

2026–2027 EMPLOYEE BENEFITS GUIDE



HARD COPY RECIPIENTS

Please ensure you refer to the online version for the most updated information.

This online version is located at this d11.org/employees/employee-benefits.

Revision date is live on this link so you know if revised.

Revised on 5/1/2026

COMMITTED TO AFFORDABLE, QUALITY BENEFITS: A MESSAGE FROM D11 LEADERSHIP

Dear Valued District 11 Employee,

Colorado Springs School District 11 takes great pride in offering a wide range of competitive employee benefits that allow you the opportunity to care for you and your family. We offer benefits designed to help you be your strongest as you support our students, whether you work with them daily in the classroom or contribute behind the scenes.

As healthcare and prescription costs continue to rise, we are proud to say that we have worked diligently to provide affordable and quality healthcare options to our employees and their families.

The District invested over \$3 million to keep employee healthcare premiums low. As a result, employee premium increases are limited to 12.8% for Kaiser and 2% for Delta Dental, while Vision Plan premiums remain unchanged. This investment reflects the District's commitment—along with our partnership with Kaiser and support from the Board of Education—to maintaining affordable coverage.

In addition, the District will continue to invest dollars into paying 75% of the premium for employee only coverage and 70% of the premium for dependent coverage on the Buy-Up Plan, while making the Base Plan even more affordable. This Employee Benefits Guide provides an overview of all District 11 healthcare benefits and tips on how you can take advantage of them. Please review this information and consider what best fits your needs.

We have enriched the medical plans with these additional benefits!

- Doula services added to both Kaiser plans
- Bariatric surgery coverage added to both Kaiser plans (deductible and co-insurance will apply)
- \$0 copay on Chiropractic services for the Kaiser Base plan
- Direct Partnership with Strata Med to include enhanced medical coverage on holistic and integrative medicine and access to their 12-month GLP-1 Program

Lastly, remember that you and your family are healthcare consumers with choices about where and how you receive care. Take advantage of free annual preventive exams, ask about generic medications, discuss your benefits with your physician, and use your coverage to meet your needs. Your healthcare benefits are an important part of your total compensation package.

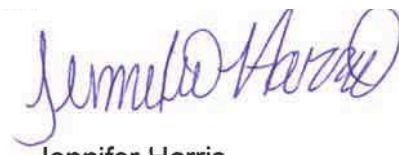
Thank you for choosing Colorado Springs School District 11. We are confident that you will find the District 11 benefits package affordable and offers a wide range of healthcare options.



Michael Gaal
Superintendent



Dr. Brandan Comfort
Deputy Superintendent



Jennifer Harris
Sr Exec Director, Talent Management

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Questions? Let's Connect!

D11 EMPLOYEE BENEFITS DEPARTMENT

Call: (719) 520-2178
Or

Email:
Employee.Benefits@d11.org

This Employee Benefits Guide covers only the highlights of your benefits program.

If you would like more detailed plan information, please visit:

<https://www.d11.org/employees/>



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ELIGIBILITY

All full-time employees working at least 30 hours per week are eligible on the first of the month following date of hire. All teachers working at least .41 FTE or 17 ½ hours per week are eligible on the first of the month following date of hire.

Employee's eligible dependents are:

- An Eligible Employee's spouse (unless legally separated) including common-law spouse;
- An Eligible Employee's domestic partner; or
- An Eligible Employee's current partner in a civil union; or
- An Eligible Employee's dependent child from birth to the end of the calendar month in which the child turns twenty-six (26).

NOTE: Proof will be required when adding a new spouse, common-law spouse or domestic partner to the plan. Contact the Employee Benefits Office at Employee.Benefits@d11.org for the required documentation.



QUALIFYING LIFE EVENTS

Click the video below to learn more.



Changes to medical, dental, and vision coverage are generally only allowed during Open Enrollment. However, you may make limited mid-year changes if you experience a Qualifying Life Event (QLE) due to a change in family or job status, as well as (in some cases) a change in physical address.

FAMILY EVENT

Families are always changing, and these changes may open the door for your coverage to change too:

- Getting Married or Divorced
- Birth or adoption of a child
- Loss of a dependent in death
- Event of critical disability for you or a dependent
- You or dependent reach age of Medicare qualification coverage
- A dependent child reaches 26 years of age, or loses coverage from another plan prior to age 26

JOB CHANGE

If you change jobs and go to a new employer, you have an automatic qualifying event. If your spouse changes jobs and their benefits are different, your window opens to include you (and dependents) on our plan. Likewise, if your spouse gains benefits in a new job that are more advantageous, you may change benefits at that point.

ADDRESS / MOVE

If your physical address moves you into a territory where you are limited or have no coverage by the network of the plan, there MAY be qualification for a QLE.

IMPORTANT REMINDERS

We suggest that you hang on to this reference guide for any questions you may have along the way.

- **All paperwork/enrollment forms MUST be submitted within 31 days of employment date.** **After 31 days,** the employee is not eligible for benefits and will have to wait until the next Open Enrollment period to enroll.
- If you do not elect coverage at date of hire, you will have another opportunity during Open Enrollment each year. Open Enrollment typically falls at the end of April/beginning of May for an effective date of July 1st.
- All benefits are effective the first of the month following your date of hire or date of transfer into a benefited position.
- If your spouse and/or dependent has a different last name than yours, you will be required to supply a marriage certificate/birth certificate at time of enrollment.
- Your dependents can be covered under ALL lines of coverage until the age of 26. Your dependent will be dropped at the end of the month in which they turn 26 years of age.
- You will receive ID cards in the mail for medical/prescription (combined card), dental and vision. If you enroll in the flexible spending account, you will receive a debit card in the mail.
- Once you receive your ID cards in the mail, we suggest that you register on all benefit websites to stay up to date.
- If you have a Qualifying Life Event (QLE) that requires you to change your benefits outside of the Open Enrollment window, you have 31 days from the date of a qualifying life event to make changes to your coverage. Proof of such event is required (i.e. birth certificate, marriage license, divorce decree, etc.).
- Summary of Benefits & Coverage, Plan Documents, legal notices and forms are available online at www.d11.org/employees/employee-benefits/home. NOTE: Plan documents are governing.

PRE-TAX PAYROLL DEDUCTIONS: MEDICAL, DENTAL & VISION

To help offset your contributions for medical, dental, and vision plans, we process these benefits on a pre-tax basis through the Section 125 (or “cafeteria”) plan. By making your contributions for these benefits on a pre-tax basis, premium is withheld from your pay before federal, state and FICA taxes are calculated. This can reduce the amount of taxes you pay per paycheck. If you would like your benefits to be taken on an after-tax basis, you must make that request at time of enrollment or during open enrollment.

MEDICAL, DENTAL & VISION PLANS



KAISER PERMANENTE OVERVIEW



As a nonprofit provider of health care and coverage together, Kaiser Permanente offers integrated care that's nationally recognized for its quality and an experience that's seamless and easy to navigate.

Integrated care means that your Kaiser Permanente doctors, pharmacists and care teams have instant access to your medical history, through a shared electronic medical record. This helps them coordinate your care – so you don't have to.

Kaiser Permanente offers a choice of providers and convenient care options designed to fit any schedule.

CHOICE OF PROVIDERS:

- Choose to see Kaiser Permanente providers at one of their medical offices (there are 5 in southern Colorado, and a total of 30 across the Front Range).
- You can also choose to see affiliated providers near you (there are 12,300 across the Front Range).
- Visit kp.org/locations to find providers near you.

IN PERSON CARE:

- Care under one roof: At most of their medical offices, you can see a doctor, fill a prescription, and get X-rays and labs done at one location.
- And for in-patient needs, members can get care at many of Colorado's top hospitals.
- Urgent and emergency care are covered anywhere in the world.
- Your dependents under the age of 26 who live outside a Kaiser Permanente service area are covered for certain routine, continuing, or follow-up care through their Out-of-Area Benefit.

CARE FROM VIRTUALLY ANYWHERE:

- An extensive suite of virtual care options, such as 24/7 on-demand video visits, and online chat with a clinician or mental health specialist, make it easy to get care at home, or on-the-go.
- Use their mobile app, or kp.org to manage both your care and coverage. You can connect with care, 24/7, choose or change Kaiser Permanente doctors (and schedule appointments, view your medical history, get reminders about screenings, prescriptions refills, and more!

Need help you choosing a doctor, transferring prescriptions, or booking appointments? Simply email our dedicated navigators at D11@KP.org with all your questions.

Visit www.kp.org/D11 to learn more about Kaiser Permanente and explore your care options.

KAISER MEDICAL PLANS

MEDICAL SERVICES	KAISER 1500 Plan	KAISER 4000 Plan
ANNUAL DEDUCTIBLE	\$1,500 IND/ \$3,000 FAM	\$4,000 IND/ \$8,000 FAM
ANNUAL OUT OF POCKET MAXIMUM Includes pharmacy and medical plan deductibles and copayments	\$3,000 IND/ \$6,000 FAM	\$6,000 IND/ \$12,000 FAM
OFFICE VISIT COPAY- PRIMARY CARE	\$20 COPAY PER VISIT	\$35 COPAY PER VISIT
OFFICE VISIT COPAY- SPECIALIST	\$40 COPAY PER VISIT	\$55 COPAY PER VISIT
DIRECT PRIMARY CARE	\$0 COPAY PER VISIT- ONE MEDICAL	\$0 COPAY PER VISIT- ONE MEDICAL
VIRTUAL CARE	\$0 COPAY PER VISIT	\$0 COPAY PER VISIT
URGENT CARE	\$50 copay each visit at a Kaiser Permanente designated Urgent Care Plan Facility inside the Service Area	\$75 copay each visit at a Kaiser Permanente designated Urgent Care Plan Facility inside the Service Area
PREVENTATIVE SERVICES	100% COVERED	100% COVERED
DIAGNOSTIC LAB	100% covered at a Plan Medical Office or in a con- tracted free standing facility / 20% coinsurance after deductible is met for services at a Plan Hospi- tal	100% covered at a Plan Medical Office or in a contracted free- standing facility / 30% coinsurance after deductible is met for services at a Plan Hospital
Xray, including Therapeutic	No Charge / 20% coinsurance	30% coinsurance after deductible is met
MRI/CAT/PET Scans	\$250 copay	30% coinsurance after deductible is met
EMERGENCY ROOM	\$500 copay	\$500 copay
OUTPATIENT SURGERY Pre-Authorization required	\$500 copay if received in a plan Ambulatory Surgery Center (ASC) / 20% coinsurance after deductible is met if received in the Outpatient Dept of a Plan Hospital (HOSC)	\$500 copay if received in a plan Ambulatory Surgery Center (ASC) /30% coinsurance after deductible is met if received in the Outpatient Dept of a Plan Hospital (HOSC)

