DCSD BENEFITS
& STAFF WELLNESS



Employee **Benefits**

Benefit plans effective July 1, 2026 - June 30, 2027

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Coverage	Contact	Phone	Website
Medical	Kaiser Permanente	303-338-3800	**choose.kp.org/dcsd**
	UnitedHealthcare	833-410-2785	**myuhc.com** **whyuhc.com/dcsdk12**
Pharmacy	CarelonRx	833-818-2132	**carelonrx.com**
Critical Illness	Voya	877-236-7564	**voya.com**
Accident	Voya	877-236-7564	**voya.com**
Hospital Indemnity	Voya	877-236-7564	**voya.com**
Health Savings Account	WEX	866-451-3399	**https://benefitslogin.wexhealth.com**
Flexible Spending Accounts	WEX	866-451-3399	**https://benefitslogin.wexhealth.com**
Dental	Delta Dental of Colorado	800-610-0201	**deltadentalco.com**
Vision	VSP	800-877-7195	**vsp.com**
Life and AD&D	Voya	888-238-4840	**voya.com**
Disability	Lincoln Financial Group	877-275-5462	**lincolnfinancial.com** Employee Code: LF1487DOU
Retirement: Pension	Colorado PERA	800-759-7372	**copera.org**
Retirement: 403(b) and 457	MetLife	800-543-2520	**metlife.com**
Retirement: 401(k)	Empower/PERA	833-426-7372	**coperaplus.org**
Employee Assistance Program	SupportLinc	888-881-5462	**mysupportlinc.com** Username: your DCSD work email Group Code: dcsd
Wellness Program	DCSD		**dcsdk12.org/staffwellness**
Employee Discount Program	DCSD		**www.DCSDPerks.com**
ID Theft Protection	LifeLock	1-800-607-9174	**gendigital.com/us/en/partner/employee-benefits/premier-and-premier-plus/**
Legal Plan	MetLife	800-821-6400	**members.legalplans.com**
Pet Insurance	MetLife	800-438-6388	**www.metlife.com/getpetquote**
Benefits Team	DCSD	720-433-0140 Option 3	**benefits@dcsdk12.org** **www.dcsdk12.org/benefits**

WELCOME TO YOUR BENEFITS

We are pleased to provide you with a wide range of competitive benefits that are a vital part of your total compensation. You have the flexibility to select from a full range of benefits to keep you and your family healthy, provide financial protection in the event of unforeseen circumstances and help you build long-term security for retirement.

This brochure was designed to answer some of the basic questions you may have about your benefits. Please take the time to review this brochure to make sure you understand the benefits that are available to you and your family and be sure to act before the enrollment deadline. It does not include all plan rules, details, limitations, and exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be an inconsistency between this brochure and the legal plan documents, the plan documents are the final authority. The District reserves the right to change or discontinue its employee benefits plans at any time.



ELIGIBILITY

If you are a full-time employee scheduled to work at least 30 hours per week or a part-time employee scheduled to work at least 20 hours per week for at least nine months (at least 169 days per school year), you are eligible for benefits.

- Your health benefits are effective on the first of the month following your date of hire. This includes medical, dental and vision coverage and the option to enroll in a Health Savings Account and/or Flexible Spending Accounts.
- For teachers hired at the start of the school year (July 1), health benefits become effective on August 1.
- You become eligible for DCSD-provided Basic Life and AD&D insurance on the first of the month following 90 consecutive days as an employee.
- You become eligible for DCSD-provided Short-Term Disability and Long-Term Disability coverage on the first of the month following 180 consecutive days of employment (Per DCSD Leave Policy).

You may also enroll your eligible dependents for coverage. Eligible dependents could be:

- Your legal spouse, qualified domestic partner or civil union partner
- Children under the age of 26, regardless of student, dependency, or marital status
- Children who are past the age of 26 and are fully dependent on you for support due to a mental or physical disability and who are indicated as such on your federal tax return

To control health care costs and meet health plan contract obligations, the District will perform periodic reviews to verify dependents' eligibility for enrollment in the benefit plans. The District requires documentation (for example, marriage and/or birth certificates) to verify eligibility. Employees are required to review their dependents and update as needed during Open Enrollment to avoid interruptions in coverage.

Typically, benefits end on the last day of the month of your termination date, and you and your family can continue your coverage through COBRA.

IMPUTED INCOME

When an employee elects to cover their domestic partner under our benefits program, the IRS considers the value of those benefits as taxable income. This is commonly referred to as imputed income. We encourage you to review your tax situation carefully, especially if you're electing domestic partner benefits. You may need to adjust your tax withholdings to account for the imputed income and avoid any surprises at tax time.





CHANGING BENEFITS AFTER ENROLLMENT

During the year, you cannot make changes to your benefits unless you have a Qualified Life Event. If you do not make changes to your benefits within 30 days of the Qualified Life Event, you will have to wait until the next annual Open Enrollment period to make changes (unless you experience another Qualified Life Event).

Qualified Life Event		Documentation Needed
Change in marital status	Marriage	Copy of marriage certificate
	Divorce/Legal Separation	Copy of divorce decree
	Death	Copy of death certificate
Change in number of dependents	Birth or adoption	Copy of birth certificate or copy of legal adoption papers
	Stepchild	Copy of birth certificate plus a copy of the marriage certificate between employee and spouse
	Death	Copy of death certificate
Change in employment	Change in your eligibility status (i.e., full time to part time)	Notification of increase or reduction of hours that changes coverage status
	Change in dependent's benefits or employment status	Notification of spouse's employment status that results in a loss or gain of coverage, including details of each coverage

HOW TO ENROLL

To make your benefit elections, log into **workday.dcsdk12.org**.

- During New Hire Enrollment, go to your Workday Inbox and complete the New Hire Enrollment task.
- To update your benefits due to a Qualified Life Event, go to your homepage in Workday, click on the Benefits & Pay Worklet, select Change Benefits and choose the Qualified Life Event type.

MEDICAL

Medical insurance is essential to your well-being, and our medical coverage provides you and your family the protection you need for everyday health issues or when the unexpected happens.

PARTS OF YOUR MEDICAL PLAN

PREVENTIVE CARE

Always 100% covered when you use in-network providers and includes things like physical exams, flu shots and screenings. Please be aware that you will be responsible for the cost of any non-preventive care services you receive at your preventive care exam based on your plan design.

ANNUAL DEDUCTIBLE AMOUNTS

The amount you pay each year for eligible in-network and out-of-network charges before the plan begins to pay.

ANNUAL OUT-OF-POCKET MAXIMUMS

The most you will pay each year for eligible in-network and out-of-network services, including prescriptions. After you reach your out-of-pocket maximum, the plan picks up the full cost of covered medical care for the remainder of the year.

COPAYS

A copay is a fixed amount you pay for a health care service. Copays do not count toward your deductible but do count toward your annual out-of-pocket maximum.

COINSURANCE

Once you've met your deductible, you and the plan share the cost of care, called coinsurance.



MEDICAL PLAN COMPARISON

The key difference between the plans is the amount of money you'll pay each month for coverage and when you need care.

Note: Both Kaiser medical plans and all UnitedHealthcare (UHC) medical plans offer infertility benefits.

Summary of Covered Benefits	**Kaiser HDHP** In-Network Only	**Kaiser DHMO** In-Network Only
	You Pay	
Plan Year Deductible		
Individual	$3,400	$1,000
Family	$6,800	$2,000
Plan Year Out-of-Pocket Maximum (Includes Deductible)		
Individual	$5,000	$4,000
Family	$10,000	$8,000
Coinsurance / Copays		
Preventive Care	$0	$0
Primary Care Physician	20%*	$30 copay
Specialist	20%*	$60 copay
Telemedicine	0%	$0 copay
Urgent Care	20%*	$75 copay**
Emergency Room	20%*	$500 copay

*After deductible

**Non-Kaiser Facility Emergency Claims Limited to Reasonable and Customary Charges

Learn more about the Kaiser Medical Plans: **https://choose.kaiserpermanente.org/dcsd**

Summary of Covered Benefits	**UHC Choice Plus HDHP** In-Network	Out-of-Network	**UHC Choice Plus PPO** In-Network	Out-of-Network	**UHC Colorado Doctor's Plan** In-Network Only
	You Pay				
Plan Year Deductible					
Individual	$3,400	$6,000	$1,750	$3,000	$1,000
Family	$6,800	$12,000	$3,500	$6,000	$2,000
Plan Year Out-of-Pocket Maximum (Includes Deductible)					
Individual	$5,000	$20,000	$4,250	$16,000	$4,500
Family	$10,000	$40,000	$8,500	$32,000	$9,000
Coinsurance / Copays					
Preventive Care	$0	40%*	$0	40%*	$0
Primary Care Physician	20%*	40%*	$30 copay	40%*	$0 copay
Specialist	20%*	40%*	$60 copay	40%*	$75 copay
Telemedicine	20%*	Not covered	$15 copay	Not covered	$0 copay
Urgent Care	20%*	40%*	$50 copay	40%*	$0 copay
Emergency Room	20%*	20%*	$250 copay	$250 copay	20%*

*After deductible

Learn more about the UHC Medical Plans: **whyuhc.com/dcsdk12**

PHARMACY PLAN COMPARISON

When you enroll in medical coverage, you will also receive prescription benefits. Here you can see the basics but be sure to check the formulary for a full list of the prescriptions that are covered by the plan. Remember, you can always ask your doctor about lower-cost alternatives. Generic drugs tend to be less expensive than brand-name drugs, so keep that in mind when shopping around.

