



2026 Benefits Guide



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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 page 18 where Notice of Creditable Coverage begins for more details.

Benefits Overview

Englewood Schools is proud to offer a comprehensive benefits package to all teachers working at least a .50 FTE and any Admin/Professional/Technical/Classified employee working at least 20 hours per week and a minimum of 174 days per year. The complete benefits package is briefly summarized in this booklet. Plan booklets, which give you more detailed information about each of these programs are available from the Human Resources department.

You share the costs of some benefits (medical and dental). In addition, there are voluntary benefits that you can purchase with reasonable group rates through Englewood Schools' payroll deductions.

Benefit Plans offered

- ◆ Medical
- ◆ Dental
- ◆ Flexible Spending Accounts
- ◆ Voluntary Vision
- ◆ Voluntary Life/AD&D
- ◆ Short Term Disability
- ◆ Long Term Disability
- ◆ Critical Illness and Cancer Plan
- ◆ Accident Plan



Eligibility

- ◆ Eligible dependents are your spouse, domestic partner, children under age 26, and disabled dependents of any age.
- ◆ Elections made now will remain until the next open enrollment unless you or your family members experience a qualifying event. If you experience a qualifying event, you must contact HR within 30 days.

IMPORTANT

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

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

Medical Benefits

Administered by Kaiser Permanente

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

Below you will find a chart outlining three plans that you can choose from

- ◆ A traditional copay-based plan
- ◆ A new plan that covers most common services at 100%, with a high deductible for hospital stays
- ◆ A high deductible HSA qualified plan

Please refer to page 6 of this booklet to review the HSA details to ensure you understand how your plan decision will impact your potential savings opportunities or existing HSA.

KAISER PERMANENTE			
Plan Name	DHMO \$1,500	Everyday Care Plan	HDHP \$4,200
Deductible (Individual/Family)	\$1,500 / \$3,000 Embedded Family Deductible	\$4,000 / \$8,000 Embedded Family Deductible	\$4,200 / \$8,400 Embedded Family Deductible
Coinsurance	Plan pays 80%	Plan pays 100%	Plan pays 80%
Out-of-Pocket Maximum (Individual/Family)	\$2,500 / \$5,000	\$4,000 / \$8,000	\$5,000 / \$10,000
Primary Care Office Visit	\$30 copay	\$0 copay	Deductible then 20%
Specialist Office Visit	\$50 copay	\$0 copay	Deductible then 20%
Preventive Care	Paid at 100%	Paid at 100%	Paid at 100%
Diagnostic Lab	Covered as part of office visit	Paid at 100%	Deductible then 20%
Diagnostic X-Ray	Deductible then 20%	Paid at 100%	Deductible then 20%
Imaging (CT/PET/MRI)	Deductible then 20%	\$500 copay	Deductible then 20%
Outpatient Surgery	Kaiser facility: \$500 copay All other facilities: Deductible then 20%	Kaiser facility: \$500 copay All other facilities: Deductible then 0%	Kaiser facility: Deductible then 10% All other facilities: Deductible then 20%
Emergency Room	\$500 copay	\$500 copay	Deductible then 20%
After Hours Care	\$30 copay, deductible then 20%	Paid at 100%	Deductible then 20%
Inpatient Hospital	Deductible then 20%	Deductible then 0%	Deductible then 20%
Outpatient Mental/Behavioral/ Substance Abuse	\$30 Copay; deductible then 20%	Paid at 100%	Deductible then 20%
Inpatient Mental/Behavioral/ Substance Abuse	Deductible then 20%	Paid at 100%	Deductible then 20%
Refractive Eye Exam	\$30 copay	Paid at 100%	Deductible then 20%
Retail RX (30 Days) All Tiers	\$10 / \$30 / \$50 / 20% up to \$250	\$0 / \$50 / \$125 / \$300	Deductible then \$10 / \$30 / 50% / 20%

Flexible Spending Accounts (FSA)

Administered by Rocky Mountain Reserve

An FSA is available for those enrolling in the DHMO plan and Everyday Care Plan. Flexible Spending Accounts (FSAs) allow employees to use pretax dollars for healthcare or child/dependent care expenses not covered by insurance plans. Employees contribute a portion of each paycheck to an FSA and save significantly on taxes. Money in an FSA can be used to pay for out-of-pocket medical, dental and vision expenses or dependent care expenses. Employees do not need to be enrolled in the Employer's Health Plan to have an FSA. Englewood Schools offers you a choice of a Healthcare Flexible Spending Accounts and a Dependent Care Flexible Spending Account.

