MCSD
Montrose County School District
MONTROSE & OLATHE

EMPLOYEE BENEFIT GUIDE

Effective January 1, 2024

Montrose County School District is committed to sustaining a working environment that motivates and inspires its employees. To this end, the district has developed a comprehensive benefits package that will provide peace of mind today, as well as offering opportunities to plan for the future. Montrose County School District will work to ensure that the benefits package is efficiently and accurately implemented and maintained. This handbook is designed to provide employees with some of the details of the different aspects of the various plans.

This summary is a bird's eye overview of the benefits package and does not constitute a policy. Please refer to the complete plan documents for details. For specific questions regarding any of the benefits, please contact the Human Resources Department.

THE DESCRIPTION OF CURRENT BENEFITS DOES NOT GUARANTEE THAT BENEFIT LEVELS WILL CONTINUE INTO THE FUTURE. MONTROSE COUNTY SCHOOL DISTRICT MAY CHANGE OR TERMINATE PLANS AND COVERAGE AT ANY TIME WITH A 60-DAY NOTIFICATION.

Presented by

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

CONTENTS & CONTACT INFORMATION

Refer to this list when you need to contact one of your benefit vendors. For general information contact Human Resources.

HUMAN RESOURCES

Benefits Coordinator	Barbara Murry
Phone	970-252-7915
Email	barbara.murry@mcsd.org

MEDICAL pages 3-5, 11

Provider	Simplified Benefits Administrators
Phone	719-365-5000
Web Address	www.simplifiedbenefitsadministrators.org

TELEMEDICINE page 6

Provider	First Stop Health
Phone	888-691-7867
Web Address	www.fshealth.com

HSA pages 7-8

FSA page 9

Provider	American Fidelity, Adam Ashby
Phone	970-556-4774
Email	adam.ashby@americanfidelity.com

DENTAL pages 10-11

Provider	Ameritas
Phone	800-487-5553
Web Address	www.ameritas .com

VISION pages 10-11

Provider	Simplified Benefits Administrators
Phone	719-365-5000
Web Address	www.simplifiedbenefitsadministrators.org

PAID LEAVE BENEFITS page 11

LIFE INSURANCE page 12

Provider	Lincoln
Phone	800-423-2765
Web Address	www.lincolnfinancial.com

DISABILITY INCOME BENEFITS page 12

Provider	PERA
Phone	800-759-7372
Web Address	www.copera.org

EMPLOYEE ASSISTANCE PROGRAM (EAP) page 13

Provider	Triad
Phone	970-242-9536 or 877-679-1100
Web Address	www.triadap.com

RETIREMENT pages 13-14

Provider	PERA
Phone	800-759-7372
Web Address	www.copera.org

ADDITIONAL VOLUNTARY BENEFITS page 14

PET INSURANCE page 15

Provider	Nationwide
Phone	1-800-540-2016
Web Address	https://www.petinsurance.com/submit-claim/

DISCLOSURE NOTICES pages 16-29

QUESTIONS AND ANSWERS page 30

BENEFITS CONSULTANTS

Name	Mountain West Insurance & Financial Services
Employee Benefits Senior Client Manager	Julie McDowell
Phone	970-549-0581
Email	juliem@mtnwst.com

BENEFIT INFORMATION

YOUR BENEFITS PLAN

Montrose County School District offers a variety of benefits allowing you the opportunity to customize a benefits package that meets your personal needs.

In the following pages, you'll learn more about the benefits offered. You'll also see how choosing the right combination of benefits can help protect you and your family's health and finances – and your family's future.

Benefit	Who pays the cost?
Medical Insurance	MCSD offers four medical plans and contributes $836 towards all four plans, no matter what level of coverage is selected. The employee contributions are shown on page 11.
Dental Insurance	You may elect dental coverage for yourself and your eligible dependents. MCSD offers this plan at no cost to the employee if paired with health insurance. If medical is waived, the employee will be responsible for the cost. The employee contributions are shown on page 11.
Vision	You may elect vision coverage for yourself and your eligible dependents. MCSD offers this plan at no cost to the employee if paired with health insurance. If medical is waived, the employee will be responsible for the cost. The employee contributions are shown on page 11.
Basic Life and AD&D	MCSD provides $50,000 in life coverage to employees contracted working over 18.75 hours and pays 100% of the premium.
Voluntary Life Insurance	You may elect additional voluntary life insurance. You will be responsible for the cost of coverage selected.
HSA and FSA	See details on pages 7-9.
Disability Income Benefits	See details on page 12.
Employee Wellness-Triad	See details on page 13.

ELIGIBILITY

All contracted employees over 18.75 hours are eligible to join Montrose County School District's benefits program once the waiting period has been satisfied. Coverage will begin on the 1st of the month following one month of employment. Contracted employees must be regularly scheduled and working at least 18.75 hours per week in order to qualify. You may also enroll your eligible dependents in the Benefits Plan when you enroll.

Eligible dependents include:

- Your legal spouse*
- Domestic partner, civil union, same-sex marriage*
- A child who is under age 26, including natural child, legally adopted child, stepchild, ward of legal guardian or other such classification as required by law
- An unmarried child of any age who is medically certified as disabled and dependent on the parent

***A spouse or partner is only considered an eligible dependent if they do not have coverage offered to them by their employer.**

WHEN CAN YOU ENROLL?

You can sign up for Benefits at any of the following times:

- As a new hire, at your initial eligibility date
- During the annual open enrollment period
- Within 30 days of a qualified family-status change (Qualifying Event)

If you do not enroll at one of the above times, you must wait for the next annual open enrollment period.

BENEFIT INFORMATION

MAKING CHANGES TO YOUR BENEFITS

Generally, you can only change your benefit choices during the annual open enrollment period which runs November 15th through December 15th. However, you may be able to change your benefit choices during the plan year if you have a change in status including:

- Your marriage
- Your divorce or legal separation
- Birth or adoption of an eligible child
- Death of your spouse or covered child
- Change in your spouse's work status that affects his or her benefits
- Change in your work status that affects your benefits
- Change in residence or work site that affects your eligibility for coverage
- Change in your child's eligibility for benefits
- Receiving Qualified Medical Child Support Order (QMCSO)

You must **submit documentation as proof of life event to within 30 days**. The IRS allows changes to be made within 60 days for those eligible for Medicaid or CHIP under HIPAA Special Enrollment Rights.

