MESA COUNTY VALLEY SCHOOL DISTRICT 51

2022 BENEFITS GUIDE

novo benefits

School District 51
MESA COUNTY VALLEY
Engage, Equip, and Empower

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This Benefits Guide is an overview of the benefits provided by Mesa County Valley School District 51. It is not a Summary Plan Description or Certificate of Insurance. If a question arises about the nature and extent of your benefits under the plans and policies, or if there is a conflict between the informal language of this Benefits Guide and the contracts, the Summary Plan Description and Certificates of Insurance will govern. Please note that the benefits in your Benefits Guide are subject to change at any time. The Benefits Guide does not represent a contractual obligation on the part of Mesa County Valley School District 51.

BENEFIT CONTACTS

PRIMARY POINT OF CONTACT

UMR	**UMR Plan Advisor Team** **Group# 76-412948**	**(800) 207-3172** **www.umr.com**

OTHER CONTACTS

Magellan Rx	**Prescription Benefit Manager (PBM)**	**(800) 424-0472** **www.magellanrx.com**
CHP – Community Health Partnership	**CHP Primary Care Provider Network**	**970-644-4000 or** **http://yourcommunityhospital.com**
Monument Health	**Monument Health Provider Network**	**970-683-5630 or** **https://monumenthealth.net**
UnitedHealthCare Options PPO Network (inside of Colorado)	**PPO In-Network**	**www.umr.com**
PHCS Extended PPO (outside of Colorado)	**PPO In-Network**	**(800) 678-7427** **www.multiplan.com**
Employee Assistance Program (EAP)	**www.triadeap.com** **Login: d51 PW: eap**	**(970) 242-9536** **(877) 679-1100**
Delta Dental	**Dental Group #1727**	**(800) 610-0201** **www.deltadentalco.com**
VSP	**Vision Service Plan** **Group #12064004**	**(800) 877-7195** **www.vsp.com**
Rocky Mountain Reserve	**Flexible Spending Accounts**	**(888) 722-1223** **www.rockymountainreserve.com**
Guardian	**Group #00540961** **Voluntary Insurance** **Accident / Hospital Indemnity / Critical Illness** **Short Term Disability**	**(888) 600-1600** **www.guardiananytime.com**
24/7 Travel Assistance (available for MetLife participants)	**All users are required to set up their Unique profile via the registration process for first time access.**	**(800) 454-3679 Inside the US** **(312) 935-3783 (Collect) Outside US** **www.metlife.com/travelassist**
Mesa County Valley School District 51 Human Resources	**Connie Mack** **Benefits Manager**	**(970) 254-5176** **connie.mack@d51schools.org**
Mesa County Valley School District 51 Human Resources	**Michelle Wilcox** **Benefits Specialist**	**(970) 254-5121** **michelle.wilcox@d51schools.org**

ENROLLMENT GUIDELINES

Welcome to the 2022 Benefits Guide for Mesa County Valley School District 51!
Mesa County Valley School District is committed to providing an environment that promotes a healthy employee population able to serve our students at the highest level. We offer a comprehensive benefits package that includes health, dental, vision, as well as other programs for our eligible employees. This enrollment guide contains important information regarding these benefits, eligibility, and how to enroll. Please take time to review the information. The information contained is only a guide; the benefit decisions are yours. Full plan summaries and plan documents are available in your OnlinEnroll online enrollment portal Library. Printed documents are available upon request.

OnlinEnroll
Please follow the steps on the following pages to access our online benefit portal through OnlinEnroll to enroll in or make changes to your existing medical, dental, vision, life insurance, and other voluntary benefits. If you are happy with your current elections, you are NOT required to re-enroll other than for your Flexible Spending Account or Dependent Care Account.

Eligibility
You are eligible to enroll in the benefits program if you are legally employed, working **20** or more hours per week.

Your legal spouse (and civil union spouse) and your dependent children until the end of the month of their 26th birthday, are eligible for District 51 sponsored benefits.

Unmarried disabled children over age 26 may be eligible to continue benefits if approved.

For Dental, Vision, Life, Supplemental Life, and Guardian Voluntary benefits, Actively at Work Provisions apply, including dependent non-confinement.