Healthcare FSA

A Healthcare FSA is a pre-tax benefit account used to pay for eligible medical, dental, and vision care expenses that aren't covered by your insurance plan or elsewhere. It's a smart, simple way to save money while keeping you and your family healthy and protected. The IRS sets a limit on how much you can contribute to this account each year. For 2026, the spending limit is \$3,400.

Dependent Care FSA

A Dependent Care FSA is a pre-tax benefit account used to pay for dependent care services, such as preschool, summer day camp, before or after school programs, and child or elder daycare. A Dependent Care FSA is a smart, simple way to save money while taking care of your loved ones so that you can continue to work. The IRS sets a limit on how much you can contribute to this account each year. The spending limit is \$7,500 if married and filing jointly or head of household or \$3,750 if married and filing separately.

Here's How an FSA Works

1. You decide the annual amount (up to the set limit for each account) you want to contribute to either or both FSAs based on your expected healthcare and/or dependent childcare/elder care expenses.
2. Elections are deducted from each paycheck before income and Social Security taxes, and deposited into your FSA. Your entire annual election is available immediately after the beginning of the plan year for the Health Care FSA. For the Dependent Care FSA you can only receive the amount that is in your account when your claim is paid.
3. For eligible healthcare expenses you can pay with the Healthcare FSA debit card or submit a claim form for reimbursement. For dependent care, you pay for eligible expenses when incurred, and then submit a reimbursement claim form or file the claim.
4. You are reimbursed from your FSA, so you actually pay your expenses with tax-free dollars.
5. Any unused balance will be forfeited.



Health Savings Account (HSA)

Administered by UMB

An HSA is available for those enrolling in the HDHP 4200 plan. 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 expenses.

What are the Advantages of the High Deductible Health (HDHP) plan with an HSA?

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

- ◆ It has a lower monthly cost.
- ◆ You have access to a Health Savings Account (HSA) that allows you to put aside money, tax-free, to pay for eligible medical, dental and vision 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 UMB. In order to open an HSA and contribute, you:

- Must be covered by a qualifying High Deductible Health Plan (HDHP);
- Must not be covered by any other health plan that is not an HDHP;
- Must not be enrolled in Medicare;
- Must not be claimed as a dependent on another person's tax return.

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 is not a complete list of rules and requirements for HSAs. More info can be found on Publication 969 at www.irs.gov.

2026 HSA Contribution Limits:

	IRS Annual Limit	District Annual Contribution	Available for Employee annual contribution	Monthly Maximum to reach IRS limit between Employee and Employer contribution
Individual	\$4,400	\$1,329.84	\$3,070.16	\$255.85
Family	\$8,750	\$1,329.84	\$7,420.16	\$618.35
Additional \$1,000 Contribution Allowed when Age 55 and Over				

The district contributes \$1,329.84 annually (\$110.82 monthly) towards your HSA.

Manage Your Health With www.KP.org

How Do I Register?

It's as easy as 1, 2, 3.

1. Visit www.kp.org/registernow using your computer (not a mobile device).
2. Follow the instructions. You will need your medical record number on your ID card.
3. Start managing care for you and your family - find a doctor, schedule an appointment, transition your prescriptions and more.

Kaiser Permanente Mobile Access

Get the Kaiser Permanente mobile app from the Apple App Store or the Android app from Google Play. Manage your health, find locations and care, refill prescription, view lab results, and more!

Get the Right Care - When You Need It and How You Want It

You can get the care that's right for you by choosing from a number of options that meet your needs and lifestyle. Visit www.kp.org for more information.



PHONE

Save yourself an office visit by scheduling a call with a doctor.



EMAIL

Message your doctor's office with non-urgent questions anytime.



E-VISIT

Fill out a short online questionnaire about your symptoms and a nurse will get back to you - usually within 6 hours. Great for coughs, colds, nausea, allergies and more.



VIDEO VISIT

An online alternative to an in-person appointment.



IN-PERSON

Same-day or next-day appointments are often available. Call 303-338-4545 (TTY 711).



CHAT ONLINE

Connect in real time with a physician by logging into www.kp.org and click "Chat". Available Mon-Fri 7am to 10pm and Sat-Sun 8am to 10pm.