Summary of Covered Benefits	Kaiser HDHP In-Network Only	Kaiser DHMO In-Network Only
	You Pay	
Retail Rx (up to 30-day supply)		
Generic	$15 copay*	$20 copay
Preferred Brand	$30 copay*	$40 copay
Non-Preferred Brand	50%*	$60 copay
Specialty	20%*	20% up to $250
Mail Order Rx (up to 90-day supply)		
Generic	2x retail copay	2x retail copay
Preferred Brand		
Non-Preferred Brand		

*After deductible

Summary of Covered Benefits	UHC Choice Plus HDHP In-Network	 Out-of-Network	UHC Choice Plus PPO In-Network	 Out-of-Network	UHC Colorado Doctor's Plan In-Network Only
Retail Rx (up to 30-day supply)**					
Tier 1	20%*	Not covered	15%/$75 copay maximum	Not covered	$10 copay
Tier 2	20%*		15%/$125 copay maximum		$35 copay
Tier 3	20%*		15%/$175 copay maximum		$100 copay
Tier 4	20%*		20%/$250 copay maximum		$300 copay
Mail Order Rx (up to 90-day supply)**					
Tier 1	20%*	Not covered	2.5x retail copay	Not covered	2.5x retail copay
Tier 2	20%*				
Tier 3	20%*				
Tier 4	20%*				

*After deductible

**Prior authorizations may be required for certain medications.

SAVE ON PRESCRIPTION DRUGS

ASK FOR GENERICS

Generic and brand-name drugs have the same active ingredients, which means they have the same efficacy for treating your condition. The main difference is the cost to you. Brand-name drugs tend to be more expensive because of the lengthy drug development process. Manufacturers charge more to recoup costs. When a patent expires, other manufacturers can produce the medication, and competition drives the price down.

HOME DELIVERY

Enjoy the convenience and savings of home delivery for medications you take on a regular basis through our mail-order prescription program. The larger 90-day supply is mailed directly to your home — saving you time and money.

ADDITIONAL UHC PROGRAMS

Fertility Solutions

Fertility coverage is included in the UHC medical plans, please see the UHC Summary Plan Document (SPD) for coverage specifics. To access this coverage, you must utilize a UHC Center of Excellence (COE) for infertility treatment. These clinics undergo stringent and comprehensive evaluation with UHC with the goal of reduced treatment costs and a higher likelihood of improved outcomes.

To support your family planning and fertility journey, UHC's Fertility Solutions program will help you navigate fertility challenges by providing guidance and compassionate support throughout the process. This includes a dedicated fertility nurse, education on treatment options, guidance in selecting a provider within the COE, and digital resources.

Visit **myuhc.com** or call the number on the back of your ID card for more information.

Visana / Midi Health

Receive all levels of women's health from home. Visana and Midi Health are virtual clinics designed to support, advocate and help women understand their bodies through all stages of life. Midi Health focuses on women experiencing menopause and perimenopausal symptoms. Visana provides care from menstruation to menopause, with varying services such as hormone health, menopause and perimenopause, sexual and reproductive health, and preventive screenings and assessments. Longer visit times allow all your concerns to be heard and your care to be personalized. Your program can include prescription medication, bloodwork and imaging, diet and exercise guides, mental health support, and preventive screenings.

Hinge Health

Hinge Health helps you conquer back and joint pain, recover from injuries or stay healthy and pain free — all at no cost to you! This program provides all the tools you need to get moving again from the comfort of your home. Your treatment plan can be tailored to you based on your unique needs:

- Get a personal care team, including a physical therapist and health coach
- Schedule as many personal physical therapy sessions as needed
- Receive wearable sensors that give live feedback on your form in the app

Visit **myuhc.com** or call the number on the back of your ID card for more information.

Livongo Diabetes Management

Livongo by Teladoc Health supports comprehensive needs across the diabetes spectrum. This program addresses care for the whole person by integrating mental health and leveraging personalized and dedicated expert coaches. Participants receive a cellular-enabled proprietary blood glucose monitor (BGM) with unlimited test strips to drive personalized real-time feedback, robust goal-setting, nutrition tracking and activity recommendations.

Visit **myuhc.com** or call the number on the back of your ID card for more information.

ADDITIONAL UHC PROGRAMS

GEM Health



GEM Health provides sleep apnea support from diagnosis to treatment from the comfort of home. Take a quick 1-minute assessment to get started on your own time. You will receive an at-home sleep study test, which will be reviewed by GEM for an accurate diagnosis. GEM's team of sleep experts, clinicians, and coaches will help you get the equipment you need with support you trust. Start your journey to get better nights so you can have your best days.
Visit **mygemsleep.com** for more information and to start your sleep quiz today.

Movn Health



An at-home cardiac rehab program, Movn provides personalized care from the comfort of your home. Your doctor or health plan can refer you after a qualifying event. After signing up, you will be assigned your own certified cardiac rehab care manager to guide you, and all necessary equipment will be delivered directly to you.

Oshi



Oshi brings gastrointestinal relief to you. With convenient virtual assistance, you get seen by a licensed GI provider right away, whether for diagnosis, treatment or management support. Their team of GI specialists diagnose and treat hundreds of digestive issues, from occasional symptoms to chronic illnesses, including but not limited to Crohn's Disease, IBS and Ulcerative Colitis. The Oshi team will review your symptoms, history and goals for a personalized care plan so you get the help you need quickly. With access to an emergency 24/7 support line, you will never be without aid.

Cove



Cove makes migraine diagnosis and treatment accessible from home. On your time, complete a quick questionnaire and consultation to start quality and individualized migraine care. Provider-recommended prescriptions and supplements are mailed directly to your door. You will have 24/7 access to licensed medical providers. Track your migraine attacks and treatment progress.
Visit **withcove.com** to begin your consultation.

Expressable



Expressable gives access to high quality speech therapy for both children and adults. With the help of a free online screener, you can find out if a speech evaluation is recommended and discuss your results with a personally matched speech therapist. Virtual, 1-on-1 sessions allow for home-based programs tailored to you. Express yourself the way you want! Visit **expressable.com** to get started today.

DispatchHealth



Get high-quality urgent care at home with DispatchHealth, available to UHC members. Book an appointment online or by phone — same-day visits are common. A medical team comes to you with support from an emergency medicine doctor, and they'll handle everything from prescriptions to billing. Services are available seven days a week from 7 a.m. to 10 p.m.

ADDITIONAL KAISER PROGRAMS

Calm

Calm is an app that uses meditation and mindfulness to help lower stress, reduce anxiety and improve sleep quality. The app offers:

- A new 10-minute Daily Calm meditation every day
- Sleep stories
- Music for focus, relaxation and sleep
- And more!
- Learn more at **kp.org/selfcareapps**

Headspace

Headspace offers 1-on-1 emotional support coaching and self-care activities to help with many common challenges. Backed by over 20 published studies, Headspace meditations have been shown to reduce stress, increase happiness, and improve focus in as little as 10 days. With the app, you have access to:

- Coaches available 24/7 through text
- Headspace's text-based coaching services at no cost
- Self-care resources personalized to your needs
- Learn more at **kp.org/selfcareapps**

Resources For Your Everyday Wellness

Take advantage of classes, services, perks, and programs to help you achieve your health goals.

- Healthy lifestyle programs
- Wellness coaching
- Special rates on fitness programs, gym memberships, and online resources

Learn more at **kp.org/health-wellness**.

Fertility Solutions

Fertility coverage is included when you enroll in a Kaiser medical plan. Whether you need guidance through experiencing early pregnancy symptoms, adjusting to life with a newborn or navigating post-partum, fertility support services through Kaiser are here to help you.

DispatchHealth

Get high-quality urgent care at home with DispatchHealth, available to Denver/Boulder Kaiser members. Book an appointment online or by phone — same-day visits are common. A medical team comes to you with support from an emergency medicine doctor, and they'll handle everything from prescriptions to billing. Services are available seven days a week from 8 a.m. to 8 p.m.