Open Enrollment
Open enrollment is once a year and benefit elections will take effect January 1st. The elections you make stay in effect the entire plan year, unless a qualifying life event occurs. Qualified life events are:

- Marriage
- Divorce
- Birth
- Adoption
- Death
- Loss of Coverage

Additional qualifying events under the medical plan:
- Open Enrollment under your Spouses' plan
- Change in work status (part time to full time or full time to part time)

When you have a qualifying event, you have 31 days beginning on the date of the event to complete and return a new enrollment/change form. **This will still be done through Human Resources** (You have 60 days to complete and return a new enrollment/change form after coverage under Medicaid or Children's Health Insurance Program terminates). **There is no open enrollment for any of the Guardian benefits, except for Voluntary Accident and Hospital Indemnity Benefits. If you did not enroll when first eligible, you must submit Evidence of Insurability.**

Premium Payment
When you enroll for benefits, your medical, dental and vision premiums will automatically be set up to be paid using pre-tax dollars. If you prefer your premiums to be paid with after-tax dollars you must specifically elect the after-tax option upon being newly hired or during open enrollment. If an option is not given, contact HR.

GLOSSARY OF TERMS

The following terms will help you better understand your benefits.

Co-pay: A Copay is the portion of the Covered Expense that is your responsibility, as shown in the Medical Schedule of Benefits. A Copay is applied for each occurrence of such covered medical service and is not applied toward satisfaction of the Deductible.

Deductible: A Deductible is the total amount of eligible expenses as shown in the Medical Schedule of Benefits, which must be Incurred by you during any Calendar Year before Covered Expenses are payable under the Plan.

Coinsurance: Coinsurance is the percentage of eligible expenses the Plan and the Covered Person are required to pay.

Out-of-Pocket Maximum (OOPM): An Out-of-Pocket Maximum is the maximum amount you and/or all of your family members will pay for eligible expenses Incurred during a Calendar Year before the percentage payable under the Plan increases to 100%.

PPO (Preferred Provider Organization): This type of plan utilizes network and non-network benefits.

In-Network: The Plan offers a broad network of providers and provides the highest level of benefits when Covered Persons utilize “in-network” providers. These networks will be indicated on your Plan identification card.

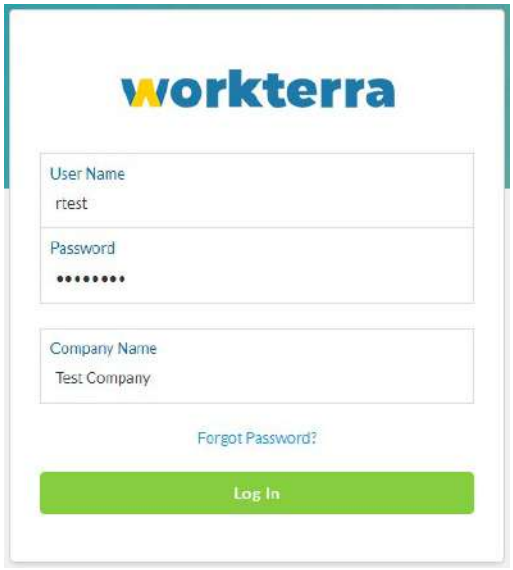
Out-of-Network: Any non-contracted providers. The services from these providers are subject to balance billing, meaning members can be billed for the difference between the insurance carrier's fee schedule and the billed charges.

Employee Self-Service Guide
D51

Workterra is a tool that allows you to directly access and update your employee information via the Internet. Using Workterra employee self-service, you can review and/or update your demographic, dependents, and benefit elections.

- You can access Workterra from any computer with an internet connection. Our secure (https) site uses the latest technology to ensure that the information entered is secure and adheres to Workterra and industry security standards.
- If you are having trouble logging into the site, Workterra Customer Service is here to help with password resets and site technical expertise. Customer Service is available Monday-Friday 8am-5pm Pacific Time 888-327-2770 or customerservice@workterra.com.