Manage Your Health Care Costs Online

- ◆ Pay your medical bills at www.kp.org/paymedicalbills.
- ◆ Get a personalized cost estimate at www.kp.org/costestimates. Use this tool to find out what you can expect to pay out-of-pocket for exams, tests, and other services.
- ◆ Go paperless at www.kp.org/gopaperless and receive medical bills and other documents online. You will get an email alert each time a bill is ready.

Need help paying for care?

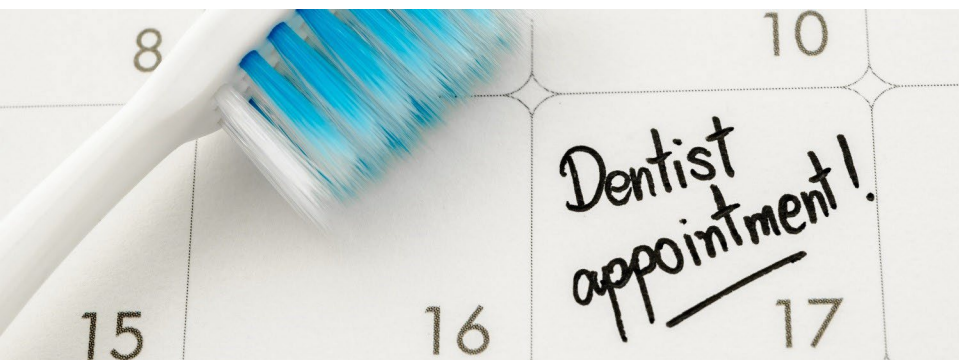
Payment plans and financial assistance are available. Call Financial Counseling at 303-338-3025 or 1-877-803-1929 (TTY: 711), Mon-Fri from 8am to 6pm.

Dental Benefits

Administered by Delta Dental of Colorado

Good oral care enhances overall physical health, appearance and mental well-being. Problems with teeth and gums are common and easily treated health problems. Keep your teeth healthy and your smile bright with the Englewood Schools dental benefit plan.

	PPO Network	Premier Network	Out-of-Network
Deductible Individual / Family	\$50 / \$150		
Diagnostic and Preventive Services Cleanings Exams X-Rays	100%	80%	80%
Basic Services Fillings Endodontics Periodontics	80%	80%	80%
Major Services Dentures Bridges Crowns	50%	50%	50%
Orthodontic Services (Children to age 19)	50%	50%	50%
Annual Plan Maximum All services except Ortho	\$2,000		
Orthodontic Lifetime Maximum	\$1,000		



Finding In-network Dentists

You pay less for services when you use a dentist in the Delta Dental PPO network. You can find an in-network dentist by visiting www.deltadentalco.com or calling 800-610-0201.

Voluntary Vision Benefits

Administered by VSP

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

VSP	In-Network	Out-of-Network
Eye Exam Once every 12 months	\$10 Copay	Up to \$45
Lenses Once every 12 Months	\$25 Copay	Up to \$65
Lens Enhancements Standard Progressive Lenses Premium Progressive Lenses Custom Progressive Lenses	\$55 \$95-\$105 \$150-\$175	Up to \$65
Frames Once every 24 Months	\$130, plus 20% discount off of balance	Up to \$70
Contact Exam	Up to \$60	N/A
Contacts—Instead of Glasses	\$130 Allowance	Up to \$105
Extra Savings	20% Discounts available	N/A

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

Administered by Sun Life

For you: An amount between \$10,000 and \$500,000, in increments of \$10,000, not to exceed 5x basic annual earnings. Guaranteed Issue Amount is \$100,000.

For your spouse: An amount between \$5,000 and \$250,000, in increments of \$5,000. Guaranteed Issue Amount is \$50,000. Spouse Voluntary Life coverage may not exceed 50% of the employee's coverage.

For your dependent child(ren): An amount between \$ 2,500 and \$25,000, in increments of \$ 2,500 for each eligible child between ages 6 months to 26 years old.; \$500 for a child who is 14 days to under 6 months.

You must elect Voluntary Life coverage for yourself in order to cover your spouse and/or children.

Your employer's plan includes voluntary accidental death and dismemberment (AD&D) Insurance which would pay an additional benefit, up to the amount of your voluntary life benefit, if you suffer a covered loss due to accident.

The plan also includes many special features including waiver of premium and accelerated benefits.