KP Rewards Program

Turn healthy habits into real rewards. With Kaiser Permanente, you can earn up to $150 each calendar year for building healthy habits, like meditation or cooking healthy recipes. Each time you finish a healthy activity, rewards are loaded onto your Kaiser rewards Visa® prepaid card, and you can spend it at many of your favorite places to shop. Whether you're picking up vitamins, grabbing dinner after a workout, or stocking up on household essentials, your rewards go where you go. Learn more at **kp.org/rewards**

TELEMEDICINE

When you need care — anytime, day or night — or when your primary care provider is not available, telemedicine can be a convenient option.

With telemedicine, you don't have to drive to the doctor's office or sit in a waiting room when you're sick — you can see your doctor from the comfort of your own bed or sofa.

REGISTER TODAY SO YOU ARE READY WHEN YOU NEED CARE



Avoid germs in the ER, urgent care clinic or doctor's office.

See a board-certified, licensed, telehealth-trained doctor on your schedule with on-demand virtual visits 24/7, including nights, weekends and holidays.

Get treated for more than 80 common conditions including colds, flu and allergies — even mental health support and counseling.

Get a prescription or short-term refill of any existing prescription sent to a pharmacy nearby, in less time than your usual doctor visit.

Avoid costly copays and deductibles of the ER and urgent care clinic.

USING TELEMEDICINE IS AS EASY AS ONE, TWO, THREE

1

Register Now

Setting up your secure account takes only minutes.

If you are enrolled in one of the Kaiser medical plans, you have access to 24/7 telemedicine services and scheduled video visits with mental health professionals through Amwell. Access your telemedicine options through **kp.org/getcare** or the Kaiser Permanente app.

If you are enrolled in one of the UHC medical plans, you have access to Teladoc, Doctor on Demand and Amwell. You may access any of these telemedicine options through **myuhc.com** or the UnitedHealthcare app.

2

Request a Visit

You can have a doctor visit right away or schedule an appointment — all by phone, computer or the app.

3

Feel Better

Get treated by one of our doctors who can prescribe medication if necessary.

WHERE TO GO FOR CARE

Becoming familiar with your options for medical care can save you time and money.

Health Care Provider		Symptoms	Average Cost	Average Wait
Non-Emergency Care				
 **Virtual Visits/ Telemedicine**	Access to care via phone, online video or mobile app whether you are home, work or traveling; medications can be prescribed 24 hours a day, 7 days a week.	Allergies Cough / Cold / Flu Rash Stomachache	$	2 – 5 minutes
 **Doctor's Office**	Generally, the best place for routine preventive care; established relationship; able to treat based on medical history. Office hours vary.	Infections Sore and strep throat Vaccinations Minor injuries, sprains, and strains	$	15 – 20 minutes
 **Retail Clinic**	Usually lower out-of-pocket cost than urgent care; when you can't see your doctor; located in stores and pharmacies. Hours vary based on store hours.	Common infections Minor injuries Pregnancy tests Vaccinations	$	15 minutes
 **Urgent Care**	When you need immediate attention; walk-in basis is usually accepted. Generally, includes evening, weekend and holiday hours.	Sprains and strains Minor broken bones Small cuts that may require stitches Minor burns and infections	$$	15 – 30 minutes
 **DispatchHealth**	Services and pricing similar to Urgent Care with personalized services arriving at your doorstep. Call 303-500-1518 or visit dispatchhealth.com. Office hours are generally 7 days a week including holidays from 8AM-8PM	Urgent, non-life-threatening illnesses and injuries at home	$$	2 – 3 hours
Emergency Care				
 **Hospital ER**	Life-threatening or critical conditions; trauma treatment; multiple bills for doctor and facility. 24 hours a day, 7 days a week.	Chest pain Difficulty breathing Severe bleeding Blurred or sudden loss of vision Major broken bones	$$$$	4+ hours
 **Freestanding ER**	Services do not include trauma care; can look similar to an urgent care center, but medical bills may be 10 times higher.	Most major injures except trauma Severe pain	$$$$$$	Minimal

Note: Examples of symptoms are not inclusive of all health issues. Wait times described are only estimates. This information is not intended as medical advice. If you have questions, please call the phone number on the back of your medical ID card.

SUPPLEMENTAL MEDICAL

Just as it sounds, Supplemental Medical plans can help you pay for costs you may incur after an accidental injury, illness or hospitalization. These plans are 100% voluntary.

ACCIDENT INSURANCE

Accident insurance pays out a lump sum if you become injured because of an accident. It allows you to claim benefits even if the injuries you incur do not keep you out of work. Accident insurance may also complement health insurance if an accident causes you to have medical expenses that your health insurance doesn't cover.

Accident insurance covers qualifying injuries, which might include a broken limb, loss of a limb, burns, lacerations, or paralysis. In the event of your accidental death, Accident insurance pays out money to your designated beneficiary. While health insurance companies pay your provider or facility, Accident insurance pays you directly.

HOW DOES ACCIDENT INSURANCE WORK?

Accident insurance policies can provide you with a lump sum paid directly to you that will help pay for a wide range of situations, including initial care, surgery, transportation and lodging, and follow-up care. Here's how it works:

- A set amount is payable based on the injury you suffer and the treatment you receive.
- Benefits are payable directly to you (unless you specify otherwise) and can be used as you see fit.
- Coverage is available for you, your spouse and eligible dependent children.
- You do not need to answer medical questions or have a physical exam to get basic coverage.
- Accident insurance covers injuries that happen on the job or off the job — unlike workers' compensation, which only covers on-the-job injuries.
- Benefit payments are not reduced by any other insurance you may have with other companies.

Additional details are available in **Voya's Accident Summary**.

WELLNESS BENEFIT

Every year, each family member with Accident coverage is eligible to receive an annual $100 benefit payment for completing a health screening test, an annual maximum of $200 for all children combined; total maximum benefit for the entire family is $400 per year. Examples of health screening tests include:

- Annual Physical
- Eye Exam
- Stress tests
- Colonoscopies
- Mammograms
- Routine Dental Exam

After you complete your health screening test, visit **voya.com/claims** and have your group policy name and group policy number (Douglas County School District 60067085-5) ready. Complete the questions regarding the health screening test, then electronically sign and submit your claim. You will receive a follow-up email with a claim number which can be used to check the status of your claim.





CRITICAL ILLNESS INSURANCE

While medical insurance is vital, it doesn't cover everything. If you suffer from a serious illness, such as cancer, stroke or a heart attack, medical insurance may not provide the coverage you need. Critical Illness insurance can ease the financial strain and help you focus on your recovery.

HOW WILL A CRITICAL ILLNESS CLAIM GET PAID?

After purchasing Critical Illness insurance, if you suffer from one of the serious illnesses covered by your policy, you'll be paid in a lump sum. The payment will go directly to you instead of to a medical provider. The payment you receive can be used for many things including:

- Child care costs
- Medical expenses
- Travel expenses for you and your family
- Lost wages from missed time at work
- Living expenses

Additional details are available in **Voya's Critical Illness Summary**.

HOSPITAL INDEMNITY INSURANCE

Hospital Indemnity insurance is a plan designed to pay for the costs of a hospital admission that may not be covered by other insurance. The plan covers employees who are admitted to a hospital or ICU for a covered sickness or injury and includes a hospital admission benefit of $1,000 or $2,000, depending on the plan you choose. Even if your medical insurance covers most of your hospitalization, you can still receive payments from your Hospital Indemnity insurance plan to cover extra expenses while you recover. Voya offers two benefit levels to fit your needs: a Low Daily Benefit of $100 or a High Daily Benefit of $200.

HOW DOES HOSPITAL INDEMNITY INSURANCE WORK?

You pay monthly premiums for your Hospital Indemnity insurance plan. If you are admitted to the hospital for an injury or illness, your Hospital Indemnity plan makes cash payments to you. And with the payments going directly to you, you can use these emergency funds to pay for costs not covered by your medical insurance, medical insurance deductibles, copays and coinsurance, child care expenses while you are in the hospital or cost-of-living expenses as you recover.

Additional details are available in **Voya's Hospital Indemnity Summary**.

IMPORTANT: THIS IS A FIXED INDEMNITY POLICY, NOT HEALTH ISURANCE

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for Comprehensive Health Insurance?

- Visit **Healthcare.gov** or call **1-800-318-2596** (TTY: **1-855-889-4325**) to find health coverage options.
- To find out if you can get health insurance though your job, or a family member's job, contact the employer.

Questions About This Policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (**naic.org**) under "Insurance Departments."
- If you have this policy through you job, or a family member's job, contact the employer.

Learn more about the Supplemental Medical Plans
https://presents.voya.com/ebrc/dcsd



HEALTH SAVINGS ACCOUNT

A Health Savings Account (HSA) is a personal savings account you can use to pay for qualified out-of-pocket medical expenses with pretax dollars — now or in the future. Important update: your HSA will transition from HSA Bank to WEX; you can choose to transfer your existing funds to WEX to keep one account or leave them with HSA Bank and manage both. Once enrolled, you'll receive a new debit card from WEX to manage your HSA expenses.