If you fail to do so you will be required to wait until the next annual enrollment period to make benefit changes unless you have another family status change.

RESIGNATION OR TERMINATION

WHEN DOES COVERAGE END?

Coverage ends the last day of the calendar month following the end of the period for which the required contribution has been made.

MEDICAL INSURANCE

The chart below provides a brief overview of the four medical plans offered by Montrose County School District through Simplified Benefits Administrators. This chart is intended only to highlight the benefits available and should not be relied upon to fully determine your coverage. If the below illustration of benefits conflicts in any way with the Summary Plan Description (SPD), the SPD shall prevail. It is recommended that you review your exact description of services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

To find participating providers go to www.Simplified Benefits Administrators.org or call Simplified Benefits Administrators during business hours at 719-365-5000.

Employee monthly deductions are on page 11. For dual employed spouses, please contact your Human Resources Department for information on premiums.

	PREMIER PLAN		STANDARD PLAN	
IN-NETWORK	**Montrose Regional Health Network**	**First Health Network Providers**	**Montrose Regional Health Network**	**First Health Network Providers**
Calendar Year Deductible (Individual / Family)**	$500 / $1,000	$850 / $1,450	$750 / $1,500	$1,100 / $1,950
Maximum Out-of-Pocket (Individual / Family)**	$2,500 / $5,000	$3,550 / $6,250	$3,500 / 7,000	$4,900 / $9,250
Out-of Pocket Max Includes	Deductible, Copays, Coinsurance, and Prescription Costs		Deductible, Copays, Coinsurance, and Prescription Costs	
Co-pays and Coinsurance				
Preventive Office Visits	Covered 100%		Covered 100%	
Primary Care Provider Office Visit	$35 Copay	$35 Copay	$40 Copay	$40 Copay
Specialist Office Visit	Covered 90% after deductible	Covered 90% after deductible	Covered 80% after deductible	Covered 80% after deductible
Inpatient Hospital / ICU	Covered 90% after deductible	Covered 90% after deductible	Covered 80% after deductible	Covered 80% after deductible
Outpatient Surgery	Covered 90% after deductible	Covered 90% after deductible	Covered 80% after deductible	Covered 80% after deductible
Emergency Room	Covered 90% after $100 copay and deductible		Covered 80% after $150 copay and deductible	
Urgent Care	Covered 90% after deductible	Covered 90% after deductible	Covered 80% after deductible	Covered 80% after deductible
Lab and X-Ray	Covered 90% after deductible	Covered 90% after deductible	Covered 80% after deductible	Covered 80% after deductible
Advanced Imaging (MRI, CAT, PET, etc.)	Covered 90% after deductible	Covered 90% after deductible	Covered 80% after deductible	Covered 80% after deductible
Skilled Nursing Facility and Home Health Care	Covered 90% after deductible	Covered 90% after deductible	Covered 80% after deductible	Covered 80% after deductible
Prescriptions				
Out-of-Pocket Max	Combined with medical		Combined with medical	
Max out-of-pocket 30 days	$150		$200	
Max out-of-pocket 90 days	$350		$450	
Retail- Generic / Brand / Diabetic	20% / 40% / 10%		30% / 50% / 10%	
OUT-OF-NETWORK				
Deductible (Individual / Family)	$1,450 / $2,650		$1,950 / $3,650	
Maximum Out-of-Pocket (Individual / Family)	$6,850 / $11,250		$9,550 / $14,250	
Physician Visit	Covered 50% after deductible		Covered 50% after deductible	
Inpatient Hospital	Covered 50% after deductible		Covered 50% after deductible	
Preventative Care	Covered 50% after deductible		Covered 50% after deductible	
Emergency Room	Covered 90% after $100 copay and deductible		Covered 80% after $150 copay and deductible	

MEDICAL INSURANCE

The chart below provides a brief overview of the four medical plans offered by Montrose County School District through Simplified Benefits Administrators. This chart is intended only to highlight the benefits available and should not be relied upon to fully determine your coverage. If the below illustration of benefits conflicts in any way with the Summary Plan Description (SPD), the SPD shall prevail. It is recommended that you review your exact description of services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

To find participating providers go to www.Simplified Benefits Administrators.org or call Simplified Benefits Administrators during business hours at 719-365-5000.

Employee monthly deductions are on page 11. For dual employed spouses, please contact your Human Resources Department for information on premiums.

	BASIC PLAN		HIGH DEDUCITBLE HEALTH PLAN (HDHP) HSA QUALIFIED	
IN-NETWORK	**Montrose Regional Health Network**	**First Health Network Providers**	**Montrose Regional Health Network**	**First Health Network Providers**
Calendar Year Deductible (Individual / Family)**	$1,500 / $3,000	$2,150 / $4,050	$5,000 / $8,000	$6,800 / $9,200
Maximum Out-of-Pocket (Individual / Family)**	$5,000 / $10,000	$7,000 / $11,250	$5,000 / $8,000	$6,800 / $9,200
Out-of Pocket Max Includes	Deductible, Copays, Coinsurance, and Prescription Costs		Deductible, Copays, Coinsurance, and Prescription Costs	
Co-pays and Coinsurance				
Preventive Office Visits	Covered 100%		Covered 100%	
Primary Care Provider Office Visit	$50 Copay	$50 Copay	Covered 100% after deductible	
Specialist Office Visit	Covered 70% after deductible	Covered 70% after deductible	Covered 100% after deductible	
Inpatient Hospital / ICU	Covered 70% after deductible	Covered 70% after deductible	Covered 100% after deductible	
Outpatient Surgery	Covered 70% after deductible	Covered 70% after deductible	Covered 100% after deductible	
Emergency Room	Covered 70% after $200 copay and deductible		Covered 100% after deductible	
Urgent Care	Covered 70% after deductible	Covered 70% after deductible	Covered 100% after deductible	
Lab and X-Ray	Covered 70% after deductible	Covered 70% after deductible	Covered 100% after deductible	
Advanced Imaging (MRI, CAT, PET, etc.)	Covered 70% after deductible	Covered 70% after deductible	Covered 100% after deductible	
Skilled Nursing Facility and Home Health Care	Covered 70% after deductible	Covered 70% after deductible	Covered 100% after deductible	
Prescriptions				
Out-of-Pocket Max	Combined with medical		Combined with medical	
Max out-of-pocket 30 days	$250		Subject to out-of-pocket max	
Max out-of-pocket 90 days	$500		Subject to out-of-pocket max	
Retail- Generic / Brand / Diabetic	40% / 60% / 10%		Covered 100% after deductible	
OUT-OF-NETWORK				
Deductible (Individual / Family)	$4,050 / $7,850		$9,250 / $11,250	
Maximum Out-of-Pocket (Individual / Family)	$13,750 / $19,250		$12,750 / $15,250	
Physician Visit	Covered 50% after deductible		Covered 50% after deductible	
Inpatient Hospital	Covered 50% after deductible		Covered 50% after deductible	
Preventative Care	Covered 50% after deductible		Covered 50% after deductible	
Emergency Room	Covered 70% after $200 copay and deductible		Covered 100% after $250 copay and deductible	