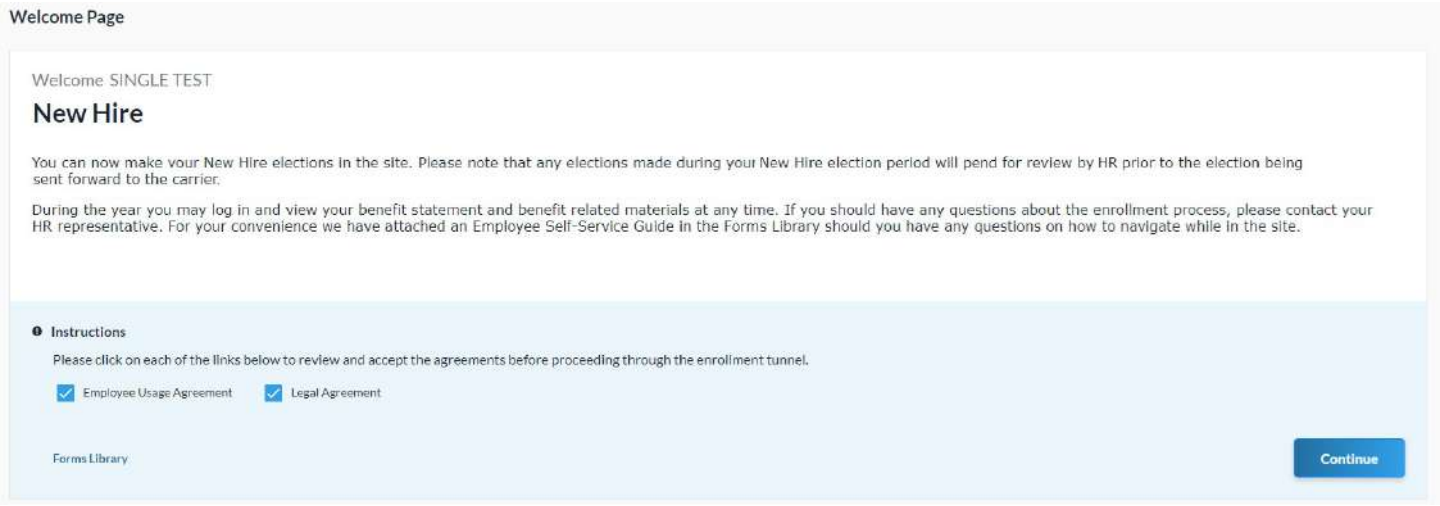
Logging In



1. Launch an Internet browser such as Chrome or Internet Explorer and turn off all “Pop-Up Blockers”.
2. Navigate to https://www.workterra.net
3. Enter the information below and click **Log In**
   - **User name:** Employee ID
     (Example: 12345)
   - **Password:** First 5 of your SSN. Example, 12345
   - **Company:** D51

Note: *if you wish to view the site in SPANISH, click on “Espanol (es-mx)” in the drop down box on the top right of the page.*

Welcome Page



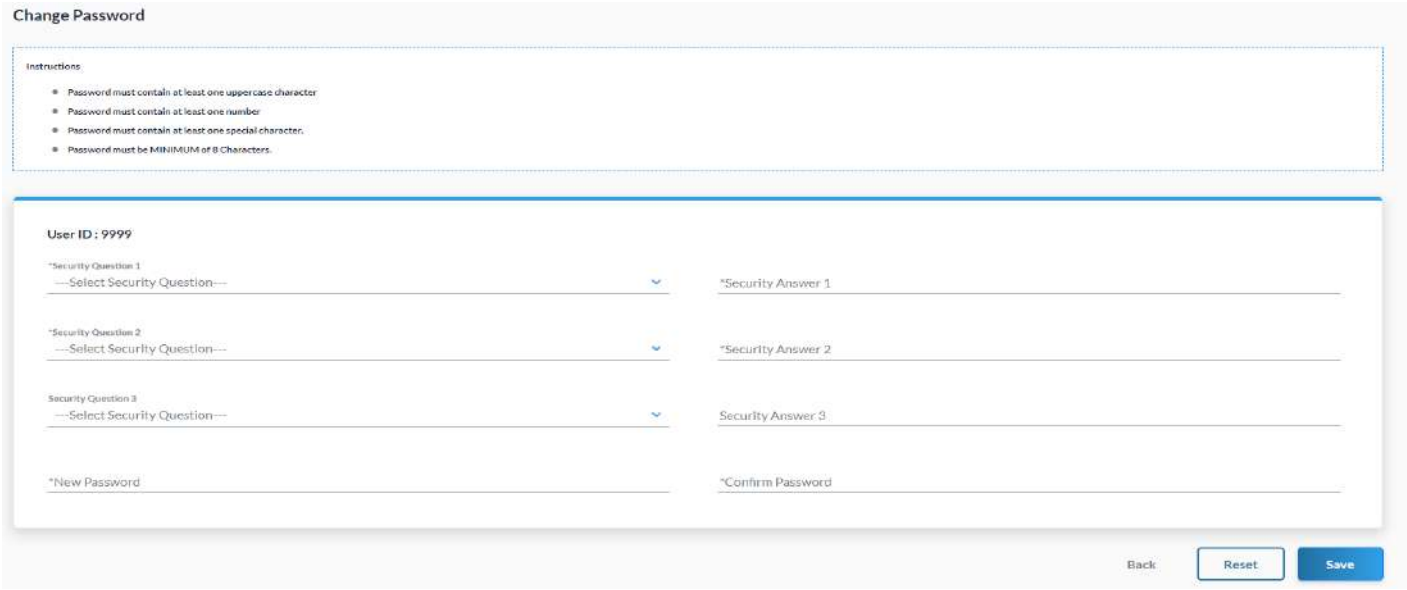
Please read your Welcome Page Information and then click the box next to the **Employee Usage Agreement and Legal Agreement**. Once you have read both, select **Continue.**

Change Password

Please provide your security questions and answers as well as update your password. When finished select **Save** to continue.