How to Enroll: Once you have selected the amount of coverage that's right for you, your spouse and your children, simply fill out the voluntary life enrollment form provided by your employer. Be sure to sign, date, and return the form to your employer. Please submit the form to your employer along with any evidence of insurability forms that may be required.

Short Term Disability

Administered by Standard Insurance Company

Features of the Plan

This coverage replaces a portion of your income when you can't work because of a qualifying disability. Even if you're healthy now, it's important to protect yourself and the people who count on your income. This insurance can help you pay the bills when you're unable to work.

Englewood Schools provides Short Term Disability (STD) at **no cost to you** and you will be automatically enrolled in the plan.

Benefits

Short-Term Disability plan provides income, after satisfying the elimination period, if you become disabled due to an injury or illness. Once enrolled in the plan, you can take advantage of the following benefits:

Elimination Period: 14 days for injury / 14 days for illness Benefit Amount: 60% of your earnings

Benefit Maximum: \$1,500 per week

Benefit Duration: up to 60 days (45 workdays)

Long Term Disability

Administered by Standard Insurance Company

Meeting your basic living expenses can be a real challenge if you become disabled. Your options may be limited to personal savings, spousal income and possibly Social Security. Disability insurance provides protection for your most valuable asset – your ability to earn an income.

Englewood Schools provides Long Term Disability (LTD) coverage at **no cost** for those employees who do not have five years vested with PERA.

LTD coverage provides income when you have been disabled for 43 working days. Your benefit is 60% to a maximum of \$4,000 per month before reduction by deductible income. Benefit payments can continue to age 65 if you are under age 60 at the time of disability.

Elimination Period: 43 working days

Benefit Amount: 60% of your earnings

Benefit Maximum: \$4,000 per month

Benefit Duration: To age 65, if you are under age 60 at the time of disability.



Employee Assistance Program

Administered by Standard Insurance Company

We all experience times when we need a little help managing our personal lives. Your employer understands this and is providing the Employee Assistance Program (EAP) to covered employees in connection with your group insurance from The Standard, to offer support, guidance and resources to help you and your family find the right balance between your work and home life.

Experienced master's-degreed clinicians will confidentially consult with you over the telephone and direct you to the solutions and resources you need. You may also receive referrals to support groups, community resources, a network counselor or your health plan. These services are available for covered employees, their dependents, including children to age 26, and all household members.

Voluntary Critical Illness and Cancer Plan

Administered by Sun Life

Any illness can have financial consequences, such as unexpected medical costs of not being able to work. This insurance pays you a lump sum amount of money – to use however you wish – if you're diagnosed with a covered illness or condition.

Benefit amounts:

For You - You can choose the benefit amounts that best meet your needs. Benefit amounts may range from \$5,000 to \$20,000, in \$5,000 increments.

Guaranteed Issue amount is \$20,000.

For your Spouse - You can choose the benefit amounts that best meet your needs. Benefit amounts may range from \$5,000 to \$10,000, in \$2,500 increments.

Guaranteed Issue amount is \$10,000.

For your Dependent Children – Benefit amount is \$5,000.

Voluntary Accident Plan

Administered by Sun Life

Lost wages and out-of-pocket expenses can set you back financially. Accident insurance pays you a lump sum amount of money—to use however you want—if you are injured as a result of a covered accident.

Features of the Plan:

- ◆ Convenient payroll deduction
- ◆ Benefits are paid directly to Insured

The plan offers a wide range of covered benefits.

For injuries: Insureds will receive a payment of a fixed amount for covered dislocations, fractures, lacerations, burns, additional injuries.

For care: Insureds will receive a payment of a fixed amount for related covered medical services, hospital services, surgeries, emergency dental.

For loss: The plan includes life and dismemberment benefits that result from a covered accident.

Please ask HR for the full information packet with full details.

Retirement & College Savings Plans

Englewood District provides assistance to save for retirement through your payroll which could supplement your Colorado PERA pension.