HOW A HEALTH SAVINGS ACCOUNT WORKS

Eligibility

You must be enrolled in the Kaiser HDHP or UHC Choice Plus HDHP.

Contributions

The District contributes: $100/month (full-time employees) or $50/month (part-time employees).
NOTE: You must elect to participate in the HSA to receive the District's contributions.

You may choose to contribute on a pretax basis and can change how much you contribute from each paycheck up to the 2026 IRS maximum of $4,400 if you enroll only yourself or $8,750 if you enroll in family coverage. You can make an additional catch-up contribution of $1,000 if you are age 55 or older.

Contribution amounts can be changed or stopped anytime.

Eligible Expenses

You may use your HSA funds to cover medical, dental, vision and prescription drug expenses incurred by you and your eligible family members.

Using Your Account

Use the debit card linked to your HSA to cover eligible expenses or pay for expenses out of your own pocket and save your HSA money for future health care expenses.

Your HSA is always yours — no matter what.

One of the best features of an HSA is that any money left in your HSA account at the end of the year rolls over so you can use it next year or sometime in the future. And if you leave the District or retire, your HSA goes with you so you can continue to pay for or save for future eligible health care expenses.

To learn more about your HSA Account through WEX, visit the WEX Resource Toolkit page at **https://www.benefit-info.com/oe/**.

FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts (FSAs) allow you to pay for eligible expenses using tax-free dollars. **Important:** There is a "use it or lose it" rule imposed by the IRS. If you do not spend all the money in your Health Care, Limited Purpose, or Dependent Care FSA by June 30, 2027, you have a 2½-month grace period to incur and submit eligible healthcare expenses. Specifically, expenses must be incurred by September 15, 2027, and all claims must be submitted by September 28, 2027. Any unused dollars remaining after these deadlines will be forfeited per IRS regulations for pretax contributions.

HEALTH CARE FSA

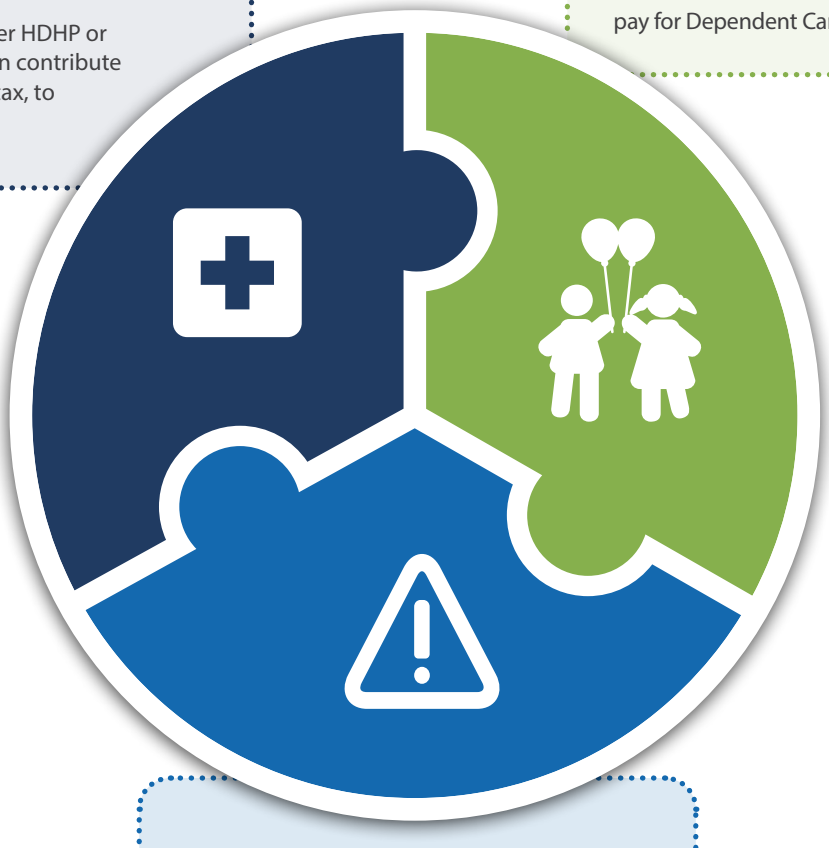
Contribute up to $3,400 per year, pretax, to pay for copays, prescription expenses, lab exams and tests, contact lenses and eyeglasses if you are enrolled in the Kaiser DHMO, UHC Choice Plus PPO or UHC Colorado Doctor's Plan.

Limited Purpose FSA

Those enrolled in the Kaiser HDHP or UHC Choice Plus HDHP can contribute up to $3,400 per year, pretax, to pay for eligible vision and dental expenses.

DEPENDENT CARE FSA

Contribute up to $7,500 per year ($3,750 if married and filing separate tax returns), pretax, to pay for day care expenses associated with caring for elder or child dependents that are necessary for you or your spouse to work or attend school full-time. You cannot use your Health Care FSA to pay for Dependent Care expenses.



USE IT OR LOSE IT

If you do not spend all the money in this FSA by the end of the September 15, 2027 grace period, per IRS regulations for pretax contributions, unused dollars will be forfeited.

Learn more about your HSA and FSA options
https://benefitslogin.wexhealth.com/login

To learn more about your FSA Account through WEX, visit the WEX Resource Toolkit page at **https://www.benefit-info.com/oe/**.

DENTAL BENEFITS

Access the most up-to-date member resources
deltadentalco.com

Taking care of your oral health is not a luxury — it is a necessity to long-term optimal health. With a focus on prevention, early diagnosis and treatment, dental insurance can greatly reduce your costs when it comes to restorative and emergency procedures. Preventive services are covered at no cost to you and include routine exams and cleanings. You will pay only a small deductible and coinsurance for basic and major services.

When you visit a dentist in the network, you will maximize your savings. These dentists have agreed to reduced fees, which means you won't get charged more than your expected share of the bill.

Summary of Covered Benefits	**Delta Dental Base Dental Plan** In-Network Only	**Delta Dental Premier Dental Plan** In-Network Only
Plan Year Benefit Maximum		
Per Individual	$1,000	$2,000
	You Pay	
Plan Year Deductible		
Individual	$50	$50
Family	$100	$150
Preventive Care		
Exams, Cleanings, X-rays	$0	$0
Basic Services		
Fillings, Sealants, Extractions, Emergency Exams	20%	20%
Major Procedures		
Crowns, Inlays/Onlays, Dentures and Bridgework, Repairs	50%	50%
Orthodontia		
Adults **Children (up to 19th birthday)**	Not covered	50% up to a lifetime maximum benefit of $1,250 per individual; deductible waived

If enrolled, Delta Dental plans also include the Right Start 4 Kids© program for dependent children up to age 13. The program removes most of the cost barriers to dental care by providing coverage for children up to their 13th birthday at 100% coinsurance for covered diagnostic and preventive, basic and major services with no deductible when in-network providers are seen. If an out-of-network provider is seen, the adult coinsurance levels will apply. Orthodontic services are not eligible for the RS4K 100% coverage level.





VISION BENEFITS

Healthy eyes and clear vision are an important part of your overall health and quality of life. You may enroll yourself and your eligible dependents, or you may waive vision coverage. You do not have to be enrolled in medical coverage to elect vision coverage or cover the same dependents under medical and vision.

The table below summarizes the key features of the vision plan. Please refer to the official plan documents for additional information on coverage and exclusions.

Learn more about your VSP Vision Plan
www.VSP.com

Summary of Covered Benefits	**VSP Vision Plan** In-Network
	You Pay
Exam	$10 copay
Single Vision Lenses	$10 copay
Bifocal Lenses	$10 copay
Trifocal Lenses	$10 copay
Frames	Amount over $180 allowance
Contacts in lieu of Frames/Lenses (Elective)	Amount over $150 allowance
Benefit Frequency	
Exams	Once every 12 months
Lenses	Once every 12 months
Frames	Once every 12 months
Contacts	Once every 12 months

INCOME PROTECTION

BASIC LIFE AND AD&D

Life insurance pays a lump-sum benefit to your beneficiary(ies) to help meet expenses in the event of your death. Accidental Death & Dismemberment (AD&D) insurance pays a benefit if you die or suffer certain serious injuries as the result of a covered accident. In the case of a covered accidental injury (e.g., loss of sight, loss of a limb), the benefit you receive is a percentage of your total AD&D coverage based on the severity of the accidental injury.

Basic Life and AD&D insurance is automatically provided to all benefits-eligible employees **at no cost to you**.