KAISER MEDICAL PLANS (CONTINUED)

MEDICAL SERVICES	KAISER 1500 Plan	KAISER 4000 Plan
OUTPATIENT MENTAL ILLNESS/ SUBSTANCE ABUSE	\$20 copay per visit / 20% coinsurance for intensive outpatient /partial hospital after deductible is met.	\$35 copay each office visit / 30% coinsurance for intensive outpatient/partial hospital after deductible is met
INPATIENT HOSPITAL SURGERY Pre-authorization required.	20% coinsurance, after Deductible	30% coinsurance, after Deductible
INPATIENT MENTAL ILLNESS/SUBSTANCE ABUSE	20% coinsurance per admission after deductible is met	30% coinsurance per admission after deductible is met
AMBULANCE	\$250 copay	30% coinsurance, after Deductible
INPATIENT THERAPIES (PT/OT/SPEECH)	20% coinsurance after deductible up to 60 days per condition per accumulation period	30% coinsurance after deductible up to 60 days per condition per accumulation period
OUTPATIENT THERAPIES (PT/OT/SPEECH)	\$20 copay each visit for up to 90 visits combined per plan year	\$35 copay each visit for up to 90 visits combined per plan year
DURABLE MEDICAL EQUIPMENT Rented or purchased Preauthorization required for items >\$500	20% coinsurance after deductible / Prosthetic arms and legs are covered at 20% coinsurance (no annual maximum benefit)	30% coinsurance after deductible is met/Prosthetic arms and legs covered at 20% coinsurance (no annual maximum benefit)
OUT OF NETWORK BENEFIT	NOT COVERED	NOT COVERED
HEARING CARE	\$20 copay / \$1,000 credit per ear every 36 months	\$35 COPAY /HARDWARE NOT COVERED
CHIROPRACTIC CARE	\$0 - \$20 COPAY / 20 visits / per Contract year	\$0-\$35 copay / 20 visits / per Contract year
ACUPUNCTURE	\$0 - \$20 COPAY / 20 visits / per Contract year	\$0 - \$30 COPAY PER VISIT / 20 visits / per Contract year
MASSAGE THERAPY	\$15 copay / 20 visits per Contract year	\$30 COPAY PER VISIT / 20 visits / per Contract year

ONE MEDICAL DIRECT PRIMARY CARE (DPC)



Our medical plan allows you access to One Medical Direct Primary Care (DPC) services for employees and dependents enrolled in the health plan.

**One Medical appointments
are NO COST to you.**

COST/COVERAGE

- \$0 Cost Unlimited Primary Care
- No deductibles
- No waiting for appointments
- Thorough consultations
- Coordination with your Kaiser Medical Plan

WHY USE ONE MEDICAL PRIMARY CARE?

Direct Primary Care Service include but are not limited to the following:

- Adult & Pediatric Care
- Chronic Disease Management: High blood pressure, diabetes, etc.
- Mental Health & Wellness
- Sports Medicine, including InBody 570 body composition analysis
- On-Site Pharmacy with wholesale pricing
- Blood draws with low-cost test results
- Wound care, including stitches, staples and/or surgical glue
- Dermatology procedures: skin tag and wart removal, skin biopsies
- Annual & School Sports Physicals
- EKG & Pulmonary Function Testing

Download the One Medical App to easily book appointments, request prescriptions, get care 24.7, message providers, view your care plan and more!

Click the video below to learn more.



COLORADO SPRINGS LOCATIONS

Downtown

321 S. Tejon St.
Ste 100

Colorado Springs, CO 80903

Phone: (719) 623-3068

Fax: (719) 694-1689

Hours: Monday – Friday 7:00 AM to 5:00 PM

Northgate

13271 Bass Pro Dr.
Ste 140

Colorado Springs, CO 80921 Phone:

(719) 394-8664

Fax: (719) 394-8665

Hours: Monday – Friday 7:00 AM to 5:00 PM

Tutt

6945 Tutt Blvd.

Colorado Springs, CO 80923 Phone:

(719) 380-7325

Fax: (719) 354-2212

Hours: Monday – Friday 7:00 AM to 5:00 PM

Become familiar with the
One Medical App:



Sign up now at:

onemedical.com/mycare-co



Virtual care at your fingertips

	DESCRIPTION AND TYPES OF CARE	RESPONSE TIME
 Urgent Video Chat	Request a Video Chat with our virtual medical team at any time (24/7 on-demand) for non-life threatening but urgent concerns and potentially avoid costly trips to the ER. Types of care: Minor injuries (sprains, strains, burns, cuts), fevers over 103°, sudden back pain	Varies based on demand, but typically ~15-20 minutes
 Treat Me Now	Get help with common issues by message. Simply answer a few questions about your symptoms and a provider will message you with next steps. Types of care: Colds/flu, seasonal allergies, skin issues (rashes, moles, acne), cold sores, STI screening	Within ~4 hours
 Prescription Requests	Request a renewal right from the app and we'll send your prescription to the pharmacy you enter. Types of care: All prescription renewals (note: controlled substances may require a consultation)	48 hours for most meds, 72 hours for controlled substances
 Messages	Send and receive secure messages with your PCP, our virtual medical team, admin team, or tech support. Types of care: Simple follow-up questions after a visit, or insurance/billing questions for the admin team	Typically between 24-72 hours
 Remote Visits	Schedule an appointment with your PCP or another provider of your choice for things that don't require an in-person exam. You'll receive a link to dial into your visit once you book it. Types of care: Mental health, sleep issues, hair loss, follow-ups for chronic conditions like diabetes	Schedule your appointment for your preferred day and time

STRATA MED

Strata is a provider facility that we have incorporated into our medical plan to support your journey to optimal health and well-being.

To be truly healthy and thrive at all levels – it's important to address the body, the mind, and the spirit. To help you do this, Strata provides holistic healthcare, here in Colorado Springs. Strata Med takes traditional, concierge, and holistic healthcare approaches and blends them for the ultimate wellness experience.

Whether you have questions, you want to start your path to a healthier lifestyle, or you simply wish to learn more about the Strata services, we encourage you to schedule an initial appointment and truly experience compassionate, leading-edge healthcare. And it's affordable too – most of your Strata care is priced at or under \$35 per visit. See the table below for an overview of the specialty care services offered through Strata Med.

STRATA MED SERVICES

BENEFIT CATEGORY	VISIT TOTAL	COPAYMENT
OFFICE VISIT (includes Naturopathic, Functional, Internal, Behavioral Health visits)	Unlimited	\$20 per visit
Chiropractic Medicine*	20 Visits per Service *These services run through Kaiser as a medical claim	up to \$35 per visit
Acupuncture*		up to \$30 per visit
Medical Massage*		up to \$30 per visit
Gua Sha	10 Combined Visits	\$20 per visit
Nutrition Therapy		\$20 per visit
Fitness Therapy		\$20 per visit
Healing Touch Therapy		\$20 per visit
Shockwave		\$20 per visit
Ultrasound	As prescribed by Strata provider, included as part of office visit copay	
Bod Pod or Resting Metabolic Rate	1 Visit	\$20 per visit
Labs	As prescribed by Strata provider	\$20 per visit
Nutraceutical Benefit Program (Supplements)	\$500 Annual Allowance	

LOCATIONS & SERVICE HOURS:

3314 Mesa Road
Colorado Springs, CO 80904
M-F: 9am-7pm, Sat: 9am-5pm

11675 Ridgeline Drive
Colorado Springs, CO 80921
M-F: 9am-6pm

CONTACT INFORMATION:

To schedule an appointment
(both locations):

(719) 428-2202
stratwell.com



Watch short video
intros to Strata using
these QR codes:



PRESCRIPTION PLAN OVERVIEW

You are automatically enrolled in the prescription drug program, administered by Kaiser Permanente, when you enroll in the Colorado Springs School District 11 medical plan. The prescription drug program provides both retail and mail-order pharmacy coverage. Your medical and prescription cards are combined into one card, which will come from Kaiser.

You may also download the Kaiser app for an electronic ID card.

	30-DAY COPAY	90-DAY COPAY
GENERIC	\$10	\$20
BRAND NAME	\$30	\$60
NON-FORMULARY	\$45	\$90
SPECIALTY / INJECTABLES / IV	20% coins. up to \$250 per RX	Not Available

- Fill your prescription at any Kaiser Permanente medical office pharmacy. Order refills at kp.org/refill for pickup within 24 hours — or select priority pickup and get your refill in 30 minutes.
- Members also may choose to use an affiliated pharmacy.
- There are nearly 100 in-network retail pharmacies in the Colorado Springs area.
- The KP Specialty Tier Drug List allows you to look up covered specialty medications.
- Learn more about Kaiser’s pharmacy services at <https://healthy.kaiserpermanente.org/learn/pharmacy>.
- The pharmacy information will be included on your Medical ID card. You’ll want to present this at the pharmacy when you are filling a script.
- If you are an established patient, some prescriptions may be available onsite at your dedicated One Medical location. Prescriptions and lab work are not covered in full at One Medical, but they are offered at low, wholesale cost to patients. In the case of prescriptions, One Medical’s prices are often less than what you might pay for even a generic prescription through the health insurance plan.