***The High Deductible Health Plan (HDHP) is HSA Qualified.**

ACA PREVENTATIVE CARE BENEFITS

Preventative Care for Adults

- Abdominal aortic aneurysm screening
- Aspirin use
- Cholesterol screening
- Depression screening
- Diet counseling
- Obesity screening & counseling
- Syphilis screening
- Preventive vaccinations
- Alcohol misuse screening and counseling
- Blood pressure screening
- Colorectal cancer screening (Colonoscopy)
- Diabetes screening
- HIV screening
- Sexually transmitted infection prevention counseling
- Tobacco use screening

Preventative Care for Women

- Anemia screening
- Breast cancer mammography screening
- Breastfeeding support & counseling
- Chlamydia infection screening
- Domestic violence screening & counseling
- Gestational diabetes screening
- Human Papillomavirus (HPV) DNA test
- RH incompatibility screening
- Well-woman visits
- Breast cancer genetic test counseling (BRCA)
- Brest cancer chemoprevention
- Cervical cancer screening
- Contraception – ACA Approved
- Folic acid supplements
- Gonorrhea screening
- Hepatitis B screening
- Osteoporosis screening
- Urinary tract or other infection screening

Preventative Care for Children

- Autism screening
- Blood pressure screening
- Depression screening
- Fluoride chemoprevention supplements
- Hearing screening
- Hematocrit or hemoglobin screening
- Hypothyroidism screening
- Lead screening
- Oral health risk assessment
- STI prevention, counseling, & screening
- Vision screening
- Behavioral assessments – based on age
- Cervical dysplasia screening
- Developmental screening
- Gonorrhea preventive medication
- Height, weight, & body mass index
- HIV screening
- Iron supplements
- Obesity screening & counseling
- Phenylketonuria (PKU) screening
- Tuberculin testing
- Vaccinations

This is a list of the services covered under the ACA. Please note some services are based on gender and age. For a more complete listing please go to https://www.healthcare.gov/coverage/preventive-care-benefits/

FIRST STOP HEALTH

MONTROSE AND OLATHE SCHOOLS' TELEMEDICINE

24/7 PHONE AND VIDEO ACCESS TO U.S.-BASED PHYSICIANS AT 888-691-7867

- Diagnosis and treatment provided conveniently via phone and video access
- No registration required, just call!
- Download our mobile app for video consults
- Prescriptions when appropriate
- Provided FREE to all employees enrolled in the medical plan and their covered dependents
- Feel sick? Call a doctor. Get on with life!

WHAT TO EXPECT

- Available 24/7
- Unlimited consultations
- U.S.-based doctors
- Physicians licensed in 50 states
- No copays or fees to use the service
- 90% of calls to First Stop Health prevent unnecessary trips to doctors offices and ERs
- Confidential medical dashboard with record of consultations + tools to upload and share medical records

LEARN MORE

- www.fshealth.com
- 888-691-7867
- 222 N. Columbus Dr., Suite D
  Chicago, IL 60601

TOP TEN REASONS MEMBERS CALL FIRST STOP HEALTH

- **Sore Throat**
- **Cough**
- **Sinus Infection**
- **Urinary Tract Infection**
- **Skin Rash**
- **Eye Infection**
- **Earache**
- **Upset Stomach**
- **Muscle/Joint Pain**
- **Medication Refill**

HEALTH SAVINGS ACCOUNT (HSA)

HEALTH SAVINGS ACCOUNT (HSA) is a health care bank account that lets people put money aside tax-free to pay for certain medical, dental, and vision costs. The IRS limits who can open and put money into an HSA. Money in an HSA can stay in the account until it is used.

HSA'S ARE ACTUALLY A TWO-COMPONENT ARRANGEMENT OF:
A- a qualified High Deductible Health Insurance Plan (HDHP) and
B- a Health Savings Account
One can have 'A' without 'B', but not 'B' without 'A'.