Please note your password must be:

- Password must be a minimum of 8 characters.
- Password must contain at least one numeric digit.
- Password must contain at least one special character.
- Password must contain at least one UPPERCASE letter.



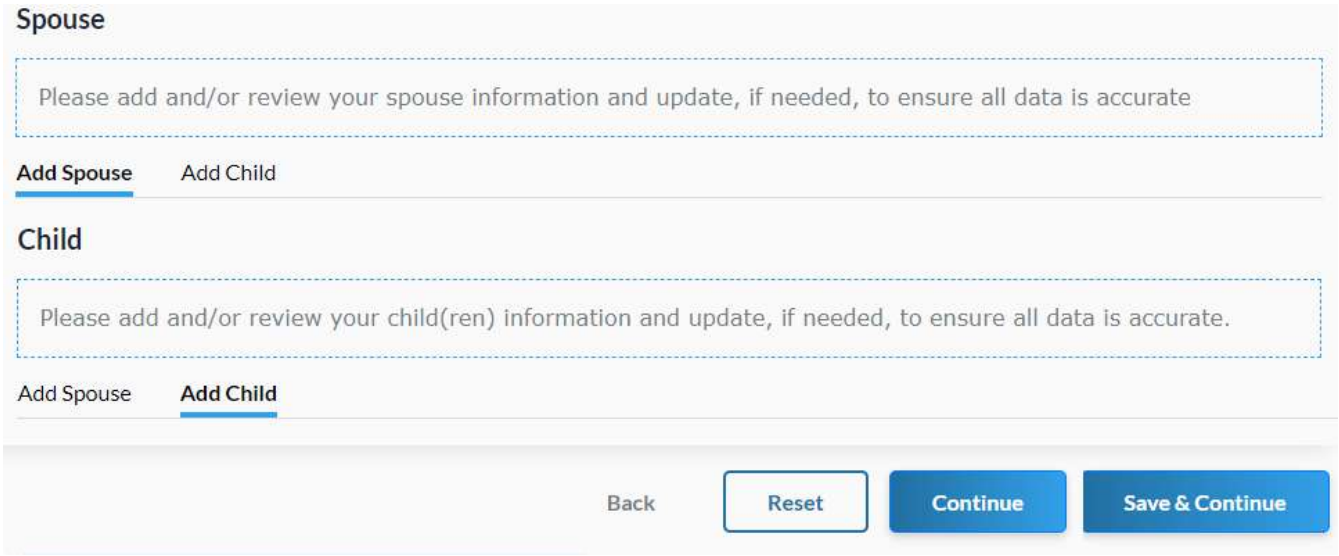
Demographics & Dependents

You will have an opportunity to review, add, or update your demographic, your spouse or child information on the next few pages.

Please note: Grayed out fields are considered "Review Only" fields. Please contact your HR administrator if any changes are needed to these fields.

Please ensure that all dependents that you would like to cover across any benefit (Medical, Dental, Life, Disability, etc…) are entered within these pages.

To add a spouse or child, fill out the required fields and click "**Save & Continue**". The screen will open for you to enter their demographic information (required data is marked with a red indicator).



If you have multiple children, select "**Add Another Child**" adding them one at a time and click "**Save & Continue**" once all are added.

If you do not have a spouse or child, click "Continue" to proceed to the next page.

