit above the Guaranteed Issue limit, you will be required to submit an Evidence of Insurability (EOI).
- If you enrolled in benefits when you were first eligible and want to increase your coverage during subsequent Open Enrollment, you may do so by up to 1 increment up to the Guaranteed Issued Amount without providing Evidence of Insurability (EOI).

Member Assistance Program (MAP)

Provided by UnitedHealthcare

Your well-being is what matters most

Medical issues can take a toll on your work and home life. To help you through difficult times, the United Healthcare Member Assistance Program (MAP) provides you and your family personal and confidential support, 24 hours a day, 7 days a week.

The help you may need, at no extra cost

- **Unlimited phone access to master's-level specialists** - 24/7
- **Up to 5 referrals for face-to-face counseling sessions*** - Our national network included 218,000 clinicians
- **Help dial down possible symptoms of stress, anxiety, and depression** - Self Care by AbleTo is an app that offers techniques and coping tools, community support and guided journeys
- **One legal consultation for 30 minutes** - Meet with an attorney by phone or in person, and you can retain an attorney for ongoing services at a 25% discounted rate**
- **A 30- to 60-minute financial consultation** - Discuss estate taxes and other financial matters with credentialed financial professionals
- **Access to liveandworkwell.com** - Easily, securely find a provider and work-life resources, confidentially connect to expert guidance and explore thousands of articles

Maintaining your privacy and confidentiality is of the utmost importance. All records, referrals and evaluations are kept private and confidential in accordance with federal and state laws.

Access your MAP benefit today

Call **1-866-811-3629, TTY 711.** Translators are available for non-English speakers.

Visit **liveandworkwell.com.** Enter anonymously using access code **FP5EAP**.

Join Self Care

Go to **liveandworkwell.com** and select the Self Care tile to get started.

*There is no charge for referrals or for seeing a clinician within our network for up to 5 visits per issue

**Due to the potential for a conflict of interest, legal consultation will not be provided on issues that may involve legal action against United Healthcare, its affiliates or any entity through which the caller is receiving services directly or indirectly.

Voluntary Benefits

Insured by UnitedHealthcare

ACCIDENTAL INJURY INSURANCE

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

CRITICAL CARE ILLNESS INSURANCE

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

HOSPITAL CARE COVERAGE

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

Benefit Assist

Provided by UnitedHealthcare

United Healthcare

Benefit Assist helps ensure supplemental health plan claims are proactively identified, processed, and paid.

Proactively Searching for Claims

Benefit Assist supports employees who have a United Healthcare Accident, Critical Illness or Hospital Indemnity plan. Using integrated medical claims data and artificial intelligence, it proactively looks for supplemental health claims that may qualify for a benefit payment. Once an eligible claim is identified, a Benefit Assistance reaches out to the employee to initiate a claim.

The Convenience of Automatic Payment

Some claims, such as those for Wellness and Hospital Indemnity, may be paid automatically. The eligible medical event is identified and a check is mailed to you without the need to file a claim or be contacted by a Benefit Assistant.

77%

of supplemental health claims were initiated by Benefit Assistants in 2020[1]

[1] United Healthcare Supplemental book of business, Jan. 1, 2020-Nov. 23, 2020.

Benefit Assist helps give employees a clear path to payment

1. Matt injures his wrist and knee during a softball game and goes to the hospital, which starts a medical claim
2. A Benefit Assistant identifies the claim as potentially eligible for a supplemental health plan payout
3. The Benefit Assistant contacts Matt and helps him initiate his claim
4. Matt opens up his laptop and goes online to submit information in support of his claim
5. The claim specialist reviews the claim and follows up with Matt

Additional Voluntary Benefits

SHORT TERM DISABILITY

Insured by UHC

When trouble arises, Short-Term Disability insurance can provide employees with the peace of mind that a protected paycheck brings. UHC's Voluntary Short-Term Disability plan provides income if you become disabled due to an injury or illness after satisfying the elimination period (7 days). Once enrolled in the plan, you can receive up to 60% of your weekly earnings or a maximum of $1,500 per week for up to 12 weeks. Visit your employee portal for further plan details.