- Certified & Classified staff are eligible for 2 times annual earnings up to $100,000
- Administrator & ProTech staff are eligible for 3 times annual earnings up to $300,000

IMPUTED INCOME

Under current tax laws, imputed income is the value of your Basic Life insurance that exceeds $50,000 and is subject to federal income, Social Security and state income taxes, if applicable. This imputed income amount will be included in your paycheck and shown on your W-2 statement.

Learn more about your Life insurance
https://presents.voya.com/ebrc/dcsd





VOLUNTARY LIFE AND AD&D

Voluntary Life and AD&D insurance for you and your dependents can help protect your family during difficult times. Use the **Voya Life Insurance Needs** calculator to find the right amount of coverage for you.

Dual Coverage Limitation: An individual may be covered as an employee or a dependent, but not both. Children may only be covered by one parent, if both parents work in the District.

Summary of Covered Benefits	Voluntary Life and AD&D Insurance – For You and Your Dependents	
Coverage Level	**Coverage Amount**	**Evidence of Insurability/ Proof of Good Health**
Employee Only	Increments of $10,000 not to exceed $500,000.	Required if electing coverage equal to or greater than $300,000.
Spouse	Increments of $10,000 up to $250,000.	Required for amounts equal to or greater than $50,000.
Child(ren)	Increments of $5,000 to a maximum of $20,000.	Evidence of Insurability not required for children.

GUARANTEED ISSUE AND EVIDENCE OF INSURABILITY

New Hires

If you and your spouse elect Voluntary Life and AD&D coverage when you are first eligible, you may elect up to the GI amount without providing EOI. If your requested amount is more than GI, you will need to provide EOI to Voya within 60 days for the amount over GI to become effective. After 60 days, your request for Voluntary Group Term Life (VGTL) will revert to the GI amount.

All Other Employees

Outside of Open Enrollment, you may enroll in Voluntary Life and AD&D coverage within 30 days of a Qualified Life Event. For any amount over $10,000 for yourself or your spouse, you will be required to provide EOI to Voya within 60 days. After 60 days, your request for Voluntary Group Term Life (VGTL) will be canceled. You will be able to resubmit a new request during the next Open Enrollment period.

To file a Short Term Disability Claim

You can either call 1-888-992-0553 or log on to **LincolnFinancial.com**. If you are a first time user, please use the company code: LF1487DO



DISABILITY

Disability insurance can keep you financially stable should you experience a qualifying disability and become unable to work. It can help provide a sense of security, knowing that if the unexpected should happen, you'll still receive a monthly income. A qualifying disability is a sickness or injury that causes you to be unable to perform any other work for which you are or could be qualified by education, training or experience.

DCSD provides Short-Term and Long-Term Disability insurance to all benefits-eligible employees at **no cost to you** through Lincoln Financial Group.

Short-Term Disability Benefits at a Glance	
Coverage	70% of your weekly income, reduced by deductible income, up to $2,500 per week.
When Benefits Begin	Benefit begins after 14 days of disability. This leave requires the employee to have completed 180 days of employment with DCSD to be eligible.
Election Required	No

Long-Term Disability Benefits at a Glance	
Coverage	60% of your monthly income, reduced by deductible income, up to $10,000 per month. Coverage may continue until you recover or reach your Social Security Normal Retirement Age, whichever is sooner.
When Benefits Begin	Benefit begins after 90 days of disability.
Election Required	No

HOW SHORT TERM AND LONG TERM DISABILITY WORK TOGETHER

Sick and personal pay 100% of your pay until Short Term Disability begins.

After 14 days of sickness or injury, approved Short Term Disability pays a portion of your income.

After 90 days, Long Term Disability begins if approved.

PLANNING FOR RETIREMENT

What does retirement look like for you? Maybe you plan to travel the world. Or maybe you'd like to take up some hobbies closer to home. Whatever your goal, it's important to take responsibility for your own finances so you have the income you'll need in the future.

One of the best ways to ensure a secure retirement is to start saving as early as possible. DCSD offers several options so you can choose the retirement savings plan that best suits your unique needs.

COLORADO PUBLIC EMPLOYEES' RETIREMENT ASSOCIATION (PERA) PENSION

As a Douglas County School District employee, it is mandatory you participate in the Colorado Public Employees' Retirement Association Pension. Please review the booklet, at **copera.org**, for complete details regarding your PERA pension plan.

For most members, PERA serves as a substitute for Social Security. PERA provides benefits to you when you retire or are disabled, or it provides benefits to your survivors upon your death. To review your PERA information, visit the PERA website at **copera.org** or contact PERA customer service at 800-759-7372.

PERA 401(k) PLAN

The PERA 401(k) savings plan allows you to save for retirement on a pretax or Roth post-tax basis. You can begin contributing to the plan at any time once you become eligible and can start making contributions to your account through convenient payroll deductions. The 401(k) is offered through Colorado PERA and is administered by Empower Retirement.

- Contribute using convenient payroll deductions up to the IRS limit of $24,500 per year.
- Change the amount of your contributions or stop your payroll contributions at any time.
- Decide how to invest your 401(k) or allow the plan to choose for you.
- Age 50 or older? Make an additional "catch-up" contribution of up to $8,000 to save even more.
- Age 60 – 63, you can make a "catch-up" contribution up to $11,250.

METLIFE RETIREMENT PLANS

You have several options to defer a portion of your salary on a pretax or Roth post-tax basis to DCSD's Retirement Plans. The current plan options with the 457 and 403(b) allow you to reach the contribution limit for a 403(b) and still contribute the entire contribution limit to a 457 or vice versa. A plan comparison is available here: **Retirement Plan Comparison**.

To review your investment options, log into **MetLife** or call 800-543-2520.



To start participating in any voluntary retirement plan, log into Workday, select the Benefits & Pay Worklet and click on Retirement Savings. If initiation is between the second and the end of the month, the effective date will be the first of the following month.

EMPLOYEE ASSISTANCE PROGRAM

You and your household automatically have access to the Employee Assistance Program (EAP). This program provides up to eight professional, confidential virtual or face-to-face visits. These eight counseling sessions are available per year, per issue to you and your household members at no cost. Also included is access to tools and resources to help you make life's big decisions with budget trackers, wellness self-assessments and more. Services are available 24 hours a day, 365 days a year for issues such as:



Marital or Family Problems



Stress, Anxiety or Depression



Substance Abuse



Financial Guidance



Legal Services



Aging Parents



Child or Elder Care

It's important to note that all EAP conversations are voluntary and strictly confidential. If you and your counselor determine that additional assistance is needed, you'll be referred to the most appropriate and affordable resource available. Although you're responsible for the cost of referrals, these costs are often covered under your medical plan.

GET SUPPORT

Access the EAP by calling 888-881-5462 or visiting **mysupportlinc.com**. Use the following login credentials:

- **Username:** your personal email or DCSD email
- **Group Code:** dcsd

Access and learn more about the EAP
mysupportlinc.com



STAFF WELLNESS PROGRAM

Because we care about your health and well-being and we believe wellness should be an integral part of our benefits program, we are excited to offer DCSD's Staff Wellness program to all employees. As health care costs continue to rise, we strive to offer competitive health benefits to take care of you and your family. A successful wellness program is a win-win — it means our employees are improving their lives and we are one step closer to reducing health insurance costs for us all.

Whether you want to learn how to take better care of yourself, have more energy, lose weight, manage stress or improve your diet, the Staff Wellness program offers a combination of free in-person and online resources to help you make wellness a part of your everyday life. The program includes:

- **Group Exercise Classes:** Free weekly exercise and yoga classes are offered for employees. Check the monthly exercise class calendar for class times and details.
- **Wellness Challenges:** The DCSD Staff Wellness program hosts a variety of wellness challenges throughout the year. Challenges focus on tracking physical activity, nutrition, stress management and healthy lifestyle behaviors. Join individually or with a team of coworkers to earn incentives and prizes!
- **Wellness Classes:** Regular 30–60 minute classes on a variety of well-being topics are offered throughout the year.
- **Financial Wellness Support:** Free classes and activities to support your financial well-being.
- **Staff Wellness Champions:** Messengers and motivators that assist in the implementation and coordination of wellness initiatives and create excitement around leading a healthy lifestyle with all DCSD employees.
- **DCSD Staff Wellness E-Newsletter:** The monthly Staff Wellness emails keep you informed about upcoming events, health programs, classes and offer support through community resources.
- **Employee Discount Program:** Many great discounts provided to DCSD employees.

ADDITIONAL BENEFITS

NORTON LIFELOCK

Identity Theft insurance provides credit monitoring and fully managed identity restoration services should you or an immediate family member become a victim of identity theft. This will help you remain productive at home and at work while your identity is restored to pre-theft status.

You can choose between two plans — LifeLock with Norton Benefit Premier and LifeLock with Norton Benefit Premier Plus — that provide protection for your identity, finances, and devices. The **LifeLock with Norton Benefit Premier** plan includes:



Credit Monitoring
Monitors your credit files across major bureaus, alerting you to key changes such as new accounts or inquiries, helping detect potential identity theft early.