PHARMACY BENEFITS

PHARMACY BENEFIT

MAIL ORDER PRESCRIPTIONS PROVIDED BY KAISER PERMANENTE

Covered prescriptions can be filled using retail participating pharmacies or through the Home Delivery Program. Prescriptions filled at a retail pharmacy can be for a maximum 30-day supply. For maintenance medications using the Home Delivery Program, Kaiser Members can obtain a 90-day supply. Through both retail and the Home Delivery Program, if generic medication is available and the Member receives Brand (Formulary and/or Non-Formulary) medication, the Member will pay the generic copayment plus the difference in cost.

	RETAIL SERVICE (30 DAY SUPPLY)	HOME DELIVERY (90 DAY SUPPLY)
GENERIC MEDICATIONS	Prescription Deductible then \$10.00 co-payment per prescription	Prescription Deductible then \$20.00 copayment per pre- scription, except as provided under the Enhanced Pre- scription Drug Benefit below.
FORMULARY MEDICATIONS	Prescription Deductible then \$30.00 co- payment per prescription	Prescription Deductible then \$60.00 copayment per pre- scription
NON-FORMULARY MEDICATIONS	Prescription Deductible then \$45.00 co- payment per prescription	Prescription Deductible then \$90.00 copayment per pre- scription
SPECIALTY/ INJECTABLES/ IV	20% coins. up to \$250 per RX	N/A

NOTE: Syringes and needles are included in the copayments for Insulin if purchased on the same day.

PREVENTATIVE PRESCRIPTION DRUGS COVERED AT 100% UNDER PPACA

DRUG/SUPPLEMENT	COVERAGE	BENEFIT
BOWEL PREP AGENTS	Prescription (generic only) bowel preparation agents for adults 50 years of age or older. Quantity limit of 1 bowel preparation product per year applies.	\$0 copay
ORAL FLUORIDES	Prescription (generic single ingredient only) oral fluoride supplement products for children ages 6 months to 6 years	\$0 copay
FOLIC ACID AND PRENATAL VITAMINS	Over-the-Counter folic acid supplements (with prescription) including prenatal vitamins for woman <55 years of age.	\$0 copay
IRON SUPPLEMENTS	Prescription or over-the-counter (with prescription) iron supplements for children ages 6 months to 12 months. Intravenous and bulk iron products are excluded.	\$0 copay
VITAMIN D	Over-the-counter single ingredient Vitamin D supplement (with prescription) for adults 65 years of age and older.	\$0 copay
CONTRACEPTIVES	Prescription contraceptive drugs as follows: -Emergency contraceptives- Generic Only -Oral contraceptives- Generic Only	\$0 copay
SMOKING CESSATION	Prescription and over-the-counter (with prescription) smoking cessation products. Quantity limit of 2 cycles per year applies to all products	\$0 copay

PHARMACY BENEFITS (CONTINUED)

PHARMACY BENEFIT

MAIL ORDER PRESCRIPTIONS PROVIDED BY KAISER PERMANENTE

Covered prescriptions can be filled using retail participating pharmacies or through the Home Delivery Program. Prescriptions filled at a retail pharmacy can be for a maximum 30-day supply. For maintenance medications using the Home Delivery Program, Kaiser Members can obtain a 90-day supply. Through both retail and the Home Delivery Program, if generic medication is available and the Member receives Brand (Formulary and/or Non-Formulary) medication, the Member will pay the generic copayment plus the difference in cost.

COVERAGE

BENEFIT

ENHANCED PRESCRIPTION DRUG BENEFIT—DIAGNOSED CONDITIONS ONLY

DEPRESSION, CLINICAL	Generic antidepressants	THROUGH MAIL-ORDER ONLY 100% coverage for mail order some generic prescriptions and, under rare circumstances, for select brands if no generic is available.
CONGESTIVE HEART FAILURE	Generic heart failure medications	
ASTHMA	At least one inhaled corticosteroid controller, short acting and long acting bronchodilator	
CORONARY ARTERY DISEASE	Generic beta-blocker, ACEI, diuretic, statin	
DIABETES	Generic diabetes medications, NPH and regular insulin, supplies	
HYPERTENSION	Generic blood pressure medications	



DENTAL PLAN OVERVIEW

DELTA DENTAL PLAN	PPO + PREMIUM PLAN #1563	PPO (In-Network Only) PLAN THERE IS NO BENEFIT OUTSIDE THE DELTA DENTAL PPO NETWORK		
Annual Maximum Benefit	\$2,000 Per Person All Covered Classes, In and Out of Network	\$2,000 Per Person All Covered Classes, PPO Network Only		
Plan Year Deductibles (7/1- 6/30) Applies to Basic and Major only	Individual Deductible- \$50 (combination of in and out-of- network) Family Deductible- \$100 (combination of in and out-of-network)	No Deductible		
RIGHT START 4 KIDS	Covers children up to their 13th birthday at 100% with no deductible (for the same services outlined in the plan, up to the annual maximum, and subject to limitations and exclusions). The child must see a Delta Dental PPO or Premier provider to receive the 100% coinsurance. If an out-of- network provider is seen, the adult coinsurance levels will apply. Orthodontics, if selected as part of the group’s plan, is not covered at 100% but at the plan’s listed coinsurance.	Covers children up to their 13th birthday at 100% with no deductible (for the same services outlined in the plan, up to the annual maximum, and subject to limitations and exclusions). The child must see a Delta Dental PPO provider to receive the 100% coinsurance. Orthodontics, if selected as part of the group’s plan, is not covered at 100% but at the plan’s listed coinsurance.		
PREVENTATIVE AND DIAGNOSTIC SERVICES				
	PPO Dentist	Premier/ Non-PPO Dentist	PPO Dentist	Premier/ Non-PPO Dentist
	In-Network	Out-of-Network	In-Network	Out-of-Network
Oral Evaluation	100% Covered		100% Covered	Not Covered
	Limited to 2 evaluations in a 12 month period		Limited to 2 evaluations in a 12 month period	
Bitewing X-Rays	100% Covered		100% Covered	Not Covered
	Limited to 2 sets in a 12 month period		Limited to 1 set in a 12 month period	
Full Mouth X-Rays or Panoramic	100% Covered		100% Covered	Not Covered
	Limited to 1 in a 36 month period		Limited to 1 in a 60 month period	
Routine Cleaning	100% Covered		100% Covered	Not Covered
	Limited to 2 cleanings in a 12 month period – if patient history shows prior periodontal treatment, 2 additional cleanings may be allowed.		Limited to 2 cleanings in a 12 month period	

DENTAL PLAN OVERVIEW (CONTINUED)

DELTA DENTAL PLAN		PPO + PREMIUM PLAN #1563		PPO (In-Network Only) PLAN THERE IS NO BENEFIT OUTSIDE THE DELTA DENTAL PPO NETWORK	
PREVENTATIVE AND DIAGNOSTIC SERVICES					
	PPO Dentist	Premier/ Non-PPO Dentist	PPO Dentist	Premier/ Non-PPO Dentist	
	In-Network	Out-of-Network	In-Network	Out-of-Network	
Fluoride Treatment	100% Covered		100% Covered	Not Covered	
	Limited to 2 treatments in 12 months to age 15		Limited to 2 treatments in 12 months to age 15		
Space Maintainers	100% Covered		100% Covered	Not Covered	
	For posterior primary teeth- to age 13		For posterior primary teeth- to age 13		
Sealants	100% Covered		100% Covered	Not Covered	
	1 per tooth in 36 months- to age 14 on unrestored molars		1 per tooth in 36 months- to age 14 on unrestored molars		
BASIC SERVICES: Fillings, Endodontics (Root Canal), Periodontics (Gum Disease), Oral Surgery (extractions), and Denture repairs					
	PPO Dentist	Premier/ Non-PPO Dentist	PPO Dentist	Premier/ Non-PPO Dentist	
	In-Network	Out-of-Network	In-Network	Out-of-Network	
Amalgam Fillings	80% Covered	75% Covered	60% Covered	Not Covered	
	Benefits on the same surface limited to 1 in 12 months		Benefits on the same surface limited to 1 in 12 months		
Resin or Composite Fillings	80% Covered	75% Covered	60% Covered	Not Covered	
	Benefit for anterior teeth only- allowance for amalgam on posterior teeth		Benefits on the same surface limited to 1 in 12 months		
General Anesthesia	80% Covered	75% Covered	60% Covered	Not Covered	
	Benefit with covered oral surgery only		Benefit with covered oral surgery only		
Surgical Periodontal (gums)	80% Covered	75% Covered	60% Covered	Not Covered	
	Benefit once every 36 months		Benefit once every 36 months		
Root Canal Therapy	80% Covered	75% Covered	60% Covered	Not Covered	
Denture Repairs/Rebase/Relines	80% Covered	75% Covered	60% Covered	Not Covered	
	Benefits limited to 1 in 12 months		Benefit 6 months after initial insertion. Then benefit 1 in 36 months		

DENTAL PLAN OVERVIEW (CONTINUED)

DELTA DENTAL PLAN		PPO + PREMIUM PLAN #1563		PPO (In-Network Only) PLAN THERE IS NO BENEFIT OUTSIDE THE DELTA DENTAL PPO NETWORK	
MAJOR SERVICES (Crowns, Bridges, Partial, Dentures)					
	PPO Dentist	Premier/ Non-PPO Dentist	PPO Dentist	Premier/ Non-PPO Dentist	
	In-Network	Out-of-Network	In-Network	Out-of-Network	
Crowns	50% Covered	45% Covered	40% Covered	Not Covered	
	Benefit 1 in 60 months on same tooth-not a benefit under age 12		Benefit 1 in 60 months on same tooth-not a benefit under age 12		
Dentures, Partial, Bridges	50% Covered	45% Covered	40% Covered	Not Covered	
	Benefit 1 in 60 months- not a benefit under age 16		Benefit 1 in 60 months- not a benefit under age 16		
Implants	50% Covered	45% Covered	Not a covered benefit on this dental plan		
	Benefit 1 in 60 months on the same tooth- not a benefit under age 12				
ORTHODONTICS (Braces)					
Complete Orthodontic Evaluation	60% Covered	50% Covered	50% Covered	Not Covered	



VISION PLAN OVERVIEW

EYEMED VISION CARE-GROUP #9764168 – ACCESS PLAN

District 11 offers one vision plan option. This plan provides coverage once per plan year for routine eye exams, frames, lenses, and contact lenses and provides other services such as Member preferred pricing on prescription eyeglasses, and non-prescription sunglasses. Please refer to the current year Plan Document for more information or call **1-866-939-3633**.