HIGH DEDUCTIBLE HEALTH PLANS (HDHP) DIFFER FROM EXISTING PPO PLANS IN THE FOLLOWING WAYS:
- ✓ HDHP has no copays (office visit or prescription drugs)
- ✓ All covered services apply towards the deductible, including office visits and Rx drugs
- ✓ Office visits and Rx drugs will be charged at carrier negotiated discounted retail prices with paid amounts applying toward the deductible
- ✓ If more than one person covered, deductible becomes family (2x individual) with all family members' covered services applying toward one family deductible

HSA'S:
- ✓ Contributions can be made to the maximum of $4,150 for an individual or $8,300 for a family in 2024 regardless of your plan deductible (if qualified)
- ✓ For an expense to be eligible for reimbursement, the HSA must be opened prior to the expense occurring
- ✓ You may contribute the annual maximum in a calendar year, regardless of when your coverage begins, as long as you are covered for the next 12 months
- ✓ Interest earned on contributions is tax deferred
- ✓ Distributions from an HSA for qualified medical expenses are not taxable
- ✓ There are no time limits for reimbursements
- ✓ Over-the-counter (OTC) drugs, medicines and biological will no longer be reimbursable through your HSA plan without a prescription
- ✓ Vision and dental services are qualified medical expenses
- ✓ Unused funds roll over each year
- ✓ Distributions made for other than qualified medical expenses are subject to income tax on that amount and a 20% penalty
- ✓ Anyone covered under Medicare cannot contribute
- ✓ Anyone covered under FSA/MERP/HRA's, a non-HDHP policy, or through the military cannot contribute
- ✓ If you are a veteran, you may not have received veteran's benefits within the last three months.
- ✓ Catch-up contribution (55+ years old) is $1,000

2024 IRS Annual Maximum* HSA Contribution Limits	
Employee Only	$4,150
Employee + Spouse, Child(ren), or both	$8,300
**Additional $1,000 annual catch-up amounts are available for employees 55 years or older for 2024.*	

KEEP YOUR RECEIPTS

Keep all records of your medical expenses in case of an IRS audit. That way, you can prove that your HSA was used for qualified expenses.

HSA QUALIFIED MEDICAL EXPENSES

COMMON MEDICAL EXPENSES* QUALIFIED FOR PURCHASE USING AN HSA

- Acupuncture
- Alcoholism treatment
- Ambulance
- Artificial limb
- Artificial teeth
- Blood sugar test kits for diabetics
- Breast pumps and lactation aids
- Chiropractor
- Contact lenses and solutions
- Crutches
- Dental treatments including X-rays, cleanings, fillings, braces, and tooth removals
- Doctor's office visits and procedures
- Drug addiction treatment
- Drug prescriptions
- Eyeglasses and vision exams
- Fertility treatment
- Health insurance premiums for COBRA plans, long-term care insurance, and health continuation insurance while receiving unemployment benefits
- Hearing aids and batteries
- Hospital services
- Insulin
- Laboratory fees
- Laser eye surgery
- Qualified long-term care services (limited)
- Over-the-counter medicines and drugs, only if prescribed by a doctor**
- Physical therapy
- Psychiatric care if the expense is for mental health care provided by a psychiatrist, psychologist, or other licensed professional
- Special education for learning disabilities
- Speech therapy
- Stop-smoking programs, including nicotine gum or patches
- Surgery, excluding cosmetic surgery
- Vasectomy
- Walker
- Weight-loss program, if it is a treatment for a specific disease diagnosed by a physician
- Wheelchair

THIS IS NOT A COMPLETE LIST. The Internal Revenue Service (IRS) decides which expenses can be paid from an HSA, which also includes but is not limited to: deductibles, copayments, and medications. The IRS can modify the list at any time.

*QUALIFIED MEDICAL EXPENSES are medical, dental, or vision expenses that the IRS says can be paid for from a health savings account (HSA) without paying income taxes on the savings.

**Because of the health care reform law passed in 2010, you will no longer be able to pay for over-the-counter (OTC) medicines with your HSA, unless you have a prescription. In addition, if you use an HSA to pay for items or services that are not qualified medical expenses and you are under age 65, the tax penalty will increase from 10 percent to 20 percent of the HSA distribution.

COMMON HEALTH CARE EXPENSES **NOT** QUALIFIED FOR PURCHASE USING AN HSA

- Costs or expenses reimbursed from another source such as health coverage or a flexible spending account
- Cosmetic surgery
- Diaper service
- Electrolysis or hair removal
- Health club dues
- Household help
- Maternity clothes
- Nutritional supplements, such as multi-vitamins, for general good health
- Over-the-counter medicines not prescribed by a doctor
- Personal use items, such as toothbrush, toothpaste, etc.
- Swimming lessons
- Teeth whitening

Want more information? If you are currently covered under an HSA-eligible health plan and would like details about what expenses are covered and count toward your deductible, please see your benefit plan documents or visit www.irs.com.

FLEXIBLE SPENDING ACCOUNTS (FSA)

HEALTH CARE AND FLEXIBLE SPENDING ACCOUNTS (FSA)

Montrose County School District provides you the opportunity to pay for out-of-pocket medical, dental, vision and dependent care expenses with pre-tax dollars through FSAs. You must enroll in the plan to participate and re-enroll for the current plan year. You can save approximately 25 percent of each dollar spent on these expenses when you participate in a FSA, depending on your tax bracket.

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

Contributions to your FSA come out of your paycheck before taxes are taken out. This means that you do not pay federal income tax, Social Security taxes, or state and local income taxes on the portion of your paycheck you contribute to your FSA. You should contribute the amount of money you expect to pay out of pocket for eligible expenses for the plan period. At the end of the plan year, you are allowed to carry over up to $610 to the next plan year. Any money above $610 will be lost.

The maximum you can contribute to the Health Care FSA $3,200 for 2024.

The maximum you can contribute to the Dependent Care FSA is $5,000 if you are a single employee or married filing jointly, or $2,500 if you are married and filing separately.

All employees must complete and sign the FSA election form. Please contact Adam Ashby at American Fidelity for more information: adam.ashby@americanfidelity.com or 970-556-4774.

2024 IRS Annual Maximum FSA Contribution Limits	
Health Care FSA	$3,200
Dependent Care FSA – Single Employee or Married and Joint Filing	$5,000
Dependent Care FSA – Married and Filing Separately	$2,500

KEEP YOUR RECEIPTS

Keep all records of your medical expenses in case of an IRS audit. That way, you can prove that your FSA was used for qualified expenses.

DENTAL INSURANCE

Montrose County School District offers dental coverage on a voluntary basis. The dental plan has adopted the Ameritas dental network. To take advantage of the Ameritas network discounts, search for providers at ameritas.com and select Classic PPO. When paired with medical coverage, there is no cost to the employee, but if medical coverage is waived, the employee will be responsible for the monthly premium. For dual employed spouses, please contact your Human Resources Department.
Employee monthly deductions are on page 11.