Cost Example for 33 year old employee (cost is deducted post-tax so benefit is tax-free):

$55,000 / 52 = $1,057.69 x 60% = $634.62 x $0.607 / 10 = **$38.52 Cost per Month**

Annual Earnings | Weekly Earnings | Benefit Percentage | Weekly Covered Benefit | Age Based Rate

$632.62 would be paid to you weekly on a tax-free basis for up to 12 weeks!

LONG TERM CARE BENEFITS

Insured by Trustmark Universal Life Insurance

At any point in your life, you may need long term care services, which could cost hundred of dollars per day. Universal Life includes a long-term care benefit that can pay for these services at any age. These long-term care benefits can include services such as, facilities care, home care, assisted living, and adult day care. Visit www.trustmarksolutions.com for more information.

IDENTITY THEFT

Insured by Identify Guard with Watson

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

PET INSURANCE

Insured by ASPCA® Pet Health Insurance

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

www.aspcapetinsurance.com/summit or call 1-877-343-5314.

Employee Contributions

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

EMPLOYEE CONTRIBUTIONS FOR MEDICAL BENEFITS

BENEFIT PLAN	PER MONTH
Medical/RX— **HDHP/HSA**	
Employee Only	$97.00
Employee / Spouse	$521.00
Employee / Employee	$194.00
Employee / Child(ren)	$384.00
Employee / Family	$784.00
Employee / Employee / Family	$481.00

BENEFIT PLAN	PER MONTH
Medical RX— **Healthy Measures PPO**	
Employee Only	$277.00
Employee / Spouse	$901.00
Employee / Employee	$554.00
Employee / Child(ren)	$720.00
Employee / Family	$1,319.00
Employee / Employee / Family	$997.00

EMPLOYEE CONTRIBUTIONS FOR VOLUNTARY SHORT-TERM DISABILITY

BENEFIT PLAN	RATE (per $10 of weekly coverage)
Short Term Disability - UHC (post-tax deduction)	
Age 0-25	$0.647
25-29	$0.681
30-34	$0.607
35-39	$0.487
40-44	$0.524
45-49	$0.452
50-54	$0.547
55-59	$0.623
60-64	$0.723
65+	$0.825

EMPLOYEE CONTRIBUTIONS FOR DENTAL AND VISION BENEFITS

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

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

BENEFIT PLAN	PER MONTH
Vision - UHC	
Employee Only	$6.63
Employee + 1 (Spouse or Child)	$13.26
Employee / Children	$13.38
Family	$21.37

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

Contact Information

BENEFIT	POLICY NUMBER	ADMINISTRATOR	PHONE	WEBSITE/EMAIL
Medical	76-416233	UMR	866.922.8266	www.member.umr.com
Dental				
Vision	931830	UnitedHealthcare of Colorado	866.801.4409	www.member.uhc.com/myuhc
District Paid Life and AD&D	371168			
Voluntary Life and AD&D				
Accident				
Critical Illness				
Hospital Indemnity				
Short-Term Disability				
Member Assistance Program	N/A		866.811.3629	www.liveandworkwell.com
Telemedicine Services	N/A	CirrusMD	818.222.4840	www.patients.cirrusmd.com
Prescription– Optum Rx	76-416233	UMR	866.922.8266	www.member.umr.com
Life with Long Term Care	N/A	Trustmark	800.918.8877	www.trustmarksolutions.com
Pet Insurance	N/A	ASPCA	877.343.5314	www.aspcapetinsurance.com/Summit
ID Theft	N/A	Identity Guard	855.443.7748	www.identityguard.com
COBRA Information	N/A	Rocky Mountain Reserve	888.722.1223	www.rockymountainreserve.com
Flexible Spending Accounts (FSA)	N/A	Rocky Mountain Reserve	888.722.1223	www.rockymountainreserve.com
Health Savings Accounts (HSA)	N/A	Health Equity	866.346.5800	www.healthequity.com

Notice #1: Annual Health Notices

Patient Protections Disclosure

The Summit School District RE-1 Health Plan generally allows 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, UMR 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 UMR at 866.922.8266 or www.member.umr.com.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from UMR 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 UMR at 866.922.8266 or www.member.umr.com.