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK REIMBURSEMENT
Exams w/ Dilation as Necessary (once every 12 months)	\$10 Copay	Up to \$35
Premium contact lens fit & follow-Up	10% Off Retail	N/A
Contact Lenses	Conventional: \$0 Copay; \$140 allowance; 15% off balance over \$140 Disposable: \$0 Copay; \$140 allowance; plus, balance over \$140 Medically Necessary: \$0 Copay; Paid-in-Full	Up to \$112 Up to \$112 Up to \$200
Frames (once every 12 months)	\$0 Copay; \$140 allowance; 80% of the charge over \$140	Up to \$70
Lenses (once every 12 months)	Single Vision: \$25 Copay Bifocal: \$25 Copay Trifocal: \$25 Copay	Up to \$25 Up to \$40 Up to \$55

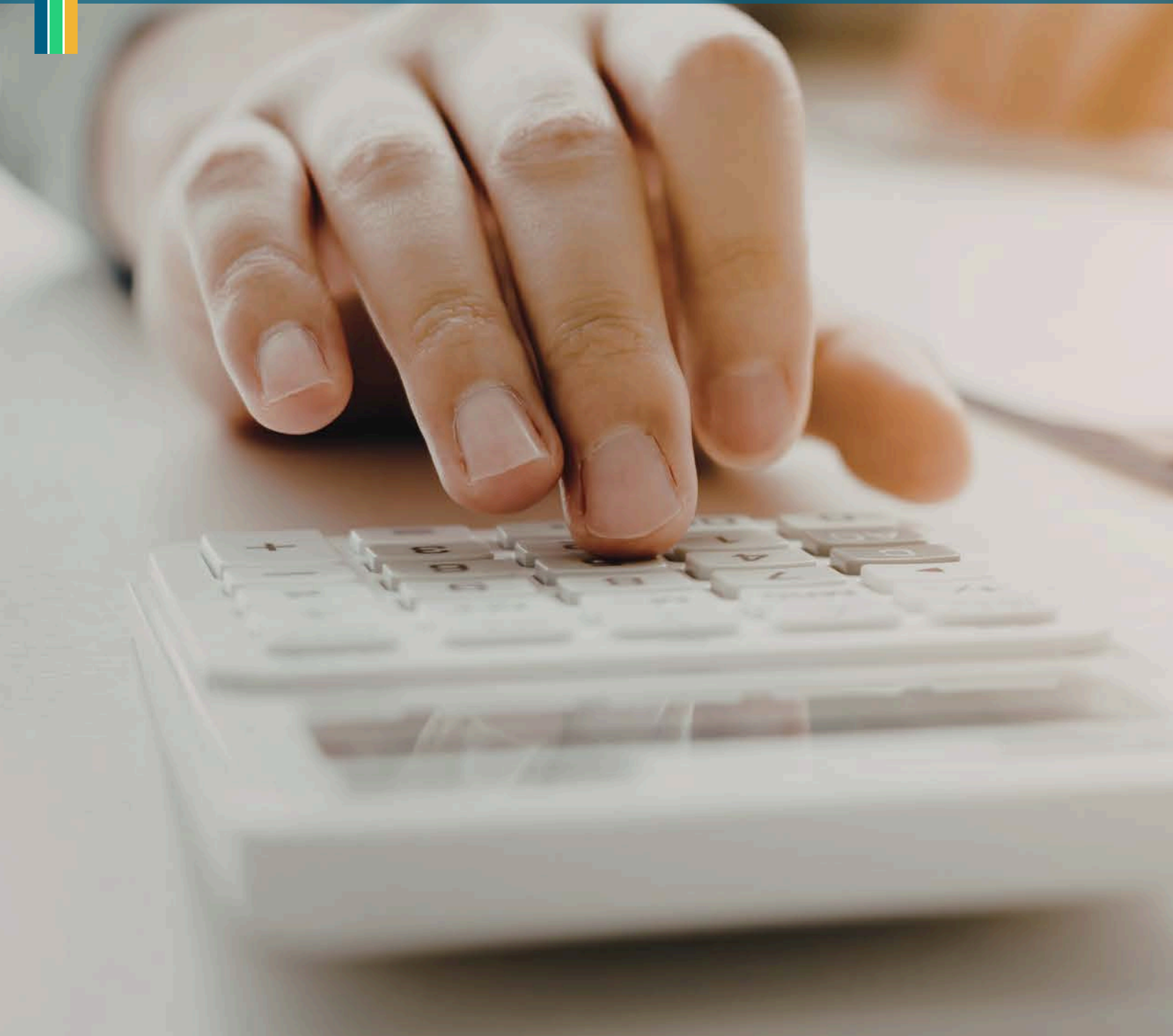
NOTE: This list not all inclusive. For a full list of benefits, please visit:
www.d11.org/employees/employee-benefits/home/vision

For a complete list of providers near you, use our Provider Locator on
www.eyemedvisioncare.com and choose the ACCESS network.

DID YOU KNOW THAT YOU CAN GET EXTRA SAVINGS WITH YOUR EYEMED BENEFITS?

You get a mix of special offers and discounts that give your benefits a boost — so you can keep your eyes healthy and save some cash while you're at it. Visit the special offers page exclusive to EyeMed members. It's chock-full of the latest deals on vision-related products and services.

MONTHLY PREMIUMS



2026/2027 MONTHLY PREMIUMS

TEACHERS ONLY – MEDICAL

Insurance premiums are prorated for teachers who work fewer than 6 hours per day. If your scheduled hours fall into one of the categories below, your benefit costs and the District contribution will be adjusted based on your full-time equivalent (FTE).

Teachers working less than 3.5 hours per day are not eligible for benefits.

Example:

A teacher working 3.5 hours per day is considered 0.50 FTE (50% of full-time). The District pays 75% of the health insurance premium for a full-time employee. At 0.50 FTE, the District pays 50% of the 75% contribution, and the employee is responsible for the remainder.

Kaiser 1500 Buy Up Plan	EMPLOYEE COST				
	.75–1.0 FTE 90–100%	.71– .74 FTE 80%	.61– .70 FTE 70%	.51– .60 FTE 60%	.41– .50 FTE 50%
EMPLOYEE ONLY	\$211.92	\$339.08	\$402.65	\$466.23	\$529.81
EMPLOYEE + SPOUSE	\$558.03	\$818.44	\$948.65	\$1,078.85	\$1,209.06
EMPLOYEE + CHILD(REN)	\$460.12	\$674.84	\$782.20	\$889.56	\$996.92
EMPLOYEE + FAMILY	\$731.21	\$1,072.44	\$1,243.06	\$1,413.67	\$1,584.29

Kaiser 4000 Base Plan	EMPLOYEE COST				
	.75–1.0 FTE 90–100%	.71– .74 FTE 80%	.61– .70 FTE 70%	.51– .60 FTE 60%	.41– .50 FTE 50%
EMPLOYEE ONLY	\$108.46	\$235.61	\$299.19	\$362.77	\$426.35
EMPLOYEE + SPOUSE	\$329.00	\$589.41	\$719.62	\$849.82	\$980.03
EMPLOYEE + CHILD(REN)	\$271.59	\$486.31	\$593.67	\$701.03	\$808.40
EMPLOYEE + FAMILY	\$430.53	\$771.76	\$942.38	\$1,112.99	\$1,283.61

2026/2027 MONTHLY PREMIUMS

TEACHERS ONLY – DENTAL & VISION

DELTA DENTAL PPO +PREMIER GROUP #1563	EMPLOYEE COST				
	.75–1.0 FTE 90–100%	.71– .74 FTE 80%	.61– .70 FTE 70%	.51– .60 FTE 60%	.41– .50 FTE 50%
EMPLOYEE ONLY	\$13.43	\$21.48	\$25.51	\$29.54	\$33.56
EMPLOYEE + FAMILY	\$70.63	\$78.68	\$82.71	\$86.74	\$90.76

DELTA DENTAL PPO IN NETWORK ONLY GROUP #9098	EMPLOYEE COST				
	.75–1.0 FTE 90–100%	.71– .74 FTE 80%	.61– .70 FTE 70%	.51– .60 FTE 60%	.41– .50 FTE 50%
EMPLOYEE ONLY	\$8.44	\$13.50	\$16.03	\$18.56	\$21.09
EMPLOYEE + FAMILY	\$53.18	\$58.24	\$60.77	\$63.30	\$65.83

EYEMED VISION #9764168	EMPLOYEE COST				
	.75–1.0 FTE 90–100%	.71– .74 FTE 80%	.61– .70 FTE 70%	.51– .60 FTE 60%	.41– .50 FTE 50%
EMPLOYEE ONLY	\$1.37	\$2.21	\$2.62	\$3.04	\$3.46
EMPLOYEE + FAMILY	\$11.15	\$11.99	\$12.40	\$12.82	\$13.24

2026/2027 MONTHLY PREMIUMS

12-MONTH EMPLOYEES– MEDICAL

Premiums are calculated on a monthly basis and reflect any prorated adjustments based on your FTE.

The amount shown in the **Employee** column is the portion the employee pays each month.

The amount shown in the **District** column is the prorated amount District 11 pays toward your benefits each month.