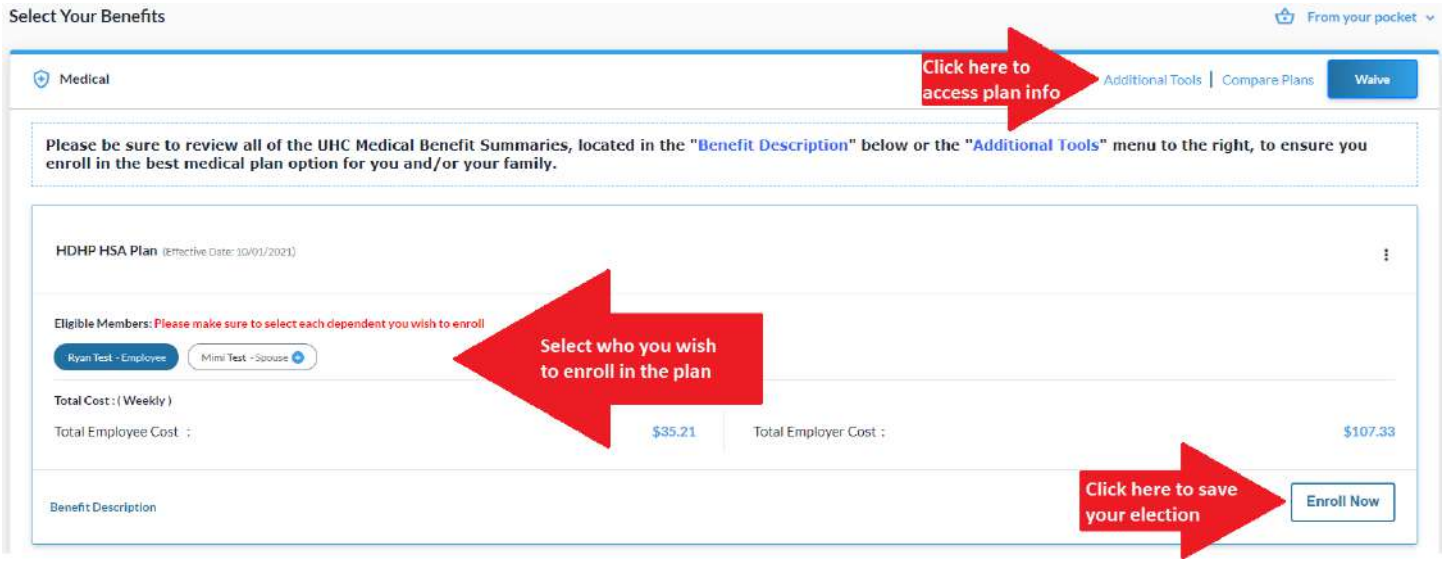
For "**Disabled Children"**, please ensure that you classify the Child Relationship as a "**Disabled Child**" in the Child Relationship box as well as clicking the radial (circle) next to the "**Yes**" in the **Disabled Child** field.

Plan Elections

Follow the steps below to enroll in your benefit plans.
If you do not wish to enroll and would prefer to decline the benefit, select "**Waive**".

Please note that the following are available for additional information to assist you in choosing your benefits.

- **Compare Plans**
  - Click the Compare Plans link to the top right of the screen to open up a side-by-side comparison of the plans offered to you.
- **Additional Tools**
  - Click the Additional Tools link to access Learn about your Health/Income Protections, which may contain links to the plan summaries. The Additional Tools link also houses the Forms Library, which may contain additional benefit information and user guides.