DENTAL MAC PLAN	
Calendar Year Maximum Benefit	$1,800
Copay (Basic / Major only)	$25 per visit
Routine Exam Frequency Limit	Two per calendar year
Cleaning Frequency Limit	Two per calendar year
Preventative Care- Type 1	Covered 100%
Basic Services- Type 2	Covered 80% after copay
Major Services- Type 3	Covered 50% after copay
Waiting Period	90 days for Type 3 services
Orthodontic Treatment	Not covered

New this year, Montrose County School District's dental plan is moving to a MAC (Maximum Allowable Charge) Plan. On this new plan, claims are paid based on the maximum amount a network provider may charge. If you visit an out-of-network dentist, claims are paid based on the lowest contracted network provider fee in your zip code. Any difference between the plan allowance and the dentist's charge will be an out-of-pocket expense for you. If you select a network provider, you may have lower out-of-pocket costs.

VISION INSURANCE

Montrose County School District offers vision coverage on a voluntary basis. The vision plan allows access to any provider without network restrictions. When paired with medical coverage, there is no cost to the employee, but if medical coverage is waived, the employee will be responsible for the monthly premium. For dual employed spouses, please contact your Human Resources Department.
Employee monthly deductions are on page 11.

VISION PLAN	
Exam	Covered 100%
Exam Frequency Limit	One per calendar year
Frames and Frame Type Lenses: Single Vision, Lined Bifocal, Lined Trifocal, Lenticular, Progressive Contact Lenses (in lieu of frames)	Covered 100% up to $150 maximum benefit per calendar year

MONTHLY PAYROLL DEDUCTIONS

The below premiums for medical, dental, and vision are for employees working 30 hours or more. Rates below are effective 10/01/2024. Please see Human Resources if you work 18.75 to 29.99 hours.

EMPLOYEE MONTHLY DEDUCTIONS – MEDICAL						
	Employee Only	Employee + Spouse	Employee + Children	Employee + Family	Dual Employee + Spouse*	Dual Employee + Family*
Premier Plan	$282	$1,037	$919	$1,667	$564	$919
Standard Plan	$190	$693	$580	$1,152	$380	$580
Basic Plan	$74	$492	$391	$868	$148	$391
HDHP Plan	$64	$436	$345	$775	$128	$345
Tobacco Surcharge	**$25**					
Employer Contribution	**$836**					

*Dual Employee + Spouse and Dual Employee + Family: If both you and your spouse work for the district. Please contact Human Resources with any questions on monthly deductions.

EMPLOYEE MONTHLY DEDUCTIONS – VISION / DENTAL		
	With Medical	Without Medical
Dental- Per Participant	$0	$40
Vision- Per Participant	$0	$12

Employee must be enrolled in dental and/or vision in order for dependents to be covered.

PAID LEAVE BENEFITS ESP / LICENSED

	SICK DAYS	PERSONAL DAYS	VACATION DAYS 1-5 YEARS	VACATION DAYS 6-12 YEARS	VACATION DAYS 13+ YEARS	GENERAL DAYS
ESP: Secretarial / Para Professional	8	4	0	0	0	0
ESP: Food Services	8	4	0	0	0	0
ESP: Custodial / Maintenance / 12 Month	10	4	10	15	20	0
Licensed: Teachers / Principals / Misc. Licensed	0	0	0	0	0	10

BASIC LIFE INSURANCE

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT

Montrose County School District provides eligible contracted employees with $50,000 in group Life and AD&D coverage through Lincoln and pays the full cost of this benefit. Note the benefit will decrease at age 65, 70, and 75. In the event you pass away while employed by Montrose County School District, this benefit is paid to the beneficiary you indicated on your enrollment. Please contact Human Resources to update beneficiaries, or for informational flyers.

LINCOLN GROUP LIFE / AD&D	
Life Benefit	$50,000
AD&D Benefit	$50,000

The following three benefits are also available to you at no additional cost:

- **Travel Assistance**- Available 24/7 help if you are traveling more than 100 miles away from home, for both you and your family members
- **Grief Counseling**- Available 24/7 via phone or face to face
- **Will Preparation**- Including both Living Wills and Power of Attorney

The cost of this benefit is 100% paid for by Montrose County School District at no cost to you!

VOLUNTARY LIFE INSURANCE

Employees who want to supplement their group life insurance may purchase additional coverage through Lincoln. When you enroll yourself or yourself and your dependents in this benefit, you are responsible for the full cost through payroll deductions. The guaranteed issue amount for this policy is $50,000/$50,000 AD&D. , provided you enroll when you are initially eligible. Please contact Human Resources for benefit amounts and monthly premiums. Note premiums are subject to increases at age 65 and 75. You must enroll in additional life insurance for your dependents to be eligible to enroll as well.

DISABILITY INCOME

PERA provides employees with at least five years of Service Credit short and long-term disability benefits. For more information or to apply, contact PERA at 800-759-7372 or go to www.copera.org.

TRIAD

Triad provides employees and their household family members five face-to-face or virtual mental health visits per year, per family. The services can include: grief and loss, life changes, financial, legal, or stress related to work, illness, and/or disabilities. Brochures are available from Human Resources. To access services, call Triad directly at 970-242-9536 or 877-679-1100.

All employees are automatically enrolled in this benefit. No enrollment form required.

RETIREMENT

To: All Employees of Montrose County School District

In compliance with the requirements of IRC §403(b)(12(A)(ii)) this Notice will advise you of the voluntary 403(b) program established and maintained for the benefit of our employees. The following information provides details of the Plan and outlines the procedures for enrollment.

Eligibility
All employees who are employed by Montrose County School District are eligible to participate in the 403(b) plan upon date of hire.

Contributions
When you enroll in the program, the amounts you designate as salary deferrals are withheld from your wages and forwarded to an investment provider of your choice. Contributions may be changed, started or stopped at any time. Several types of contributions are available in your Plan:

- Pre-Tax Salary Deferrals – These are amounts you contribute into a 403(b) plan that are deferred from you paycheck before federal income taxes are applied. State income taxes may or may not be applicable.