The following companies are available to assist employees with retirement account options:

- ♦ **AXA Equitable** - Benjamin Lindgren 763-464-6426
- ♦ **Security Benefit Group** - Cooper Peters 720-244-4212
- ♦ **PERA Colorado** - www.copera.org 1-800-759-7372

Provider	Plan
AXA Equitable	403(b)
AXA Equitable	403(b) Roth
Security Benefit	403(b)
Security Benefit	403 (b) Roth
PERAPlus	401(k)
PERAPlus	401(k) Roth
PERAPlus	457
PERAPlus	457 Roth

CollegeInvest is available to assist employees with college planning and related tax-saving opportunities. It is a not-for-profit division of the Colorado Department of Higher Education, which administers the State of Colorado's 529 college savings program. Their first Step Program, provides every child born or adopted in Colorado on or after January 1, 2020 with a \$118 starter contribution to a CollegeInvest 529 account. Employees should contact CollegeInvest directly for enrollment and matching fund promotions. Contributions are made directly to CollegeInvest and are not processed through district payroll deductions.

The following contact is available to assist employees with their enrollment and questions:

- ♦ **CollegeInvest** - khemlock@collegeinvest.org or call 303-376-8806



Employee and Employer Cost for Benefits

Effective February 1, 2026

	2026 Monthly Premium	District Monthly Share	Employee Monthly Share	Employee Annual Amount	District Monthly HSA Contribution	District Annual HSA Contribution
DHMO \$1,500 FSA Eligible						
Employee Only	\$798.02	\$612.00	\$186.02	\$2,272.24	N/A	N/A
Employee + Spouse	\$1,635.95	\$612.00	\$1,023.95	\$12,327.40		
Employee + Child(ren)	\$1,596.05	\$612.00	\$984.05	\$11,848.60		
Family	\$2,306.29	\$612.00	\$1,694.29	\$20,351.48		
Everyday Care Plan FSA Eligible						
Employee Only	\$759.56	\$612.00	\$147.56	\$1,810.72	N/A	N/A
Employee + Spouse	\$1,557.09	\$612.00	\$945.09	\$11,381.08		
Employee + Child(ren)	\$1,519.11	\$612.00	\$907.11	\$10,925.32		
Family	\$2,195.12	\$612.00	\$1,583.12	\$19,037.44		
HDHP \$4,200 HSA Eligible						
Employee Only	\$574.77	\$501.18	\$73.59	\$923.08	\$110.82	\$1,329.84
Employee + Spouse	\$1,178.28	\$501.18	\$677.10	\$8,165.20	\$110.82	\$1,329.84
Employee + Child(ren)	\$1,149.54	\$501.18	\$648.36	\$7,820.32	\$110.82	\$1,329.84
Family	\$1,661.08	\$501.18	\$1,159.90	\$13,958.80	\$110.82	\$1,329.84
Dental						
Employee Only	\$36.56	\$18.62	\$17.94	\$215.28	N/A	N/A
Employee + One	\$66.82	\$18.62	\$48.20	\$578.40		
Employee + Family	\$107.91	\$18.62	\$89.29	\$1,071.48		
Voluntary Vision						
Employee Only	\$7.66	\$0.00	\$7.66	\$91.92	N/A	N/A
Employee + One	\$11.10	\$0.00	\$11.10	\$133.20		
Employee + Family	\$19.91	\$0.00	\$19.91	\$238.92		





Health Plan Annual Notices for Englewood Schools

For the Plan Year January 1, 2026– December 31, 2026

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

Notice # 1 : Annual Health Plan Notices

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

Notice # 3: COBRA General Notice

Notice # 4: Marketplace Notice

Notice # 5: No Surprise Billing Notice

Notice # 1: Annual Health Plan Notices

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: DHMO \$1,500 (Individual: 80% coinsurance and \$1,500 deductible; Family: 80% coinsurance and \$3,000 deductible)

Plan 2: Everyday Care Plan (Individual: 100% coinsurance and \$4,000 deductible; Family: 100% coinsurance and \$8,000 deductible)

Plan 3: HDHP \$4,200 (Individual: 80% coinsurance and \$4,200 deductible; Family: 80% coinsurance and \$8,400 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 303-806-2007 or susan_jean@engschools.net.

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

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

UNIFORMED SERVICES EMPLOYMENT & REEMPLOYMENT RIGHTS ACT (USERRA)

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

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).

HIPAA NOTICE OF PRIVACY PRACTICES REMINDER

Protecting Your Health Information Privacy Rights

Englewood Schools is committed to the privacy of your health information. The administrators of the Englewood Schools 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 Susan Jean - Human Resource Specialist at 303-806-2007 or susan_jean@engschools.net.