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: HDHP / HSA PLAN (Individual: 20% coinsurance and $1,600 deductible; Family: 20% coinsurance and $3,200 deductible)
Plan 2: HEALTHY MEASURES PPO (Individual: 20% coinsurance and $2,500 deductible; Family: 20% coinsurance and $5,000 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator, Kara Drake at 970.368.1008 or kara.drake@summitk12.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).

Notice #2: CHIP Notice

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, 2024. 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)	Health Insurance Premium Payment Program 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/agecies/dms	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=e n_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: 771 Email: masspremassistance@ccenture.com
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: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA Medicaid and CHIP	**OREGON Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA Medicaid and CHIP	**RHODE ISLAND Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA Medicaid	**SOUTH DAKOTA Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS Medicaid	**UTAH Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT Medicaid	**VIRGINIA Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://covera.dmas.virginia.gov/learn/premiumassistance/famis-select https://convera.dmas.virginia.gov/learn/premiumassistance/health-insurance-premium-payment-hipp-programs Medicaid/ CHIP Phone: 1-800-432-5924
WASHINGTON Medicaid	**WEST VIRGINIA Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN Medicaid and CHIP	**WYOMING Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

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

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

Paperwork Reduction Act Statement

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

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

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

Notice #3: HIPAA Privacy Practices Reminder and Special Enrollment Rights

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights

Summit School District RE-1 is committed to the privacy of your health information. The administrators of the Summit School District RE-1 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 Kara Drake – Chief Financial Officer at 970.368.1008 or kara.drake@summitk12.org.

HIPAA Special Enrollment Rights

Summit School District RE-1 Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Summit School District RE-1 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 Kara Drake – Chief Financial Officer at 970.368.1008 or kara.drake@summitk12.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 #4: Notice of Credible Coverage

Important Notice from Summit School District RE-1

About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Summit School District RE-1 and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.
There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

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

2. **Summit School District RE-1 has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current Summit School District RE-1 coverage will be affected.

If you do decide to join a Medicare drug plan and drop your current Summit School District RE-1 coverage, be aware that you and your dependents may not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with Summit School District RE-1 and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Summit School District RE-1 changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	**September 1, 2024**
Name of Entity/Sender:	**Summit School District RE-1**
Contact—Position/Office:	**Kara Drake – Chief Financial Officer**
Office Address:	**150 School Rd** **Frisco, Colorado 80443** **United States**
Phone Number:	**970.368.1008**

Notice #5: 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; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Summit School District RE-1
Kara Drake – Chief Financial Officer
150 School Rd
Frisco, Colorado 80443
United States
970.368.1008

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

Notice #6: Marketplace Notice

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1 2]

> **Note:** If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
[2] An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Kara Drake at 970.368.1008 or kara.drake@summitk12.org.

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.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name **Summit School District RE-1**		4. Employer Identification Number (EIN) **84-6011247**
5. Employer address **150 School Rd**		6. Employer phone number **970.368.1008**
7. City **Frisco**	8. State **Colorado**	9. ZIP code **80443**
10. Who can we contact about employee health coverage at this job? **Kara Drake**		
11. Phone number (if different from above)	12. Email address Kara.drake@summitk12.org	

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

As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

■ Some employees. Eligible employees are: All full-time eligible employees working at least 30 hours week.

With respect to dependents:

■ We do offer coverage. Eligible dependents are: your legal spouse (including domestic partners), your child(ren) under the age of 26 (including disabled dependents of any age)

☐ We do not offer coverage.

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

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

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

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

A. How much would the employee have to pay in premiums for this plan? $_____

B. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

How much would the employee have to pay in premiums for this plan? $_____

How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

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

Notice #7: Surprise Billing Notice

OMB Control Number: 0938-1401
Expiration Date: 05/31/2025

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed, contact https://www.cms.gov/nosurprise/consumers or call 1-800-985-3059 to obtain more information and complaints.

Visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

Visit State Balance-Billing Protections | Commonwealth Fund for more information about your rights under applicable state laws.

Disclaimer

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to the amount charged by your out-of-network provider. Your out-of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language. Contact your claims payer or insurer for more information.

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