Kaiser 1500 Buy-Up Plan	EMPLOYEE COST Monthly	DISTRICT COST Monthly	TOTAL MONTHLY
EMPLOYEE ONLY	\$211.92	\$635.77	\$847.69
EMPLOYEE + SPOUSE	\$558.03	\$1,302.06	\$1,860.09
EMPLOYEE + CHILD(REN)	\$460.12	\$1,073.61	\$1,533.73
EMPLOYEE + FAMILY	\$731.21	\$1,706.16	\$2,437.37

Kaiser 4000 Base Plan	EMPLOYEE COST Monthly	DISTRICT COST Monthly	TOTAL MONTHLY
EMPLOYEE ONLY	\$108.46	\$635.77	\$744.23
EMPLOYEE + SPOUSE	\$329.00	\$1,302.06	\$1,631.06
EMPLOYEE + CHILD(REN)	\$271.59	\$1,073.61	\$1,345.20
EMPLOYEE + FAMILY	\$430.53	\$1,706.16	\$2,136.69

2026/2027 MONTHLY PREMIUMS

12-MONTH EMPLOYEES- DENTAL & VISION

DELTA DENTAL PPO +PREMIER GROUP #1563	EMPLOYEE COST Monthly	DISTRICT COST Monthly	TOTAL MONTHLY
EMPLOYEE ONLY	\$13.43	\$40.28	\$57.30
EMPLOYEE + FAMILY	\$70.63	\$40.28	\$110.09

DELTA DENTAL PPO IN- NETWORK ONLY GROUP #9098	EMPLOYEE COST Monthly	DISTRICT COST Monthly	TOTAL MONTHLY
EMPLOYEE ONLY	\$8.44	\$25.31	\$33.75
EMPLOYEE + FAMILY	\$53.18	\$25.31	\$78.49

EYEMED VISION #9764168	EMPLOYEE COST Monthly	DISTRICT COST Monthly	TOTAL MONTHLY
EMPLOYEE ONLY	\$1.37	\$4.18	\$5.55
EMPLOYEE + FAMILY	\$11.15	\$4.18	\$15.33

2026/2027 MONTHLY PREMIUMS (9 MONTHS)

FOOD & NUTRITION SERVICE EMPLOYEES- MEDICAL

The **9-month rates** are calculated for Food & Nutrition Services employees because 12 months of coverage are paid over a 9-month period.

Premiums are calculated on a **monthly** basis. The amount shown in the **Employee** column is the portion the employee pays each month.

The amount shown in the **District** column is the amount District 11 pays toward your benefits each month.

Kaiser 1500 Buy-Up Plan	EMPLOYEE COST Monthly	DISTRICT COST Monthly	TOTAL MONTHLY
EMPLOYEE ONLY	\$282.56	\$847.69	\$1,130.25
EMPLOYEE + SPOUSE	\$744.04	\$1,736.08	\$2,480.12
EMPLOYEE + CHILD(REN)	\$613.49	\$1,431.48	\$2,044.97
EMPLOYEE + FAMILY	\$974.95	\$2,274.88	\$3,249.83

Kaiser 4000 Base Plan	EMPLOYEE COST Monthly	DISTRICT COST Monthly	TOTAL MONTHLY
EMPLOYEE ONLY	\$144.88	\$847.43	\$992.31
EMPLOYEE + SPOUSE	\$439.30	\$1,735.45	\$2,174.75
EMPLOYEE + CHILD(REN)	\$362.31	\$1,431.29	\$1,793.60
EMPLOYEE + FAMILY	\$575.48	\$2,273.44	\$2,848.92

2026/2027 MONTHLY PREMIUMS (9 MONTHS)

FOOD & NUTRITION SERVICE EMPLOYEES

DENTAL & VISION

DELTA DENTAL PPO +PREMIER GROUP #1563	EMPLOYEE COST Monthly	DISTRICT COST Monthly	TOTAL MONTHLY
EMPLOYEE ONLY	\$17.90	\$53.70	\$71.60
EMPLOYEE + FAMILY	\$94.17	\$53.70	\$147.87

DELTA DENTAL PPO IN- NETWORK ONLY GROUP #9098	EMPLOYEE COST Monthly	DISTRICT COST Monthly	TOTAL MONTHLY
EMPLOYEE ONLY	\$11.25	\$33.75	\$45.00
EMPLOYEE + FAMILY	\$70.90	\$33.75	\$104.65

EYEMED VISION #9764168	EMPLOYEE COST Monthly	DISTRICT COST Monthly	TOTAL MONTHLY
EMPLOYEE ONLY	\$1.85	\$5.55	\$7.40
EMPLOYEE + FAMILY	\$14.89	\$5.55	\$20.44



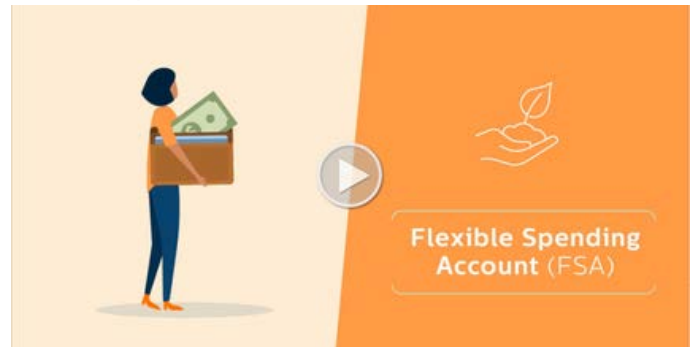
FINANCIAL PROTECTION BENEFITS

FLEXIBLE SPENDING ACCOUNTS (FSA)–OVERVIEW

A **Flexible Spending Account (FSA)** allows you to use **pre-tax** dollars for eligible health care and/or dependent care expenses not covered by insurance. Participants contribute a portion of their paycheck to an FSA and may save approximately **25%–40% in taxes**.

You must elect your total annual contribution before the start of the plan year. Your annual election is then **divided into equal pre-tax deductions** taken from each paycheck. Funds in your FSA can be used to pay for eligible out-of-pocket medical or dependent care expenses.

**Click the video to learn
more**



KNOW THE RULES

- Outside of Open Enrollment, you can only change your contributions if you have a Qualifying Life Event (QLE).
- Only “out-of-pocket” expenses are eligible for reimbursement (i.e. copayments, deductible).
- Claims must be submitted no later than 90-days after the plan year has ended.

Health Care FSA’s

- \$20–\$680 can rollover to the next plan year with the Health Care FSA.
- Expenses for general well-being such as cosmetic surgery are not eligible for reimbursement
- The annual Health Care FSA amount is available any time during the plan year.

Dependent Care FSA’s

- Any unused funds in the Dependent Care FSA are lost at the end of the plan year.
- Expenses must be incurred by participants or eligible dependents during the current plan year and while participating.
- Only the amount contributed year-to-date in the dependent care FSA is available for reimbursement.

FLEXIBLE SPENDING ACCOUNTS (FSA)– HEALTH CARE

	MINIMUM	MAXIMUM	ROLLOVER
HEALTH CARE FSA	\$300.00	\$3,400.00	\$20 to \$680 annually

*If you enroll in a **Health Care FSA**, you may use **pre-tax dollars** to pay for eligible out-of-pocket medical, dental, and vision expenses for you and your dependents. These expenses are costs **not covered or reimbursed** by your health plan or any other insurance. In general, eligible expenses are those allowed by the IRS for health care spending and that are not claimed as deductions on your tax return.

ELIGIBLE	INELIGIBLE
Copayments	Cosmetic Surgery
Eyeglasses, eye exams, sunglasses (prescription), LASIK eye surgery	Personal Use: toiletries, cotton swabs, toothbrush
Dental & Orthodontic treatments	Teeth Whitening
Stop Smoking Programs	Nutritional Supplements
Chiropractor	Electrolysis or hair removal
Hearing Aides and batteries	Maternity Clothes

FLEXIBLE SPENDING ACCOUNTS (FSA)– DEPENDENT CARE

	MINIMUM	MAXIMUM	ROLLOVER
DEPENDENT DAYCARE FSA	\$300.00	\$7,500.00	NONE

If you enroll in a **Dependent Care FSA**, you may use **pre-tax dollars** to pay for eligible work-related dependent care expenses. The care must be necessary to allow you and your spouse to work or attend school. Eligible expenses generally include dependent care costs that meet **IRS guidelines**. A dependent receiving care must be a **child under age 13** or a qualifying tax dependent who is unable to care for themselves and lives with you. Care may be provided by anyone other than your spouse or a child under age 19.

ELIGIBLE	INELIGIBLE
Expenses for Pre-School	Educational fees/tuition
Before and after-school care	Payments to a spouse or parent of a dependent
Care provided in your home (provider can not be an IRS tax dependent or a dependent under the age of 19)	Overnight camps
Summer camp for children under 13 years old	Nursing homes
Licensed day care provider	Food/clothing
Registration fee (provided the qualified dependent actually receives care)	Transportation expenses provided by parents

BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) PLAN OVERVIEW

District 11 provides **Basic Life and Accidental Death & Dismemberment (AD&D)** insurance at **no cost** to benefit-eligible employees. Eligible employees are automatically enrolled on the **first of the month following their date of hire**.

To **change your beneficiaries**, please contact the Employee Benefits office at Employee.Benefits@d11.org. You cannot make changes to beneficiaries through your Peoplesoft Self-Service Account.

Benefit Amount: Coverage is equal to **two times your annual salary**, with a **minimum benefit of \$50,000**. Coverage ends upon termination of employment or retirement. There is **no age-based reduction** to the Basic Life and AD&D benefit.

As part of your life insurance plan through **Sun Life Financial**, you have access to **online will preparation and claimant support services** designed to help you and your loved ones protect your assets. Some services are available for an additional fee.

ONLINE WILL PREPARATION

A will is the cornerstone of any estate plan and can protect your assets and loved ones. Through an easy-to-use secure website, you and your spouse can now create and download a will in about 20 minutes.

This service includes the following:

- Step-by-step guidance and customization for your unique situation,
 - Glossary of legal definitions,
- Ability to name an executor to carry out your wishes and a guardian(s) to care for your children,
- Ability to create a living will (for an additional fee), and
- Ability to create a final arrangement document (for an additional fee)

www.EstateGuidance.com

Promotional Code: **SLFVAS**

Online Will Preparation provided by ComPsych to active employees enrolled in Sun Life's Life insurance. This service is not insurance.

CLAIMANT SUPPORT SERVICES

Losing a loved one or becoming disabled can be overwhelming to say the least. With Claimant Support Services, you have access to no-cost, objective financial planning, legal information, and emotional support, if you or your family member has filed a claim with us.