Device Security
Provides advanced protection against malware, ransomware, and hacking attempts for your PCs, Macs, and mobile devices, safeguarding your personal and financial information.



PC Cloud Backup
Offers secure cloud storage for your important files, ensuring data recovery in case of hard drive failures, stolen devices, or ransomware attacks.



Parental Controls / Child Monitoring
Provides parental control and monitoring tools to help manage children's online activities. Key features include web supervision (blocking/warning), screen time scheduling, app supervision, location tracking, and YouTube video monitoring.

The **LifeLock with Norton Benefit Premier Plus** plan includes all the benefits of the LifeLock with Norton Benefit Premier plan, plus:



Cyber Crime Coverage
Covers up to $50,000 in costs related to cyber threats such as ransomware, social engineering scams, online fraud, and cyber bullying — helping you recover from digital attacks.



Norton AntiTrack
Helps protect your privacy by blocking online trackers and disguising your digital fingerprint, so your browsing activity stays private.



And more!
Get increased device coverage and expanded digital safety tools for even stronger protection across all your devices.



METLIFE LEGAL ASSISTANCE PROGRAM

Cover the costs on a wide range of common legal issues with a Legal Plan. Quality legal assistance can be pricey. And it can be hard to know where to turn to find an attorney you can trust. With MetLife Legal Plans, you have access to the expert guidance and tools you need to navigate a broad range of personal legal needs.

Get started with your MetLife Legal Plans
http://members.legalplans.com/

For $17.50 per month, you, your spouse and dependents get legal assistance for some of the most frequently needed personal legal matters — with no waiting periods, no deductibles and no claim forms when using a network attorney for a covered matter. And, for non-covered matters that are not otherwise excluded, your plan provides 15 hours of network attorney time and services per year.

GET HELP WITH

- Money Matters
- Home and Real Estate
- Estate Planning
- Family and Personal Issues
- Civil Lawsuits
- Elder-Care Issues
- Traffic and Other Matters

1	**Find an attorney**	Create an account at **members.legalplans.com** to see your coverages and select an attorney for your legal matter. Or, give us a call at 800-821-6400 for assistance.
2	**Make an appointment**	Call the attorney you select and schedule a time to talk or meet.
3	**That's it!**	There are no copays, deductibles or claim forms when you use a network attorney

PET INSURANCE

Let's not forget about our furry friends! MetLife Pet insurance helps offset the cost of caring for your pet with a wide range of covered medical treatments.

- It covers everything from preventive care to accidents and illness, as well as the costs of x-rays, office visits, medications, surgeries and hospital stays.
- You can either choose your own vet or use a licensed in-network vet.
- The cost of coverage depends on your pet's age, species, and the coverage level that you select.

Learn more about Pet Insurance
metlife.com/getpetquote

GET STARTED

Enroll at **metlife.com/getpetquote** or call 800-438-6388.

MONTHLY EMPLOYEE CONTRIBUTIONS

You may choose to have your medical, dental and vision premiums deducted from your paycheck on either a pretax or post-tax basis. Upon retirement, your monthly PERA Pension Benefit is determined by your Highest Average Salary (HAS). If your current compensation will be included in PERA's Highest Average Salary (HAS), you may wish to have your health insurance premiums deducted on a post-tax basis to ensure this does not reduce your reportable salary for pension purposes. PERA's definition of pensionable (PERA-includable) salary is based on compensation for services rendered. Please contact your tax advisor for help in determining whether to have your premiums deducted on a pretax or post-tax basis.

Your contributions are based on your benefits' effective date. If, for any reason, full premiums are not withheld, any uncollected premiums will be invoiced or withheld on your next paycheck. **If you do not pay your premiums within 60 days, your coverage may terminate the first of the following month.**

Level of Coverage	Kaiser HDHP			Kaiser DHMO		
	Full-Time Employees	Part-Time Employees	COBRA	Full-Time Employees	Part-Time Employees	COBRA
Employee Only	$8.73	$170.16	$619.67	$12.25	$270.03	$870.67
Employee + Spouse	$192.90	$438.71	$1,270.32	$535.10	$817.75	$1,784.87
Employee + Child(ren)	$172.46	$419.83	$1,239.34	$513.70	$793.48	$1,741.34
Employee + Family	$350.34	$658.86	$1,790.85	$796.38	$1,174.12	$2,516.24

Level of Coverage	UHC Choice Plus HDHP			UHC Choice Plus PPO			UHC Colorado Doctor's Plan		
	Full-Time Employees	Part-Time Employees	COBRA	Full-Time Employees	Part-Time Employees	COBRA	Full-Time Employees	Part-Time Employees	COBRA
Employee Only	$41.49	$239.94	$866.61	$71.66	$321.48	$931.53	$31.12	$179.96	$808.34
Employee + Spouse	$304.56	$608.98	$1,732.00	$648.90	$926.82	$1,863.06	$228.42	$456.74	$1,616.72
Employee + Child(ren)	$287.99	$589.24	$1,682.20	$631.82	$903.54	$1,809.46	$215.99	$441.93	$1,570.19
Employee + Family	$518.02	$905.81	$2,706.16	$970.36	$1,336.24	$2,911.71	$388.52	$679.36	$2,526.69

Level of Coverage	Delta Dental Base Dental Plan			Delta Dental Premier Dental Plan		
	Full-Time Employees	Part-Time Employees	COBRA	Full-Time Employees	Part-Time Employees	COBRA
Employee Only	$15.00	$23.33	$36.11	$27.21	$35.54	$49.00
Employee + Spouse	$44.81	$53.89	$72.40	$69.08	$78.16	$98.01
Employee + Child(ren)	$52.27	$61.50	$81.47	$79.56	$88.79	$110.28
Employee + Family	$91.03	$100.96	$128.65	$133.98	$143.91	$173.97

Level of Coverage	VSP Vision Plan		
	Full-Time Employees	Part-Time Employees	COBRA
Employee Only	$8.50	$8.50	$8.67
Employee + Spouse	$19.16	$19.16	$19.54
Employee + Child(ren)	$20.73	$20.73	$21.14
Employee + Family	$33.13	$33.13	$33.79

MONTHLY EMPLOYEE CONTRIBUTIONS

Accident	Voya
Employee Only	$5.70
Employee + Spouse	$11.22
Employee + Child(ren)	$13.23
Employee + Family	$18.75

Critical Illness	Voya Monthly Rates Per Amount of Coverage						
Attained Age	$5,000		$10,000		$20,000		$30,000
	Employee	Spouse	Employee	Spouse	Employee	Spouse	Employee
Under 30	$1.55	$1.25	$3.10	$2.50	$6.20	$3.75	$9.30
30-39	$2.10	$2.15	$4.20	$4.30	$8.40	$6.45	$12.60
40-49	$4.05	$4.65	$8.10	$9.30	$16.20	$13.95	$24.30
50-59	$6.45	$8.90	$12.90	$17.80	$25.80	$26.70	$38.70
60-69	$10.25	$12.55	$20.50	$25.10	$41.00	$37.65	$61.50
70+	$19.10	$17.35	$38.20	$34.70	$76.40	$52.05	$114.60
Child(ren)	$2.50		$5.00		N/A		N/A

Hospital Indemnity	Voya	
	Admission $1,000 / Daily $100	Admission $2,000 / Daily $200
Employee Only	$9.62	$19.44
Employee + Spouse	$19.45	$39.25
Employee + Child(ren)	$17.52	$35.36
Employee + Family	$27.35	$55.17

Voluntary Life and AD&D	Voya Rates Per $1,000 of Coverage	
	Employee	Spouse
24 and under	$0.058	$0.058
25-29	$0.066	$0.066
30-34	$0.081	$0.081
35-39	$0.089	$0.089
40-44	$0.097	$0.097
45-49	$0.135	$0.135
50-54	$0.204	$0.204
55-59	$0.364	$0.364
60-64	$0.540	$0.540
65-69	$1.015	$1.015
70-74	$1.657	$1.657
75+	$2.080	$2.080
Child Rate	$0.038	

Your Voluntary Life rates will change 1st of the month following your birthday when changing age bands. The insurance amount will decrease to 50% of the original amount on the first day of the month that is on or next follows your/your spouse's 70th birthday.