- Roth Salary Deferrals – These amounts are also deferred from your paycheck, but are subject to federal and state income taxes. When you withdraw monies, however, the funds may be excluded from taxation. Special rules apply to Roth contributions and you should contact your tax advisor before election this option.
    - For 2024, you may defer from your wages, a maximum of $22,500 to all 403(b) and 401(k) plans unless you will reach 50 years of age during the year. In that case you will be eligible to contribute an additional $6,500. Deferrals may not exceed 100% of your wages.
- Rollovers – You may also rollover funds from another employer's plan if you receive an eligible rollover distribution. Before you can complete a rollover in this Plan, you must first receive an acceptance authorization before the monies to be applied to your account.

Plan Investment Options
Your contributions to the 403(b) Plan must be made to an investment provider approved by your Employer. (Before enrolling in the Plan, you should first establish an account with one of the Providers listed in this Notice.) Once you have executed an investment contract, you should establish an account through the Plan's web site and create a secure login and password.

Assistance
You may enroll in the Plan or received assistance with these provisions by first contacting one of the Investment Companies listed in this Notice, contacting the Plan's Third Party Administrator, your Employer's Benefit Administrator. Additional information about the provisions and options in your Plan are available by contacting PenServ Plan Services, Inc. at 800-849-4001 or from the Plan's website

RETIREMENT

INVESTMENT PROVIDER OPTIONS		
Provider and Product Name	**Product Type**	**Contact**
American Funds – PenServ	Mutual Funds	American Funds, General Enrollment Phone 800-849-4001
American Fidelity Assurance Company	Annuities	Adam Ashby Phone 970-556-4774 adam.ashby@americanfidelity.com
AXA – Equitable	Annuities	Phone 800-628-6673 www.axaonline.com
Horace Mann Insurance Company	Annuities	Phone 800-999-1030 www.horacemann.com
Variable Annuity Life Insurance Company (VALIC)	Annuities	Phone 800-548-9651 www.valic.com

Third Party Administrator
Pen Serv Plan Services, Inc.
Plan Record-keeper
Phone 800-849-4001
Email 403badministration@pensev.com
Website www.penserv.com
Select Login to Your Account

Employer Benefits Administrator
Montrose County School District
Barbara Murry
Phone 970-252-7915
Email barbara.murry@mcsd.org

ADDITIONAL VOLUNTARY BENEFITS

As a Montrose County School District employee, you also have the ability to purchase additional voluntary insurance products through American Fidelity. Below are the plans available as payroll deductions. If you have questions about or have an interest in any of the products, please call Adam Ashby with American Fidelity at 970-556-4774

- Supplemental Accident
- Supplemental Cancer
- Disability Income Protection
- Life Insurance
- Medical Gap Plan
- Critical Care Plan
- Long Term Care
- 403(b)

PET INSURANCE

Montrose County School District now offers Pet Insurance through Nationwide on a voluntary basis. Eligible veterinary expenses will be reimbursed for accidents, injuries, or illnesses. This plan is offered for dogs and cats. Please contact Nationwide for additional plan details.

PET INSURANCE – NATIONWIDE	
Annual Deductible	$250
Reimbursement	Up to 70%
Maximum Annual Benefit	$7,500
Pre-existing Conditions	Not Included
Accidents and Illnesses	Included
Hereditary and Congenital	Included
Cancer	Included
Dental Disease	Included
Hospitalization or Treatment	Included
Behavioral Treatments	Included
Rx Therapeutic Supplements	Included
24/7 **vet***helpline* ($150 value)	Included
Advertising and Reward	Included
Emergency Boarding	Included
Loss due to Theft	Included
Mortality Benefit	Included

COLORADO – Canine, Mixed Breed Small

Age	MPP 250/70%	MPP 250/50%
0	28.07	21.05
1	23.59	17.69
2	24.06	18.05
3	24.06	18.05
4	25.24	18.93
5	27.60	20.70
6	32.08	24.06
7	34.68	26.01
8	36.80	27.60
9	44.82	33.61
10	50.01	37.51

COLORADO – Canine, Mixed Breed Medium

Age	MPP 250/70%	MPP 250/50%
0	31.58	23.68
1	26.53	19.90
2	27.07	20.30
3	27.07	20.30
4	28.39	21.29
5	31.05	23.28
6	36.09	27.07
7	39.01	29.25
8	41.39	31.05
9	50.42	37.81
10	56.25	42.19

COLORADO – Feline, Domestic Short Hair

Age	MPP 250/70%	MPP 250/50%
0	18.99	14.24
1	16.52	12.39
2	16.02	12.01
3	16.02	12.01
4	16.02	12.01
5	17.18	12.88
6	21.14	15.85
7	22.13	16.60
8	21.80	16.35
9	25.93	19.45
10	30.06	22.54

Discounts

	My Pet Protection
Multi-pet (2-3 pets)	5%
Multi-pet (4+ pets)	10%

How to file a claim

1. Pay for the pet's treatment at the time of service, then send the claim form along with paid invoices:
   Online: my.petinsurance.com **OR** Mail: Nationwide Claims Dept., P.O. Box 2344, Brea, CA 92822-2344
   OR Fax: 714-989-5600 (no cover sheet necessary)
2. Receive eligible reimbursements after meeting the policy's annual deductible

REQUIRED ANNUAL EMPLOYEE DISCLOSURE 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, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	INDIANA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.in.gov/medicaid/ Phone 1-800-457-4584
ALASKA – Medicaid	**IOWA – Medicaid and CHIP (Hawki)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://health.alaska.gov/dpa/Pages/default.aspx	Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: http://dhs.iowa.gov/ime/members/Medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562
ARKANSAS – Medicaid	**KANSAS – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: http://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-500-766-9012
CALIFORNIA – Medicaid	**KENTUCKY – Medicaid**
Website: Health Insurance Premium Payment (HIPP) Program https://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website https://chfs.ky.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**LOUISIANA – 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/ Customer Service: 1-855-692-6442	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
FLORIDA – Medicaid	**MAINE – Medicaid**
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268	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
GEORGIA – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
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	Website: http://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 617-886-8102