You can receive the following:

- Up to five telephonic professional counseling sessions per claim for legal, financial, and emotional assistance,
 - 24x7 access to counseling provided by ComPsych's on-staff professionals, including clinicians, licensed attorneys, CPAs, CFPs, and other financial experts,
- Assistance with topics such as inheritance taxes, loss of income, creditors, and probate, and
- Support dealing with trauma, loss, and adjusting to a reduced quality of life, and other concerns.

If you need to talk to a counselor or need legal or financial information because of a Life or Disability insurance claim with Sun Life, you can call **ComPsych** for no-cost, objective assistance at **(888) 475-3827**

VOLUNTARY SUPPLEMENTAL LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) PLAN OVERVIEW

In addition to the coverage provided by District 11, you may elect **Supplemental Life insurance** for yourself, your spouse, and eligible dependents. Premiums are based on **age** and the **amount of coverage selected**. To enroll your spouse or dependents, you must also enroll in employee coverage.

During your initial eligibility period (hire date or when you become benefit eligible), you may elect coverage with **automatic approval** up to \$100,000 for employee coverage, \$25,000 for spouse coverage and \$10,000 for each eligible dependent.

Coverage amounts above these limits require completion of an Evidence of Insurability application.

Monthly Cost Calculation:

To calculate your monthly premium, divide your selected coverage amount by 1,000, then multiply by your age-banded rate.



EXAMPLE: 47-year-old wanting \$50,000 of life insurance:
 $\$50,000 / 1,000 = 50 \times \$0.150 = \$7.50$ rate per month.

Rates and Eligibility

Employee and spouse premiums are based on the **employee's age** and the **amount of coverage selected** at the time of enrollment. When you move to a new age band, the updated rate is automatically reflected on your paycheck.

Coverage ends upon termination of employment or retirement.

Coverage Limits

Guarantee issue amounts apply **only during your initial enrollment period** at hire. Elections made during any other enrollment period require completion of an **Evidence of Insurability (EOI)** application.

Age Reductions

Benefits are reduced to **65% at age 65** and **50% at age 70**.

AGE	RATE
00-24	0.062
25-29	0.07
30-34	0.087
35-39	0.095
40-44	0.103
45-49	0.145
50-54	0.212
55-59	0.379
60-64	0.571
65-69	1.08
70-99	1.739

	COVERAGE	GUARANTEED ISSUE AMOUNT*	MAXIMUM COVERAGE AMOUNT
EMPLOYEE	Purchased in \$10,000 increments	\$100,000**	\$500,000
SPOUSE	Purchased in \$5,000 increments	\$25,000** (cannot exceed 50% of the employee's approved amount of coverage)	\$150,000
CHILD(REN) UP TO AGE 26	\$10,000 in coverage	\$10,000*	\$10,000 Cost is \$2.66 per month—one premium covers all eligible children.

To find the **Evidence of Insurability (EOI)** application online, follow these steps:

1. Go to <https://www.sunlife-usa.net/eoi/>
2. Enter Group# **235819**
3. Answer all questions. One application is required per applicant (i.e. employee, spouse, child)

VOLUNTARY SHORT-TERM DISABILITY (STD) PLAN

WAGE REPLACEMENT FOR SHORT-TERM INJURIES, ILLNESS OR HAVING A BABY.

A surgery, having a baby or even an illness can keep you away from work. Sun Life Financial's Short-Term Disability Insurance may give you the financial support you need to pay for housing and food-and even dinners out or diapers- until you are back on your feet, and back to work.

HOW DOES IT WORK? There is a 15- day waiting period before the benefit begins to pay. You will receive up to 60% of your weekly salary for up to 11 weeks (6-8 weeks for maternity), to a maximum of \$1,500 per week. Employees must use all paid leave (use of vacation optional) time prior to the benefit being paid.

HOW MUCH WILL I NEED? Add up your monthly expenses to determine how much replacement income you might need. Then, check your plan to see if it fits your needs.

HOW MUCH COVERAGE AM I ELIGIBLE TO APPLY FOR?

You can elect a minimum weekly benefit amount of \$50 per week. The maximum weekly benefit amount is 60% of your weekly salary up to \$1,500 per week.

EXAMPLE: 32-year-old, making \$40,000 per year. $\$40,000 / 52 \text{ weeks per year} = \$769.23 \times 60\% = \$450.00 / \$10 = \$45.00 \times \$0.514 = \$23.13 \text{ month}$



HOW TO CALCULATE MONTHLY COST FOR EMPLOYEE STD COVERAGE:

1. Take your annual salary
2. Divide by 52 (weeks in a year)
3. Multiple by 60% (weekly benefits)
4. Divide by \$10
5. Multiply your age banded rate
6. This is your monthly premium

For the Full Short-Term Disability policy and rate calculation, please visit:

www.d11.org > Employee Benefits > Life & Disability

AGE BAND	RATE
UNDER AGE 25	\$0.50
25-29	\$0.57
30-34	\$0.51
35-39	\$0.35
40-44	\$0.25
45-49	\$0.27
50-54	\$0.31
55-59	\$0.39
60-64	\$0.47
65-69	\$0.54
70+	\$0.64

VOLUNTARY LONG-TERM (LTD) DISABILITY PLAN

WAGE REPLACEMENT FOR LONG-TERM ILLNESS OR ACCIDENTS

Long-Term Disability (LTD) is an employee-paid benefit designed to replace a portion of your monthly salary if you experience a covered disability.

Benefit Amount:

LTD provides a monthly benefit of up to 60% of your basic monthly salary, not to exceed \$5,000 per month. The minimum monthly benefit is \$50.

Benefit Coordination:

The LTD benefit is designed to complement District sick leave, PERA, Workers' Compensation, Social Security, and other employer-sponsored salary continuation plans. Total combined benefits will not exceed 60% of your basic monthly salary.

Benefit Duration:

Benefits are payable for up to three years if you are unable to perform your own occupation. After three years, benefits continue if you are unable to perform any occupation for which you are reasonably trained, for as long as the disability continues or until age 65, whichever occurs first.

Waiting Period:

Benefits begin after a 90-day waiting period or the end of all paid leave benefits (use of vacation is optional), whichever occurs later.

EXAMPLE: if you make \$40,000 per year. $\$40,000 / 12 \text{ months per year} = \$3,333.33 \times .175 = \$583.33 / 100 = \$5.83 \text{ month.}$

HOW MUCH COVERAGE AM I ELIGIBLE TO APPLY FOR?

Your election is 60% of your monthly salary for a maximum monthly benefit amount of \$ 5,000 per month.



HOW TO CALCULATE MONTHLY COST FOR EMPLOYEE LTD COVERAGE:

1. Take your annual salary
2. Divide by 12 (months in a year)
3. Multiple by .175
4. Divide by 100
5. This is your monthly premium

Pre-Existing Conditions

Short-Term and Long-Term Disability coverage includes a pre-existing condition limitation. A pre-existing condition is any injury, sickness, or pregnancy for which you received medical treatment, consultation, care, services, diagnostic measures, or took prescribed medication within three months prior to the effective date of your STD/LTD coverage.

School-Year Employees

For teachers and other employees working a school-year schedule, disabilities that begin during the summer break will have the waiting period start on the first scheduled workday of the new school year.

For the Full Long-Term Disability policy and rate calculation, please visit:

www.d11.org > Employee Benefits > Life & Disability



HEALTH AND WELLBEING PROGRAMS

EMPLOYEE ASSISTANCE PROGRAM

PROFILE EAP– COMMONSPIRIT



District 11 understands that you or your family members may experience personal challenges that can affect well-being at home and work. To support you, the District provides a confidential Employee Assistance Program (EAP) at no cost. Your use of EAP services is **not reported** to District 11. The EAP offers professional counseling, legal and financial guidance, and additional resources to support your emotional and mental well-being and help bring balance to your life.

YOUR BENEFITS INCLUDE:

- Unlimited access to information resources on **commonspirit.mylifeexpert.com**
 - Company Code: **CSD11**

There is NO COST to employees or dependents!

- (8) Sessions per person, per problem, per year
- Legal/financial services
 - Free consultation
 - Discounted rates on additional services



WILL DISTRICT 11 KNOW THAT I AM USING THE EAP?

EAP services are strictly confidential. There is no co-pay, nor do they use your medical benefit. Your use of the EAP services is NOT reported to District 11. EAP serves two clients– District 11 and the employee. It is important to note that even though District 11 pays for the counseling service, it has no special privilege to access information that is obtained in a counseling session.

WHAT TYPES OF PROBLEMS CAN I GO TO EAP FOR?

EAP is adept at helping with marital and family problems, anxiety and depression, chemical dependency and co- dependency, grief and loss, job stress and co-worker conflict to name just a few. Almost any personal problem or work- related problem is appropriate for seeking assistance through EAP. Not problem is too large or too small. Please note that EAP uses professional discretion on determining the appropriateness of whether counseling and assistance is needed on a short term or long term basis. You are encouraged to speak with an EAP representative to discuss counseling options.

Contact Profile EAP directly at (800) 645-6571. Normal business hours are 8:00am through 5:30pm Monday through Thursday and 8am through 4pm on Fridays, but if you need help handling a crisis, after hours, a counselor can be reached **24-hour a day** at the same number. EAP counselors are experienced in responding to traumas and will quickly respond to assist you in dealing with traumatic events. There are offices in Colorado Springs, Denver, Pueblo and Canon City.

STRATA VOLUNTARY GLP-1 PROGRAM



PERSONALIZED FOR **YOU**,
GUIDED BY EXPERT CLINICIANS

Comprehensive Weight Management and Wellbeing Program



IMPROVE HEALTH
ACHIEVE WEIGHT LOSS
FEEL YOUR BEST

"This program helped me improve my health, feel stronger, and take charge of my wellbeing. It's more than a benefit—it's a life upgrade."