HIPAA SPECIAL ENROLLMENT RIGHTS

Englewood Schools Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Englewood Schools 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 Susan Jean - Human Resource Specialist at 303-806-2007 or susan_jean@engschools.net.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

NOTICE OF CREDITABLE COVERAGE

Important Notice from Englewood Schools

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 Englewood Schools 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. Englewood Schools 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 Englewood Schools coverage will be affected.

If you do decide to join a Medicare drug plan and drop your current Englewood Schools 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 Englewood Schools 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 Englewood Schools 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:	January 01, 2026
Name of Entity/Sender:	Englewood Schools
Contact—Position/Office:	Susan Jean - Human Resource Specialist
Office Address:	4101 S Bannock St Englewood, Colorado 80110-4605 United States
Phone Number:	303-806-2007

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. 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 (HIPP) Program Website: 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	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
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://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/la hipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	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: HSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://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. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	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 and CHIP
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.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html 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 Rlte 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	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/

VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, 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: 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: Susan Jean.

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 period¹ 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>.

¹ <https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start>

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**Englewood Schools**

Susan Jean - Human Resources Generalist

4101 S Bannock St

Englewood, Colorado 80110-4605

United States

303-806-2007

Notice # 4: 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](https://www.healthcare.gov) and either- submit a new application or update an existing application on [HealthCare.gov](https://www.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](https://www.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-medicicaid-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 Susan Jean.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.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 Englewood Schools		4. Employer Identification Number (EIN) 84-6000858
5. Employer address 4101 S Bannock St		6. Employer phone number 303-806-2007
7. City Englewood	8. State Colorado	9. ZIP code 80110-4605
10. Who can we contact about employee health coverage at this job? Susan Jean		
11. Phone number (if different from above)		12. Email address susan_jean@engschools.net

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

- As your employer, we offer a health plan to:
 - ☒ All employees. Eligible employees are: Full time regular working 174 days per 12 months or 20 hours per week
 - ☐ Some employees. Eligible employees are:
- With respect to dependents:
 - ☒ We do offer coverage. Eligible dependents are: Your legal spouse, Natural, adopted or step-children up to age 26.
 - ☐ 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](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.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?** <<Select Yes or No.>>

☐ **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? <<Insert date when employee will be 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*? <<Select Yes or No.>>

☐ 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? <<Insert amount of premiums as described in Question 15 above.>>

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly
<<Select frequency of employee contribution.>>

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? <<Insert anticipated changes.>>
<<Select any choice below that applies.>>

☐ 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.)

a. How much would the employee have to pay in premiums for this plan? \$_____ << Insert amount of premium in accordance with instructions in Question 15 above.>>

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly
<<Select frequency of employee contribution.>>

* 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)

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 balance 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** balancebill 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/nosurprises/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.

Notes

Notes

Contact Information

Benefit	Administrator	Phone	Website
Medical	Kaiser	303-338-3800	www.kp.org
Dental	Delta Dental	800-610-0201	www.deltadentalco.com
Vision	VSP	800-877-7195	www.vsp.com
FSA	Rocky Mountain Reserve	888-722-1223	www.rockymountainreserve.com
HSA	UMB	866-520-4472	https://hsa.umb.com
Voluntary Life	Sun Life	800-247-6875	www.sunlife.com/us
Short Term Disability	Standard	800-368-1135	www.standard.com
Long Term Disability	Standard	800-368-1135	www.standard.com
EAP	Standard	866-468-9461	workhealthlife.com/standard3
Critical Illness	Sun Life	800-247-6875	www.sunlife.com/us
Accident	Sun Life	800-247-6875	www.sunlife.com/us
Retirement	AXA Equitable	763-464-6426	benjamin.lindgren@equitable.com
	Security Benefit Group	720-244-4212	cooperpeters@legendequities.co
	PERA	1-800-759-7372	questions@copera.org
College Savings Plan	College Invest	303-376-8806	khemlocke@collegeinvest.org



The information contained in this summary should in no way be construed as a promise or guarantee of employment. The company reserves the right to modify, amend, suspend, or terminate any plan at any time for any reason. If there is a conflict between the information in this brochure and the actual plan documents or policies, the documents or policies will always govern. Complete details about the benefits can be obtained by reviewing current plan descriptions, contracts, certificates, policies and plan documents available from your Human Resources Office. This benefits enrollment guide highlights recent plan design changes and is intended to fully comply with the requirements under the Employee Retirement Income Security Act ("ERISA") as a Summary of Material Modifications and should be kept with your most recent summary plan description.