ID Theft	Norton LifeLock	
	LifeLock with Norton Benefit Premier	LifeLock with Norton Benefit Premier Plus
Employee Only	$7.99	$12.49
Employee + Family	$14.98	$21.48

Legal	MetLife Legal
Employee and/or Family	$17.50

REQUIRED OE AND NEW HIRE NOTICES

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2026. Contact your State for more information on eligibility –

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

GEORGIA – Medicaid

GA HIPP Website: **https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp**

Phone: 678-564-1162, Press 1

GA CHIPRA Website: **https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra**

Phone: 678-564-1162, Press 2

INDIANA – Medicaid

Health Insurance Premium Payment Program All other Medicaid

Website: **https://www.in.gov/medicaid/**

http://www.in.gov/fssa/dfr/

Family and Social Services Administration

Phone: 1-800-403-0864

Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:

Iowa Medicaid | Health & Human Services

Medicaid Phone: 1-800-338-8366

Hawki Website:

Hawki - Healthy and Well Kids in Iowa | Health & Human Services

Hawki Phone: 1-800-257-8563

HIPP Website: **Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)**

HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: **https://www.kancare.ks.gov/**

Phone: 1-800-792-4884

HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:

https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx

Phone: 1-855-459-6328

Email: **KIHIPP.PROGRAM@ky.gov**

KCHIP Website: **https://kynect.ky.gov**

Phone: 1-877-524-4718

Kentucky Medicaid Website: **https://chfs.ky.gov/agencies/dms**

LOUISIANA – Medicaid

Louisiana Medicaid Website:

https://www.ldh.la.gov/healthy-louisiana

Medicaid Customer Service Line: 1-888-342-6207

Louisiana Medicaid email: **healthy@la.gov**

Louisiana Health Insurance Premium Program (LaHIPP) Website:

https://www.ldh.la.gov/lahipp

LaHIPP phone: 1-877-697-6703

LaHIPP email: **La.HIPP@la.gov**

LaHIPP fax: 1-888-716-9787

LaHIPP mailing address:
100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084

MAINE – Medicaid

Enrollment Website: **https://www.mymaineconnection.gov/benefits/s/?language=en_US**

Phone: 1-800-442-6003

TTY: Maine relay 711

Private Health Insurance Premium Webpage:

https://www.maine.gov/dhhs/ofi/applications-forms

Phone: 1-800-977-6740

TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: **https://www.mass.gov/masshealth/pa**

Phone: 1-800-862-4840

TTY: 711

Email: **masspremassistance@accenture.com**

MINNESOTA – Medicaid

Website: **https://mn.gov/dhs/health-care-coverage/**

Phone: 1-800-657-3672

MISSOURI – Medicaid

Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm

Phone: 573-751-2005

MONTANA – Medicaid

Website:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: **HHSHIPPProgram@mt.gov**

NEBRASKA – Medicaid

Website: **http://www.ACCESSNebraska.ne.gov**
ACCESSNebraska
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: **http://dhcfp.nv.gov**
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: **https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program**
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
Email: **DHHS.ThirdPartyLiabi@dhhs.nh.gov**

NEW JERSEY – Medicaid and CHIP

Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: **http://www.njfamilycare.org/index.html**
CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid

Website: **https://www.health.ny.gov/health_care/medicaid/**
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: **https://medicaid.ncdhhs.gov/**
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: **https://www.hhs.nd.gov/healthcare**
Phone: 1-844-854-4825 or 866-614-6005

OKLAHOMA – Medicaid and CHIP

Website: **http://www.insureoklahoma.org**
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP

Website: **http://healthcare.oregon.gov/Pages/index.aspx**
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website: **https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html**
Phone: 1-800-692-7462
CHIP Website: **Children's Health Insurance Program (CHIP) (pa.gov)**
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: **http://www.eohhs.ri.gov/**
Phone: 1-855-697-4347, or
401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: **https://www.scdhhs.gov**
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid

Website: **http://dss.sd.gov**
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: **Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services**
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP)
Website: **https://medicaid.utah.gov/upp/**
Email: **upp@utah.gov**
Phone: 1-888-222-2542
Adult Expansion Website:
https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website:
https://medicaid.utah.gov/buyout-program/
CHIP Website: **https://chip.utah.gov/**

VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: **Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access** Phone: 1-800-250-8427	Website: **https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select** **https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs** Medicaid/CHIP Phone: 1-800-432-5924 or 1-855-242-8282
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: **https://www.hca.wa.gov/** Phone: 1-800-562-3022	Website: **https://bms.wv.gov/** **https://dhhr.wv.gov/bms/** **http://mywvhipp.com/** Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: **https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm** Phone: 1-800-362-3002	Website: **https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/** Phone: 1-855-294-2127

To see if any other states have added a premium assistance program since January 31, 2026, or for more information on special enrollment rights, contact either:

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

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

IMPORTANT NOTICE TO EMPLOYEES FROM DOUGLAS COUNTY SCHOOL DISTRICT ABOUT CREDITABLE PRESCRIPTION DRUG COVERAGE AND MEDICARE

The purpose of this notice is to advise you that the prescription drug coverage listed below under the Douglas County School District medical plan are expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2026. This is known as "creditable coverage."

Why this is important: If you or your covered dependent(s) are enrolled in any prescription drug coverage during 2026 listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty – as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

If you or your family members aren't currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.

Please read the notice below carefully. It has information about prescription drug coverage with Douglas County School District and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

NOTICE OF CREDITABLE COVERAGE

You may have heard about Medicare's prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by one of the Douglas County School District prescription drug plans listed below, you'll be interested to know that the prescription drug coverage under the plans is, on average, at least as good as standard Medicare prescription drug coverage for 2026. This is called creditable coverage. Coverage under one of these plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

UHC PPO, UHC CO DOCTOR'S PLAN, UHC HDHP, KAISER DHMO, KAISER HDHP

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, the Douglas County School District plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop Douglas County School District coverage, Medicare will be your only payer. You can re-enroll in the employer plan at annual enrollment or if you have a special enrollment or other qualifying event, or otherwise become newly eligible to enroll in the Douglas County School District plan mid-year, assuming you remain eligible.

You should know that if you waive or leave coverage with Douglas County School District and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future – such as before the next period you can enroll in Medicare prescription drug coverage, if this Douglas County School District coverage changes, or upon your request.

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. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

- Visit **www.medicare.gov** for personalized help.
- Call your State Health Insurance Assistance Program (see a copy of the *Medicare & You* handbook for the telephone number) or visit the program online at **https://www.shiptacenter.org/**.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at **www.socialsecurity.gov** or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For more information about this notice or your prescription drug coverage, contact:

DCSD Benefits Team

620 Wilcox St.

Castle Rock, CO 80104

720-433-0140, option 3

NOTICE OF SPECIAL ENROLLMENT RIGHTS FOR HEALTH PLAN COVERAGE

As you know, if you have declined enrollment in Douglas County School District's health plan for you or your dependents (including your spouse) because of other health insurance coverage, you or your dependents may be able to enroll in some coverages under these plans without waiting for the next open enrollment period, provided that you request enrollment within 30days after your other coverage ends. 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 eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Douglas County School District will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have 60 days – instead of 30 – from the date of the Medicaid/CHIP eligibility change to request enrollment in the Douglas County School District group health plan. Note that this new 60-day extension doesn't apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

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. If you would like more information on WHCRA benefits, call your plan administrator at 720-433-0140, option 3.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

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). If you would like more information on maternity benefits, call your plan administrator at 720-433-0140, option 3.

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 9.96%[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 9.96%[2] of the employee's household income.

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

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[1] Indexed annually; see **https://www.irs.gov/pub/irs-drop/rp-25-25.pdf** for 2026 & **https://www.irs.gov/pub/irs-drop/rp-24-35.pdf** for 2025.

[2] Indexed annually; see **https://www.irs.gov/pub/irs-drop/rp-25-25.pdf** for 2026 & **https://www.irs.gov/pub/irs-drop/rp-24-35.pdf** for 2025.

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.

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 DCSD Benefits Team at 720-433-0140, option 3, or **benefits@dcsdk12.org**.

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

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

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

3. Employer name: Douglas County School District	4. Employer Identification Number (EIN): 84-6011446	
5. Employer address: 620 Wilcox St.	6. Employer phone number: 720-433-0140, option 3	
7. City Castle Rock	8. State: CO	9. ZIP code: 80104
10. Who can we contact about employee health coverage at this job? DCSD Benefits Team		
11. Phone number (if different from above) 720-433-0140, option 3	12. Email address: **benefits@dcsdk12.org**	

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

- As your employer, we offer a health plan to:

  ☐ All employees. Eligible employees are:

  ☒ Some employees. Eligible employees are: If you are a full-time employee scheduled to work at least 30 hours per week or a part-time employee scheduled to work at least 20 hours per week for at least nine months (at least 169 days per school year), you are eligible for benefits.

- With respect to dependents:

  ☒ We do offer coverage. Eligible dependents are: Your legal spouse, qualified domestic partner or civil union partner. Children under the age of 26, regardless of student, dependency, or marital status. Children who are past the age of 26 are fully dependent on you for support due to a mental or physical disability and who are indicated as such on your federal tax return.

  ☐ We do not offer coverage.