-Strata Patient

HERE'S WHAT YOUR 12-MONTH CARE PLAN INCLUDES:

Comprehensive Lab Testing	Baseline health evaluation and ongoing tracking Labs as needed
Monthly GLP-1 Prescription	Self-Injectable compound GLP-1 medication under clinical supervision
Medical Weight Loss Care Coaching	Monthly check-ins with your care team at your convenience
Nutritional Program:	Personalized meal planning and nutrition guidance
Lifestyle Therapies:	Emotional and stress management strategies
Fitness:	Custom activity planning to support your goals
Nutraceutical Plan	Optional supplements to support long-term wellness as needed

Employee must meet one or more eligible medical criteria:

Cardiovascular Risk | BMI ≥ 25 w/Comorbidity | Type 2 Diabetes | Metabolic Syndrome

Wellness Service	Service Fee	Monthly Subscription Fee
Initial Online Intake	\$0.00	\$295 Per Patient
Tier 1 GLP-1 (Compound Injectable)	\$40/month	
Tier 2 GLP-1 (Compound Injectable)	\$80/month	
Labs	\$0.00	

QUESTIONS? Contact Strata | 719-419-9936 or at benefits@stratawell.com

3314 Mesa Road Colorado Springs, CO 80904

11675 Ridgeline #110, Colorado Springs, CO 80921

STRATA VOLUNTARY GLP-1 PROGRAM

Frequently Asked Questions [FAQ]

Comprehensive Weight Management & Wellbeing Plan

What is GLP-1?

GLP-1 (Glucagon-Like Peptide-1) is a natural hormone made in your gut that helps regulate blood sugar and control appetite. It signals your brain to feel full, reduces cravings or “food noise,” and slows down how fast food leaves your stomach.

This helps you feel satisfied longer, eat less, and better manage your weight and blood sugar.

What side effects should I know about?

The most common side effects of GLP-1 medications are related to the digestive system, such as: nausea, bloating, vomiting, diarrhea, constipation. This happens because the medication slows down how quickly food leaves your stomach. These symptoms are usually mild and often improve over time.

Less common but more serious side effects can include: Pancreatitis (inflammation of the pancreas, causing

severe abdominal pain), Gallbladder issues (such as gallstones), Kidney problems (especially if you're dehydrated), Low blood sugar (usually when used with other diabetes medications) and increased heart rate.

Will I be automatically accepted into the program?

Acceptance into the Employer GLP-1 program is based off of your health and medications are scripted based on a variety of clinical factors. Though we cannot guarantee the clinical need for every person applying, we have a wide variety of medical conditions that allow acceptance into the program.

What are examples of GLP-1 medications?

Common medications include Ozempic® (semaglutide), Wegovy® (semaglutide), and Mounjaro® (tirzepatide). We use an FDA approved, compounded version that allows for more patient specific dosing, minimizing side effects.

How do I pay for the program?

The monthly subscription fee of \$295 per patient will be charged monthly at a regular interval. The co-payment will be charged upon the monthly scripting of your medication to whichever credit/debit card you put on file.

How much medication do I receive?

Each prescription is set on a four week cycle. You are given your recommended dosage for four separate weekly injections. You have the option to self-inject or schedule an in-office appointment for assistance.

How do I enroll in the GLP-1 Supplementary Medical Program, and what are eligibility requirements?

Enrollment is as easy as scanning the QR code to the right.

From there, you will click “Start Your Application” and complete your intake questionnaire.

From there, a provider will review your answers and you will receive email notification if you are clinically eligible and next steps.



QUESTIONS? Contact Strata | 719-419-9936 or at benefits@stratawell.com

3314 Mesa Road Colorado Springs, CO 80904

11675 Ridgeline #110, Colorado Springs, CO 80921

STRATA VOLUNTARY GLP-1 PROGRAM (CONTINUED)



New Benefit Opportunity: Strata GLP-1 Medical Benefit Program

Strata is pleased to introduce a new health benefit designed to support employees in managing weight and metabolic health through access to GLP-1 medications, when clinically appropriate.

About the GLP-1 Medical Benefit Program

GLP-1 medications are a class of treatments that may assist with:

- Managing Type 2 Diabetes
- Supporting healthy weight loss and metabolic improvement
- Reducing obesity-related health risks
- Reducing Cardiovascular Risk

Participation in this benefit allows eligible employees to access GLP-1 medication therapy under the medical plan, following applicable coverage criteria and provider authorization.

Who Is Eligible

- Benefit-eligible employees enrolled in the medical plan who elect to participate in the GLP-1 Voluntary Program
- Participants who meet clinical criteria as determined by an intake assessment questionnaire and/ or meeting with the Strata GLP-1 medical personnel

How to Enroll

1. Enrollment is as easy as scanning the QR code to the right. From there, you will click "Start Your Application" and complete your intake questionnaire. From there, a provider will review your answers and you will receive email notification if you are clinically eligible and next steps.
2. Your election will take effect on the first day of following month of election.



Once elected, this benefit remains in effect for the full 12-month plan year and may only be changed if you experience a qualifying life event.

Cost Information

- D11 Employees will be billed directly for the program fees.
- See your benefits guide for rates.

Questions

Contact your Benefits Manager or Strata directly at benefits@stratawell.com

HOW TO ENROLL IN VOLUNTARY SUPPLEMENTAL LIFE, SHORT TERM DISABILITY(STD) AND/OR LONG TERM DISABILITY (LTD)

To apply for Voluntary Supplemental Life Insurance, Short-Term Disability and/or Long-Term Disability, you must follow the steps below:

STEP 1: Complete the hard copy enrollment form given to you either through your onboarding process (new employees) or, if it is a Qualifying Life Event (QLE), through the Employee Benefits office.

STEP 2: Return the completed enrollment form to the Employee Benefits office in person or at employee.benefits@d11.org within 31 days of hire or QLE.

Pre-Existing Conditions: If you submit a claim within 12 months of your insurance taking effect, or 12 months following any increase in your amount of insurance, we will not pay any benefit for any pre-existing condition. A pre-existing condition includes anything you have sought treatment for in the 3 months prior to your insurance becoming effective. Treatment can include consultation, advice, care, services or a prescription for drugs or medicine.

Don't forget to update your Short-Term Disability (STD)! Be sure to update your STD election amount if you have had an increase or a decrease in your salary since your last election period. This amount will not adjust automatically with a change in annual income.

Please note that coverage will not go into effect or be deducted from your paycheck the first day of the month following your hire date or QLE

QUESTIONS? Contact our provider, Sun Life!

Phone: 1-800-SUN-LIFE (786-5433)

E-mail: USWeb_General_Information@sunlife.com

Address: Sun Life, One Sun Life Executive Park, 96 Worcester St., Wellesley Hills, MA 02481



RESOURCES



RESOURCE: PRE-RETIREMENT INFORMATION

THINKING ABOUT RETIREMENT IN THE NEXT 3-5 YEARS?

Did you know...

- If you plan to retire within the next 3-5 years, you may want to consider changing your insurance deductions to “after-tax” during open enrollment in order to maximize your Highest Average Salary (HAS). This can only be done during open enrollment through your PeopleSoft Self-Service account. Simply log on and check the box next to your current deduction to “after-tax” (you will need to check the “after-tax” box next to each benefit individually - medical, dental and vision).
- You may want to consider stopping any “before-tax” deductions, such as a flexible spending account.
- Be sure to log on to www.copera.org to access your PERA information. Use the PERA retirement calculator to estimate your retirement monthly benefit.
- The top 20 ESP, top 40 teachers, and top 7 Exec professionals who apply to retire, in seniority date order, may be eligible for up to 2 additional years of District shared medical insurance and payment for their un-used sick leave at 75% of its value. Information comes out annually around the end of September regarding this process titled the D11 “Retirement Incentive Program”. Keep an eye on your inbox for more information!

Retirement Resources

Colorado PERA
(800) 759-7372
www.copera.org

Pikes Peak Area Council of Governments
Area Agency on Aging
14 South Chestnut Street
Colorado Springs, CO
(719) 471-2096 ext 142
www.ppacg.org/aaa/senior-insurance

Office Hours:

Monday-Friday from 9am-4pm
No appointments necessary and walk-ins are welcome!

- Senior Insurance Assistance
- Helping you understand your health insurance options—Medicare vs. PERA vs. Employer Insurance



RESOURCE: PROVIDER CONTACT INFORMATION

Kaiser Permanente

Claims Administered by Kaiser Customer Service/Billing Questions: Email: D11@KP.org
Provider List: www.KP.org
Group# 47301

Pharmacy Services—Kaiser Permanente

Customer Service: (800) 632-9700 Pharmacy List/Mail Order: www.kp.org

One Medical Direct Primary Care

Customer Service: (844) 673-2563, option2
Website: www.OneMedical.com/mycare-co
Email: pm-membermgt@onemedical.com

Strata Med

Customer Service: (719) 428-2202
Website: stratawell.com

Delta Dental of Colorado

Customer Service: (800) 610-0201
Provider List: www.deltadentalco.com
Group#: PPO- #1563 or EPO- #9098

EyeMed Vision Care

Customer Service: (866) 939-3633
Provider List: www.eyemedvisioncare.com
Group# 9764168 - Access Plan

Rocky Mountain Reserve

Flexible Spending Account Plans
Customer Service: (888) 722-1223
Claims Fax: (866) 557-0109
Claims Email: claims@rmrbenefits.com
Claims Submission & Receipt Upload:

Employee Assistance Program (EAP)

(800) 645-6571
Website: www.ProfileEAP.org
Company Name: D11

Colorado PERA

Customer Service: (800) 759-7372
Website: www.copera.org

Sun Life Financial

Customer Service: (800) 262-6513



DII'S HEALTH PLAN WEBSITE/MOBILE APP RESOURCES

SCAN ANY OF THE BELOW QR CODES USING YOUR MOBILE DEVICE TO LEARN MORE!



Kaiser Permanente – DII partners with Kaiser Permanente to offer robust, integrated health care solutions for you and your family. You can make the most of your Kaiser membership by utilizing this resource in conjunction with your KP Member Portal.