REQUIRED ANNUAL EMPLOYEE DISCLOSURE NOTICES

MINNESOTA – Medicaid	PENNSYLVANIA – Medicaid and CHIP
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-services.jsp Phone: 1-800-657-3739	Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx CHIP Phone: 1-800-986-KIDS (5437)
MISSOURI – Medicaid	RHODE ISLAND – Medicaid and CHIP
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
MONTANA – Medicaid	SOUTH CAROLINA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEBRASKA – Medicaid	SOUTH DAKOTA - Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEVADA – Medicaid	TEXAS – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW HAMPSHIRE – Medicaid	UTAH – Medicaid and CHIP
Website: https://www.dhhs.nh.gov//Programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NEW JERSEY – Medicaid and CHIP	VERMONT– Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://dvha.vermont.gov/members/medicaid/hipp-program Phone: 1-800-250-8427
NEW YORK – Medicaid	VIRGINIA – Medicaid and CHIP
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid / CHIP Phone: 1-800-432-5924
NORTH CAROLINA – Medicaid	WASHINGTON – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
NORTH DAKOTA – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Websites: http://dhhr.wv.gov.bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
OKLAHOMA – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
OREGON – Medicaid	WYOMING – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if other states have added premium assistance programs since January 31, 2024 or for more information on special enrollment rights, contact:

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

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

PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512. The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

REQUIRED ANNUAL EMPLOYEE DISCLOSURE NOTICES

REMINDER OF AVAILABILITY OF HIPAA PRIVACY NOTICE

The plans listed previously maintain a privacy policy pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Earlier, you should have received a copy of a privacy notice summarizing the plan's privacy policy. If you would like another copy of the privacy notice, you may contact Human Resources.

PATIENT PROTECTION

The Group Health Plan may require the designation of a primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the carrier 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 the network who specializes in obstetrics or gynecology. The health care professionals, 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, or for information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator or refer to the carrier website.

It is your responsibility to ensure that the information provided on your application is accurate and complete. Any omissions or incorrect statements made by you on your application may invalidate your coverage. The carrier has the right to rescind coverage on the basis of fraud or misrepresentation.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT (CHIPRA) OF 2009

Effective April 1, 2009, a special enrollment period provision is added to comply with the requirements of the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009. If you or a dependent is covered under a Medicaid or CHIP plan and coverage is terminated as a result of the loss of eligibility for Medicaid or CHIP coverage, you may be able to enroll yourself and/or your dependent(s). However, you must enroll within 60 days after the date eligibility is lost. If you or a dependent becomes eligible for premium assistance under an applicable State Medicaid or CHIP plan to purchase coverage under the group health plan, you may be able to enroll yourself and/or your dependent(s). However, you must enroll within 60 days after you or your dependent is determined to be eligible for State premium assistance. Please note that premium assistance is not available in all states.

MEDICARE PART D

This notice applies to employees and covered dependents who are eligible for Medicare Part D.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Simplified Benefits Administrators and about your options under Medicare's prescription drug Plan. If you are considering joining, you should compare your current coverage including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plan (like an HMO or PPO) that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Simplified Benefits Administrators has determined that the prescription drug coverage offered by the Welfare Plan for Employees of Montrose County School District under all plan options is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

You should also know that if you drop or lose your coverage with Simplified Benefits Administrators and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

When can you join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What happens to your current coverage if you decide to join a Medicare drug plan?

If you decide to join a Medicare drug plan, your current Simplified Benefits Administrators coverage will not be affected. You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage.

If you decide to join a Medicare drug plan and drop your current Simplified Benefits Administrators coverage, be aware that you and your dependents may or may not be able to get this coverage back. You will need to speak to your employer.

REQUIRED ANNUAL EMPLOYEE DISCLOSURE NOTICES

When will you pay a higher premium (penalty) to join a Medicare drug Plan?

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

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

For more information about this notice or your current prescription drug coverage…

Contact our office for further information (see contact information below). NOTE: You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Simplified Benefits Administrators changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage…

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

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

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

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date:	10/01/2024
Name of Entity/Sender:	Montrose County School District
Contact:	Barbara Murry
Address:	PO Box 10000 Montrose, CO 81402
Phone Number:	970-252-7915

Procedures for Requesting a Certificate of Creditable Coverage

A "Certificate of Creditable Coverage" is a written certification, provided by any plan that offers medical coverage that confirms the duration and type of your coverage under that plan.

In most cases, you and/or your dependents automatically will receive a Certificate of Creditable Coverage at the time your coverage under the plan ceases. Further, at any time while you are covered under a plan, you may request a Certificate of Creditable Coverage for yourself or for your dependent(s). If your coverage under the plan has terminated, you must make any request for a Certificate of Creditable Coverage within 24 months after the date your coverage ceases. In order to request a Certificate of Creditable Coverage from the MCSD Employee Medical / Simplified Benefits Administrators Plan you must prepare a written request including: Your full name and current address, the full name and address of the individual to whom the Certificate should be sent, if you prefer to receive your Certificate via facsimile, include a secure phone number, the name(s) of the individuals for whom you are requesting Certificates, your employee number or social security number, and the date of coverage termination (if applicable). Submit your request to Simplified Benefits Administrators, Inc. PO Box 21367 Billings, MT 59104-1367

The Plan Administrator will make every effort to provide your Certificate according to your preferred method; however, if any difficulties arise or there is a concern regarding the security of the preferred method, the Certificate will be sent to the address you specify by U.S. First Class Mail. You should receive your Certificate within a reasonable period of time following the date on which your request is received by the Plan. If you have any questions concerning

Certificates of Creditable Coverage, please contact Simplified Benefits Administrators Customer Service, 866-421-9927.

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).

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the Plan deductibles and coinsurance apply. If you would like more information on WHCRA benefits, contact your HR Department.

EMPLOYEE RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

Leave Entitlements

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits and Protection

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave. Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave; * and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

Requesting Leave

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

REQUIRED ANNUAL EMPLOYEE DISCLOSURE NOTICES

GENERAL NOTICE OF COBRA RIGHTS

**** Continuation Coverage Rights Under COBRA****

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

The end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.HealthCare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact listed previously.