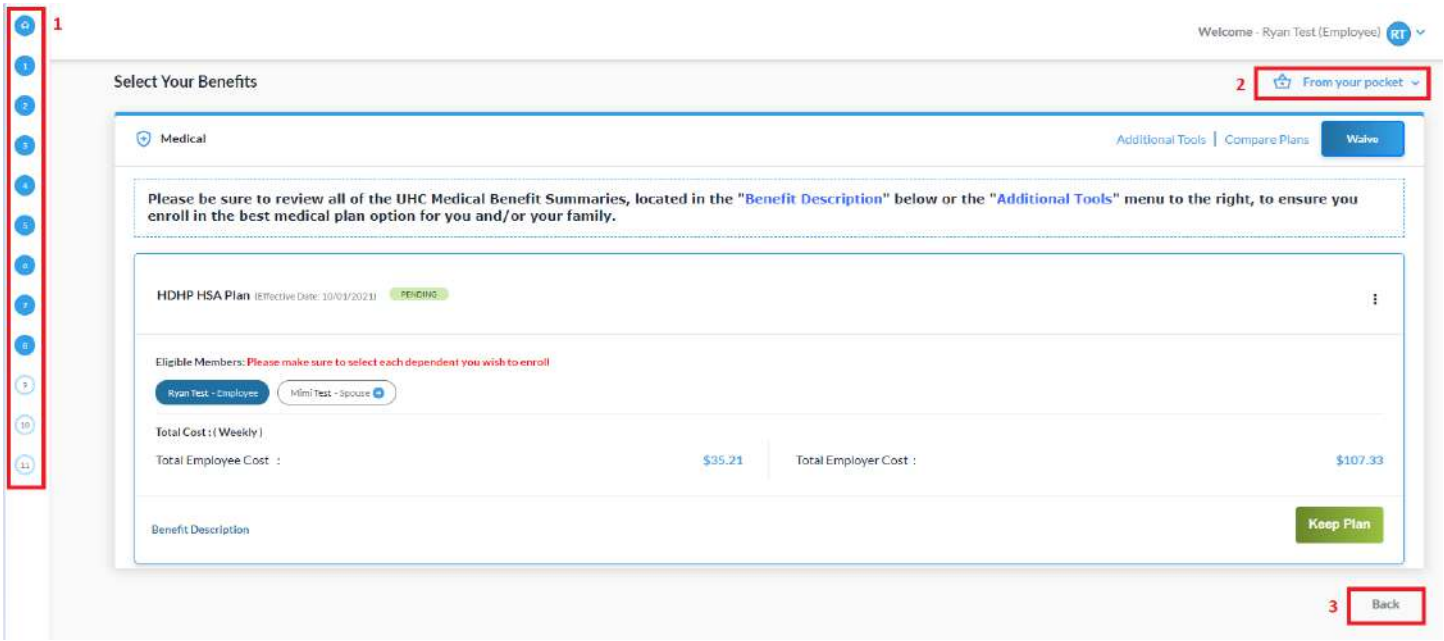


Navigation

Please be sure to use only the navigational buttons provided within the tool. **Do not use your browser's back button**.

You can navigate into previous pages using these three options:

1. The slide out menu bar will allow you to move back to any page that you have previously visited
2. To revisit a plan, you may click on the benefit plan listed in the election summary
3. Use the back button provided by the tool



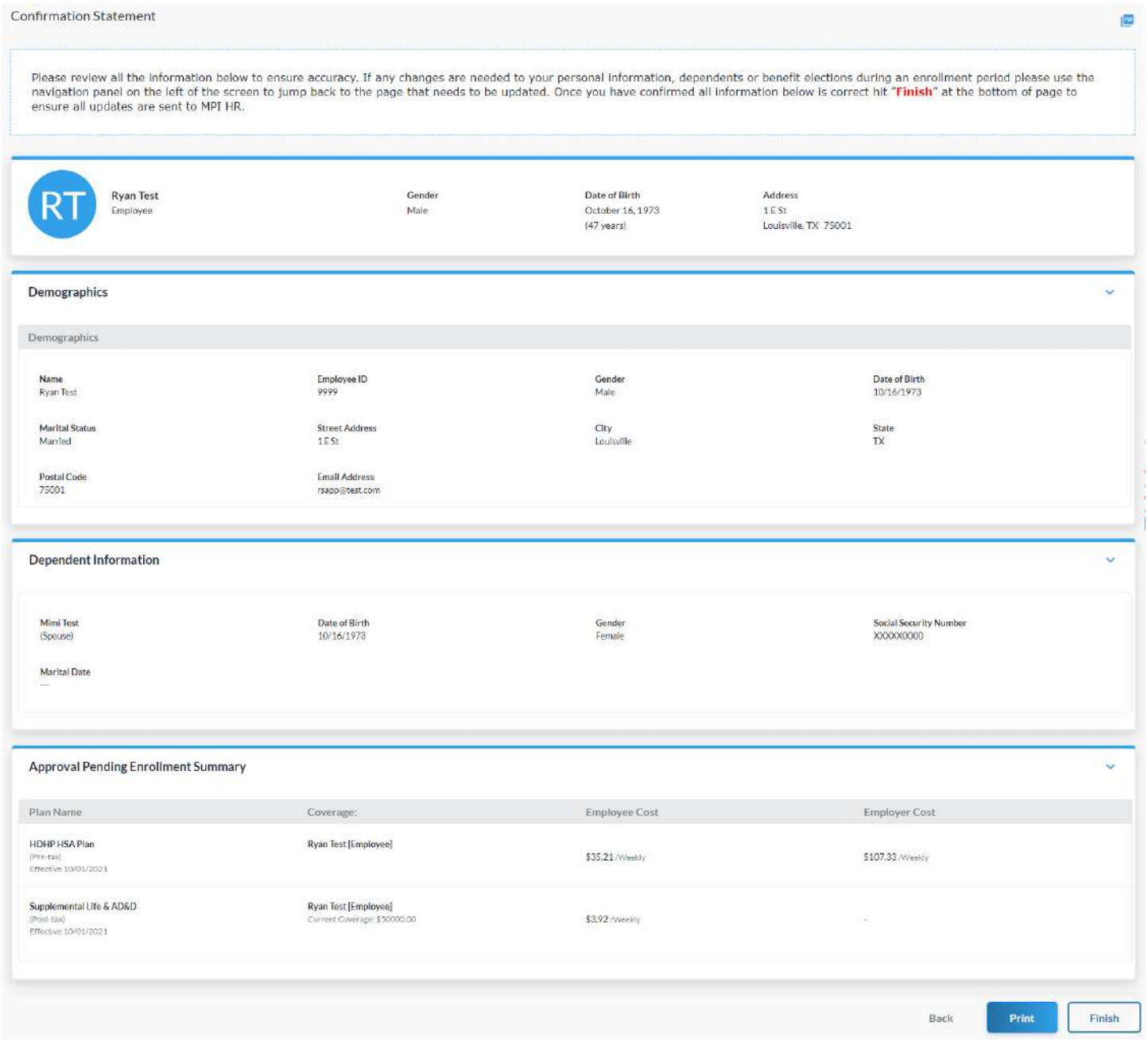
1
2

Completing the Enrollment Process

After completing all of your plan elections, you will come to the Confirmation Statement. Please review all of your elections for accuracy.