One Medical – Your no-cost access to Primary Care through office visits, phone calls, text messaging, email, and even virtual office visits. Enjoy this simplified solution to getting affordable medical care in a timely manner from providers that actually know you on a more wholistic level.



24/7 Virtual Care – Board-certified doctors and pediatricians can diagnose, treat, and prescribe most medications for minor medical conditions. Fast, personalized support, around the clock – no appointment needed. Get 24/7 care by phone or video from a Kaiser Permanente clinician.



Delta Dental – A healthy smile is a powerful thing. That's why DII partners with Delta Dental of Colorado to improve the oral health of our dental plan members. Delta's Member Web provides you a digital service experience to view and manage dental benefits information securely and easily.



EyeMed Vision – EyeMed vision benefits help you get eye exams, save money and buy your favorite eyewear. Their Member Web gives you the ability to view your benefits, find an in-network eye doctor, get special offers in a snap, and much more.



Online Will Preparation – As part of your employer-paid life insurance plan with Sun Life Financial, you have access to their Online Will Preparation and Claimant Support Services designed to help you and your loved protect your assets. Promotional Code: SLFVAS



Rocky Mountain Reserve – Use the RMR web portal or mobile app to submit Flexible Spending Account claims, look up your FSA balance, and view recent transactions.



Employee Assistance Program – (8) Eight sessions per person, per problem, per plan year (7/1-6/30). All DII employees, spouses, and unmarried dependent children, to age 26, are covered. You DO NOT have to be a member of the Health Plan to use the EAP services. To register for your free, CONFIDENTIAL counseling, call Profile EAP at 1-800-645-6571, scan this QR Code, or visit centura.mylifeexpert.com. Company Name: DII Password: 2520

DII'S HEALTH PLAN WEBSITE/MOBILE APP RESOURCES

SCAN ANY OF THE BELOW QR CODES USING YOUR MOBILE DEVICE TO LEARN MORE!

KAISER HEALTH & WELLNESS RESOURCES:



Mental Health Video Visit (scheduled) with KP or an Amwell therapist – Can help you and your family find solutions and restore your peace of mind. You can now schedule a mental health video visit with a Kaiser provider, or a one-on-one video counseling session with an Amwell therapist. No referral needed.



Calm – Adult members can use meditation and mindfulness to build mental resilience, reduce stress, and improve sleep with Calm.



HeadSpace Care – With HeadSpace Care, members can get emotional support by text for anxiety, stress, grief, issues with personal and professional relationships, and more. Mental health care through behavioral health coaching, self-guided learning activities and content. Support available 24/7/365.



myStrength – With myStrength adult members can set mental health goals, track progress, and get support managing depression, anxiety, and more.



ClassPass – Choose from thousands of on-demand workout videos and get reduced rates on in-person classes with ClassPass.



Active&Fit Direct – You have access to contracted fitness centers in the Active&Fit Direct network. Get access to more than 11,000 gyms with one membership.

GLOSSARY OF TERMS

Brand-Name Drug – Prescription drugs marketed with a specific brand name by the company that manufactures it, usually the company which develops and patents it. When patents run out, generic versions of many popular drugs are marketed at lower cost by other companies.

COBRA – Federal legislation that allows you to continue to purchase health insurance for up to 18 months if you lose your job or your employer-sponsored coverage is otherwise terminated. The insured is responsible for the full cost of the premiums (plus a 2 percent administrative fee) if COBRA is elected.

Coinsurance – A percentage of covered expenses paid by you after you meet the deductible.

Co-payment (Co-Pay) – A fixed dollar amount you are responsible for paying at the time of service.

Deductible – The amount you must pay out of your pocket for covered services in the plan year before the health plan begins to pay.

Explanation of Benefits (EOB) – The insurance company's written explanation regarding a claim, showing what they paid and what the client may be required to pay. It is not a bill. It is recommended that the member compare the bill from the physician and the EOB for accuracy of a claim.

Generic Drug – Once a company's patent on a brand-name prescription drug has expired, other drug companies are allowed to sell the same drug under a generic label. Generic drugs are less expensive.

In-Network – Providers or health care facilities that are part of a health plan's network of providers with which it has negotiated a discount. Insured individuals usually pay less when using an in-network provider, because those networks provide services at lower cost to the insurance companies with which they have contracts.

Late Enrollee – If you fail to enroll in the dental plan at the time of initial enrollment period, there is a 24-month wait period for any major dental and orthodontia.

Open Enrollment – A window during which employees may add or drop their health insurance or make changes to their coverage.

Out-of-Pocket Maximum – The maximum you will be required to pay for covered services in a plan year. Under this provision, the health plan will pay 100 percent (100%) of the allowable amount for most covered services after you have reached the out-of-pocket maximum.

Qualifying Life Event (QLE) – An event that triggers an open enrollment window for an individual or family to elect or change health insurance outside of the scheduled open enrollment periods. Includes the birth or adoption of a child, marriage or divorce, or the loss of other coverage.

Specialty Drug – Specialty drugs are high-cost prescription medications used to treat complex, chronic conditions like cancer, rheumatoid arthritis and multiple sclerosis.

LEGAL NOTICES

IMPORTANT LEGAL NOTICES AFFECTING YOUR HEALTH PLAN COVERAGE

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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 this plan.

NEWBORNS ACT DISCLOSURE – FEDERAL

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 the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

LEGAL NOTICES (CONTINUED)

ADA NOTICE REGARDING WELLNESS PROGRAMS

Colorado Springs School District 11's wellness program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program, you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening; you are not required to complete the HRA or to participate in the blood test or other medical examinations.

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

We are required by law to maintain the privacy and security of your personal identifiable health information. Although the wellness program and Colorado Springs School District 11 may use aggregate information it collects to design a program based on identified health risks in the workplace, Colorado Springs School District 11 will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for the purpose of providing you services as part of the wellness program will abide by exact same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) your medical team associated with any to services to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Andrea Palos at employee.benefits@d11.org

LEGAL NOTICES (CONTINUED)

HIPAA WELLNESS PROGRAM DISCLOSURE

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at employee.benefits@d11.org and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

PATIENT PROTECTION MODEL DISCLOSURE

Kaiser Permanente 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 can accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Kaiser Permanente at <https://healthy.kaiserpermanente.org/colorado/consumer-sign-on#/signon>

You do not need prior authorization from Kaiser Permanente or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Kaiser Permanente at <https://healthy.kaiserpermanente.org/colorado/consumer-sign-on#/signon>

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

Recipients of the notice are encouraged to read the entire notice.

Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

LEGAL NOTICES (CONTINUED)

OUR USES AND DISCLOSURES

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

YOUR RIGHTS

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you.

Ask us how to do this.

- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.

- We may say "no" to your request, but we'll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for up to six years prior to the date you ask, who we shared it with, and why.

- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

LEGAL NOTICES (CONTINUED)

FILE A COMPLAINT IF YOU FEEL YOUR RIGHTS ARE VIOLATED

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/hipaa/filing-a-complaint/index.html.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- In these cases, we never share your information unless you give us written permission:

Marketing purposes

Sale of your information

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

LEGAL NOTICES (CONTINUED)

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Uses and Disclosures of Substance Use Disorder (SUD) Treatment Information

If we receive or maintain records about you from a SUD treatment program subject to 42 CFR part 2 (a "Part 2 Program") through consent you provide the Part 2 Program to use or disclose the records, or testimony relaying the content of such records, they are given extra protection. These records shall not be used or disclosed in civil, criminal, administrative, or legislative proceedings against you unless you provide written consent, or a court order is issued after notice and an opportunity to be heard is provided by you or the holder of the records.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

Other Instructions for Notice

- 7/1/2026
- Andrea Palos

719-520-2241

employee.benefits@d11.org

LEGAL NOTICES (CONTINUED)

MODEL INDIVIDUAL **CREDITABLE COVERAGE** DISCLOSURE NOTICE LANGUAGE FOR USE ON
OR AFTER APRIL 1, 2011

If you are receiving a copy of this notice electronically, you are responsible for providing a copy of it to any Part-D eligible dependents covered under the group health plan.

Important Notice from Colorado Springs School District 11 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 District 11 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. District 11 has determined that the prescription drug coverage offered by the Medical Plan for the plan year 2026 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, the following options may apply:

- You may stay in the Medical Plan and not enroll in the Medicare prescription drug coverage at this time. You may be able to enroll in the Medicare prescription drug program at a later date without penalty either:
 - During the Medicare prescription drug annual enrollment period, or
 - If you lose The Medical Plan creditable coverage.

LEGAL NOTICES (CONTINUED)

- You may stay in the Medical Plan and also enroll in a Medicare prescription drug plan. The Medical Plan will be the primary payer for prescription drugs and Medicare Part D will become the secondary payer.
- You may decline coverage in the Medical Plan and enroll in Medicare as your only payer for all medical and prescription drug expenses. If you do not enroll in the Medical Plan you are not able to receive coverage through the plan unless and until you are eligible to reenroll in the plan at the next open enrollment period or due to a status change under the cafeteria plan or special enrollment event.
- 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 District 11 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 District 11 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).

LEGAL NOTICES (CONTINUED)

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)**.

In the state of Colorado, you may be eligible for assistance paying your employer health plan premiums. Below is the contact information for more information on eligibility.

For more information on special enrollment rights, contact either: U.S. Department of Labor or U.S. Department of Health and Human Services.

COLORADO – HEALTH FIRST COLORADO (COLORADO'S MEDICAID PROGRAM) & CHILD HEALTH PLAN PLUS (CHP+)

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

Employee Benefits Security Administration Centers for Medicare & Medicaid Services www.dol.gov/agencies/ebsa
www.cms.hhs.gov 1-866-444-EBSA (3272) 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)

LEGAL NOTICES (CONTINUED)



Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

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.^[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 these factors in determining whether to purchase a health plan through the Marketplace.

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

[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.

LEGAL NOTICES (CONTINUED)

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:

Date: 7/1/2026

Name/Entity of Sender: District 11

Contact Position/Office: Andrea Palos

Address: 1115 N. El Paso Street, Colorado Springs, Colorado United States 80903

Phone Number: 719-520-2241

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.



The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Talent Management.