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

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

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

DOUGLAS COUNTY SCHOOL DISTRICT HIPAA PRIVACY NOTICE

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by Douglas County School District health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of these plans: Medical, Prescription Drug, and Health Care Flexible Spending Account. The plans covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

THE PLAN'S DUTIES WITH RESPECT TO HEALTH INFORMATION ABOUT YOU

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not Douglas County School District as an employer — that's the way the HIPAA rules work. Different policies may apply to other Douglas County School District programs or to data unrelated to the Plan.

HOW THE PLAN MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.
- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing "behind the scenes" plan functions, such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.
- **Health care operations** include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include evaluating vendors; engaging in credentialing, training, and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

HOW THE PLAN MAY SHARE YOUR HEALTH INFORMATION WITH DOUGLAS COUNTY SCHOOL DISTRICT

The Plan, or its health insurer or HMO, may disclose your health information without your written authorization to Douglas County School District for plan administration purposes. Douglas County School District may need your health information to administer benefits under the Plan. Douglas County School District agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Benefits, Payroll, Finance, and IT are the only Douglas County School District employees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and Douglas County School District, as allowed under the HIPAA rules:

- The Plan, or its insurer or HMO, may disclose "summary health information" to Douglas County School District, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.
- The Plan, or its insurer or HMO, may disclose to Douglas County School District information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

In addition, you should know that Douglas County School District cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by Douglas County School District from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs — is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

OTHER ALLOWABLE USES OR DISCLOSURES OF YOUR HEALTH INFORMATION

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protective services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the Plan's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those communications. If we keep psychotherapy notes in our records, we will obtain your authorization in some cases before we release those records. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use, or disclosure of your unsecured health information as required by law.

The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

HOW THE PLAN WILL TREAT CERTAIN SUD TREATMENT INFORMATION

The Plan is not a federally assisted substance use disorder diagnosis, treatment or referral program that is covered by 42 CFR Part 2 (a "Part 2 Program") and does not create and does not typically maintain any records that are subject to 42 CFR Part 2. If the Plan does receive any Part 2 Program records pursuant to your written consent for claim administration and payment, the records will only be used and disclosed in accordance with HIPAA and your consent. In no event will the Plan use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings against you, unless authorized by your written consent or a court order accompanied by a subpoena or other legal requirement compelling disclosure after you received notice and an opportunity to respond.

YOUR INDIVIDUAL RIGHTS

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

RIGHT TO REQUEST RESTRICTIONS ON CERTAIN USES AND DISCLOSURES OF YOUR HEALTH INFORMATION AND THE PLAN'S RIGHT TO REFUSE

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid out of pocket and in full for the item or service.

RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATIONS OF YOUR HEALTH INFORMATION

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

RIGHT TO INSPECT AND COPY YOUR HEALTH INFORMATION

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible on site), the Plan will provide you with one of these responses:

- The access or copies you requested
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous, and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan's cost.

RIGHT TO AMEND YOUR HEALTH INFORMATION THAT IS INACCURATE OR INCOMPLETE

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

- Make the amendment as requested
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

RIGHT TO RECEIVE AN ACCOUNTING OF DISCLOSURES OF YOUR HEALTH INFORMATION

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment, or health care operations
- To you about your own health information
- Incidental to other permitted or required disclosures
- Where authorization was provided
- To family members or friends involved in your care (where disclosure is permitted without authorization)
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances
- As part of a "limited data set" (health information that excludes certain identifying information)

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE FROM THE PLAN UPON REQUEST

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

CHANGES TO THE INFORMATION IN THIS NOTICE

The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on February 16, 2026. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice e-mailed to you.

COMPLAINTS

If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint, please contact the DCSD Benefits Team at 720-433-0140, option 3, or email **benefits@dcsdk12.org**.

CONTACT

For more information on the Plan's privacy policies or your rights under HIPAA, contact the DCSD Benefits Team at 720-433-0140, option 3, or email **benefits@dcsdk12.org**.

PROVIDER-CHOICE RIGHTS NOTICE

The Douglas County School District UHC Colorado Doctor's Medical Plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the UHC CO Doctor's Plan at 866-801-4409.

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

You do not need prior authorization from Douglas County School District Medical Plan 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 UHC CO Doctor's Plan at 866-801-4409.

NO SURPRISES ACT NOTICE

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

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

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

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

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

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

You're protected from balance billing for:

Emergency services

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

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

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

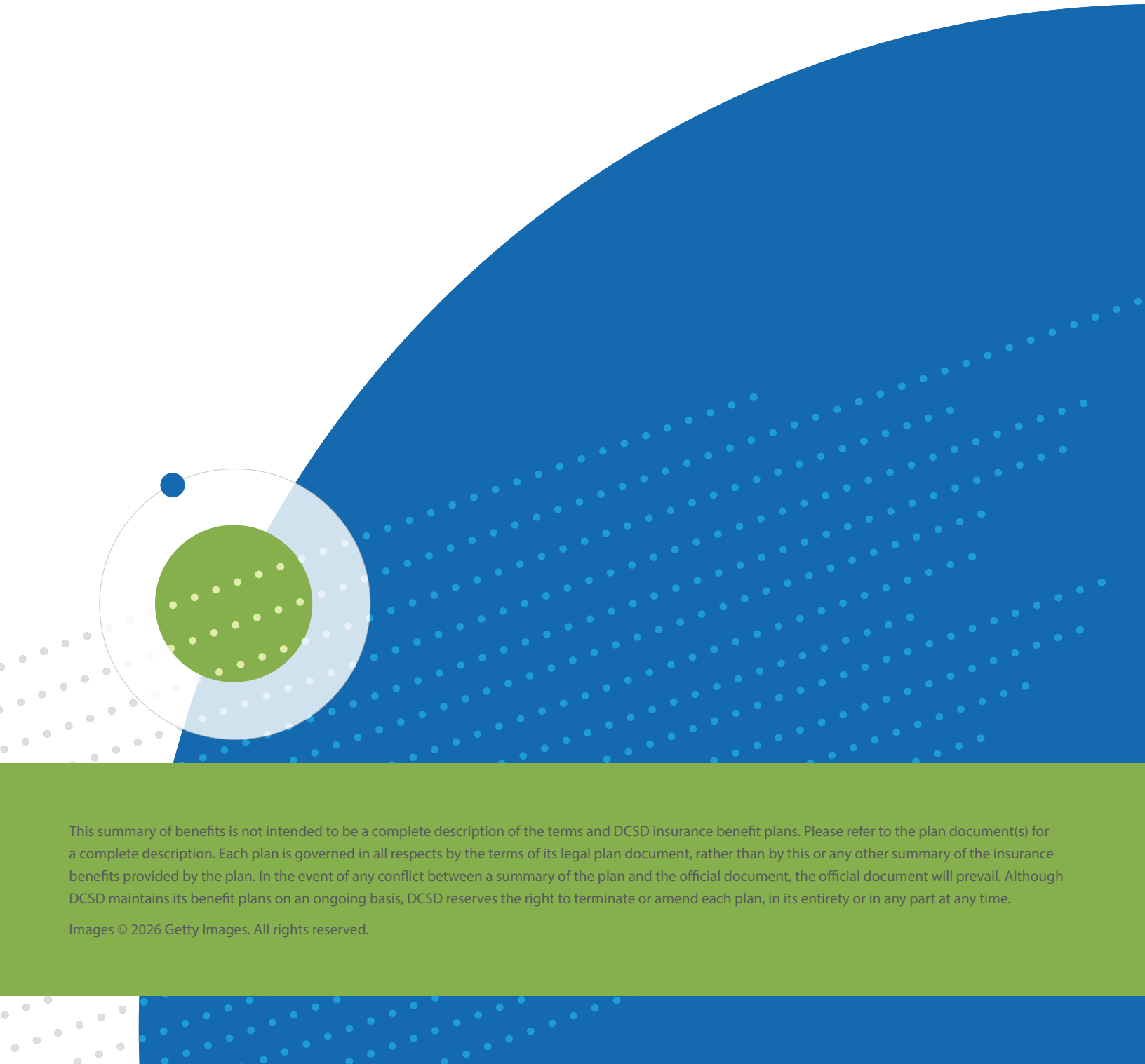
If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

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

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

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact U.S. Department of Health and Human Services. The federal phone number for information and complaints is: 1-800-985-3059. Visit **No Surprises Act | CMS** for more information about your rights under federal law.



This summary of benefits is not intended to be a complete description of the terms and DCSD insurance benefit plans. Please refer to the plan document(s) for a complete description. Each plan is governed in all respects by the terms of its legal plan document, rather than by this or any other summary of the insurance benefits provided by the plan. In the event of any conflict between a summary of the plan and the official document, the official document will prevail. Although DCSD maintains its benefit plans on an ongoing basis, DCSD reserves the right to terminate or amend each plan, in its entirety or in any part at any time.

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