Please be sure to keep a copy of the confirmation statement for your records by clicking on the PDF button to download save & print.

Please click “Finish” at the bottom of the page once you have reviewed your elections. Once you click “Finish”, you will be taken to your Employee Home Page. Your enrollment process is now complete.



PREMIUMS

Employee Contributions
Effective January 1, 2022

Community Health Partnership and Monument Health Plan Options	MONTHLY PREMIUM	FULL TIME EMPLOYEE		PART TIME EMPLOYEE	
		DISTRICT SHARE	FULL TIME EMPLOYEE COST	DISTRICT SHARE	PART TIME EMPLOYEE COST
Employee	$746.24	$711.26	$34.98	$355.63	$390.61
Employee + Child(ren)	$1234.69	$711.26	$523.43	$355.63	$879.06
Employee +Spouse	$1492.48	$711.26	$781.22	$355.63	$1136.85
Family	$1940.22	$711.26	$1228.96	$355.63	$1584.59

Premium Payment
When you enroll for benefits, your medical, dental and vision premiums will automatically be set up to be paid using pre-tax dollars. If you prefer your premiums to be paid with after-tax dollars you must specifically elect the after-tax option upon being newly hired or during open enrollment. If an option is not given, contact HR.

Company Couples Benefit
If you and your spouse work for MCVSD51 and are enrolled in the Medical Plan, MCVSD51 will honor the District Share for both of you. Contact HR for more information.

MEDICAL BENEFITS

Mesa County Valley School District 51 offers medical benefits through UMR. This medical plan balances affordability with the freedom to go outside the network. You may choose a participating or a non-participating provider. Participating providers have agreed to provide services at a discounted fee. For out-of-network care, you are responsible for charges above the in-network allowance for the same services, in addition to the deductible and coinsurance. To find a participating provider, visit www.umr.com.

Benefit	In-Network	Out-of-Network
Deductible • Per Person • Per Family - individual "Embedded" Deductible	 $3,000 $6,000 $3,000	 $6,000 $12,000 $6,000
Out-of-Pocket Max **(**Includes deductible, copays, Coinsurance and RX) • Per Person • Per Family - Individual "Embedded" Out-of- Pocket	 $4,500 $9,000 $4,500	 $9,000 $18,000 $9,000
Preventive Care	100% (Deductible Waived) & $300 Deductible Credit*	50% After Deductible
Mammogram - No age restrictions; includes collective ultrasound and readings	100% (Deductible Waived) for Preventive and Diagnostic	50% After Deductible
Colonoscopy – no age restrictions; includes collective readings and anesthesia • 1st of calendar year regardless if preventive or diagnostic • More than 1 in a calendar year	 100% (Deductible Waived) 70% After Deductible	 50% After Deductible 50% After Deductible
Teladoc Visit - NEW	$0 copay	N/A
Primary Care Physician Office Visit (PCP)	$0 copay Affiliated Plan Provider (Deductible Waived) $50 copay Non-Affiliated Plan or UHC Options PPO Plan Provider (Deductible Waived)	50% After Deductible
Specialist Office Visit - NEW	$50 copay (Deductible Waived)	50% After Deductible
Counseling Office Visit: Not part of Clinic	$30 copay (Deductible Waived)	50% After Deductible

***Each covered employee and each covered spouse who completed their annual routine preventive visit in calendar year 2021 receive a $300 deductible credit for calendar year 2022.**

MEDICAL BENEFITS (CONTINUED)