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For additional information about the Marketplace, please visit the website www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

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

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

If you are declining enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. However, you must request enrollment within 60 days after you or your dependents become eligible for the premium assistance.

REQUIRED ANNUAL EMPLOYEE DISCLOSURE NOTICES

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

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, such as a copayment, coinsurance, and/or a deductible. You may have other 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" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay 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 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.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). 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 may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

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

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

In Colorado, some patients are protected from surprise medical bills. It is important to know your rights to protect yourself from these bills. If you have insurance through Medicare, Health First Colorado, or are on Veterans Affairs Health Care, you are fully protected from surprise bills. This tip sheet is for people covered under any other type of insurance.

If your insurance plan is regulated by Colorado state law, you are protected from surprise bills in three situations:

1. Emergency treatment by an out-of-network provider.
2. Treatment by an out-of-network provider at an in-network facility without your consent.
3. Emergency transportation by private out-of-network ground ambulances.

If your plan is state-regulated, the card will have "CO-DOI" printed on it. In these three situations listed above, you cannot be charged for anything more than what you would normally owe for in-network treatment. The out-of-network provider should not send you a bill. If you do receive one, you should not pay it. Follow the steps below on "How to fight a surprise bill," and inform your insurer at once.

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

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

Your health plan generally must:

1. Cover emergency services without requiring you to get approval for services in advance (prior authorization).
2. Cover emergency services by out-of-network providers.
3. 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.
4. Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, file a complaint with your insurer. Then file a complaint with the Division of Insurance online or at 303-894-7490. You should also file a complaint with the Colorado Division of Professions and Occupations Medical Board or at 303-894-7800. If you have already paid the bill, notify your provider that you want a refund. The provider is required to send you a refund within 60 days after you notify them.

Visit https://doi.colorado.gov/ for more information about your rights under federal law.

Your Information. Your Rights. Our Responsibilities.

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

Your Rights

You have the right to:

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

Your Choices

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

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

Our Uses and Disclosures

We may use and share your information as we:

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

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

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

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

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

Your Choices

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

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

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

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

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

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

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

Help manage the health care treatment you receive

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

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

Run our organization

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

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

Pay for your health services

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

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

Administer your plan

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

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

How else can we use or share your health information?

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

Help with public health and safety issues

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

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

Do research

We can use or share your information for health research

Comply with the law

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

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

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

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

We can use or share health information about you:

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

Respond to lawsuits and legal actions

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

Our Responsibilities

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

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

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

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2024 for coverage starting as early as January 1, 2024.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.12% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1] Qualified dependents may be eligible for a tax credit if the family premium is more than 9.5% of the household income.

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please contact your HR Department.

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		4. Employer Identification Number (EIN)
Montrose County School District		
5. Employer Address		6. Employer Phone Number
PO Box 10000		970-252-7915
7. City	8. State	9. Zip Code
Montrose	CO	81402
10. Who can we contact about employee health coverage at this job?		
Barbara Murry		
11. Phone Number (if different from above)	12. E-mail address	
	barbara.murry@mcsd.org	

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

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

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

[X] All Employees. Eligible employees are:

All Full Time Employees working at least 18.75 hours and have been employed at least one month.

[ ] Some employees. Eligible employees are:

- With respect to dependents:

[X] We do offer coverage. Eligible Dependents are:

Your Legal Spouse. Your married or unmarried natural children, step-children living with you, legally adopted children and any other children for whom you have legal guardianship, who are under 26 years of age. A dependent who is older than 26 years of age who is medically certified as disabled and dependent on the parent/s.

[ ] We do not offer coverage.

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

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

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

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

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

[X] **Yes** (Continue)

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

[ ] **No** (STOP and return this form to employee)

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

[X] Yes (Go to question 15) [ ] No (STOP and return form to employee)

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

a. How much would the employee have to pay in premiums for this plan? **$** See Page 11

b. How often? [ ] Weekly [ ] Every 2 weeks [ ] Twice a month [ ] Monthly [ ] Quarterly [ ] Yearly

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

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

[ ] Employer won't offer health coverage

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

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

b. How often? [ ] Weekly [ ] Every 2 weeks [ ] Twice a month [ ] Monthly [ ] Quarterly [ ] Yearly

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

QUESTIONS & ANSWERS

What are changes that can be made during Open Enrollment (DATES) and will take effect January 1, 2024?

During Open Enrollment you are able to:
- Change medical plans
- Enroll or terminate individual and/or any level of dependent coverage in medical vision, or dental plans
- Enroll in the FSA plan
- Enroll in the Pre-Tax Insurance Premium plan
- Add or make changes to the Voluntary Life and AD&D plan

What forms need to be completed when enrolling or making changes?

You will need to complete medical and dental enrollment forms when first enrolling in either/both plans. You will need to complete change forms for medical and dental when changing individual and/or and level of dependent coverage. For Voluntary Life and AD&D, you will need to complete enrollment and or medical underwriting forms.

What forms must be completed regardless of enrolling or waiving coverage?

The FSA enrollment form/ direct deposit form must be completed whether enrolling, re-enrolling, or waiving for each current year. The Pre-Tax Insurance form must be completed by everyone in order to elect pre/post tax premium contribution.

Where do I find these forms?

You can contact Human Resources for all forms or visit www.mcsd.org:
- Barbara Murry- barbara.murry@mcsd.org
- Danice Kindall- danice.kindall@mcsd.org

When are the forms due and where do I return them?

All forms are due within 30 days of employment for new hires, and by December 15th for Open Enrollment. Please return all forms to Human Resources.

Who do I contact with questions?

Contact Barbara Murry or Danice Kindall in the Human Resources Department with any questions you may have.

Additional Information:

New elections must be made to FSA's each year to continue participation. If you do not make changes to your current medical, dental and vision elections, those elections will remain the same for the plan year January 1 to December 31, 2024. Additional forms and documentation may be needed for qualifying life events, additional life insurance above guaranteed amounts, and other specific circumstances.