Benefit	In-Network	Out-of-Network
Therapy Services – Maximum of 20 visits per year, unless medically necessary. • Outpatient or Office Visit • Inpatient	 $30 copay (Deductible Waived) 70% After Deductible	 50% After Deductible 50% After Deductible
Chiropractic Services – Maximum of 20 visits per year, unless medically necessary	$30 copay (Deductible Waived)	50% After Deductible
Labs: • CHP and MH Primary Care Select Labs • Physician Office Processing • Facility Processing	 $0 copay $15 copay Up to $100 copay per day	 50% After Deductible 50% After Deductible 50% After Deductible
X-Ray • Physician Office Processing • Facility Processing (including ultrasounds, bone densitometry, holter monitors and other outpatient radiology tests)	 $40 copay Up to $100 copay per day	 50% After Deductible 50% After Deductible
Durable Medical Equipment (including insulin pumps, glucometers and CPAP machines. CGM's are covered under RX)	70% After Deductible	50% After Deductible
Advanced Imaging– (MRI, MRA, PET, CT)	70% After Deductible	50% After Deductible
Inpatient and Outpatient	70% After Deductible	50% After Deductible
Emergency Room • Note – this does not include Advanced Imaging (MRI, MRA, PET & CT) • If Admitted to Facility from the ER	$500 Copay (Deductible Waived) Copay Waived – then 70% After Deductible	
Ambulance	70% After Deductible	
Urgent Care	$25 copay (Deductible Waived)	$150 copay
Maternity Prenatal Delivery and All Inpatient Services	 100% (Deductible Waived) 70% After Deductible	 50% After Deductible 50% After Deductible

PRESCRIPTION BENEFITS

Benefit	In-Network	Out-of-Network
Prescriptions • Generic Rx* • Preferred Rx • Non-Preferred and HCG* Rx • Specialty Rx • Mail Order	 $10 copay $40 copay $75 copay 20% Copay to a max of $200 per fill 90-day supply at 2x retail copay	Not Covered

IMPORTANT CHANGES FOR 2022

Mesa County Valley School District 51 has elected to utilize several cost saving programs offered by Magellan Rx. These prescription formulary programs are intended to provide the most clinically effective medications at the lowest cost to our members and to the District's health plan. Following is a description of each Rx formulary program.

Program Name	Program Description
Brand Wise	Excludes certain *Minimum Value Brand* drugs that bring low clinical value and have many generic alternatives in the class.
Generic Smart	Excludes certain *Minimum Value Generic* drugs that have very low clinical value and have many low cost alternatives within the class.
High Cost Generics (HCG) *	Places certain *High Cost Generics* which have many lower cost alternatives within the therapeutic class at a Non-Preferred Rx Copay*
Precision Formulary	Excludes a small number of *High Cost Brand and Specialty* medications which have lower cost, clinically equivalent alternatives.

Please Note: For any medications that are excluded under the new formulary management programs there are multiple alternatives that fall within the lowest cost Copay tier. If you have any questions about what Copay tier applies to your medication, please call Magellan's customer service line at 800-424-0472.

PLAN GUIDELINES

CHP and Monument Health Plan - Network Provider Organizations	
In-Network Inside Colorado	CHP - Community Health Partnership Providers 970-644-4000 or https://yourcommunityhospital.com/CHP_Participating_Providers.com
	Monument Health Providers 970-683-5630 or https://monumenthealth.net/provider-directory/
	UnitedHealthCare Options PPO https://umr.com
In-Network Outside Colorado	Private Health Care Systems PHCS Healthy Directions Network https://phcs.com 1-855-428-4472

Contact the UMR Plan Advisors Team for assistance in determining the appropriate facility or provider for services. Certain types of services may be paid at the in-network Tier 1 benefit level when performed at another Network facility.

In order to receive benefits, you MUST use a PPO Network Provider. Under special circumstances, listed below, payment will be made for services provided by Non-PPO Network Providers. Under the following circumstances, payment will be made for certain Non-PPO Network Services:

- If a Covered Person has a Medical Emergency requiring immediate care (Hospital Emergency Room and Emergency Room Physician).
- If a Covered Person receives Physician or anesthesia services by a Non-PPO Provider at a PPO Network facility.
- If Non-PPO services are precertified as Medically Necessary because the Covered person has no choice of a PPO Provider.

NOTE: If Non-PPO Network services exceed the Usual & Reasonable Charge, the amount in excess of the Usual & Reasonable Charge is not covered under the Plan.

Preventive Care Services
Includes: Standard Preventive Care, office visits, pap smear, mammogram, prostate screening, gynecological exam, routine physical examination, X-rays, lab tests, hearing tests, vision tests, immunizations/flu shots, tobacco cessation program, colonoscopies, and preventive childcare screening. Coverage also includes all recommended preventive services that have a rating of "A" or "B" from the U.S. Preventive Task Force, recommendations made by the Advisory Committee on Immunization Practices, and guidelines supported by the Health Resources and Services Administration. A current listing of required preventive care can be accessed at: www.HealthCare.gov/center/regulations/prevention.html and http://www.cdc.gov/vaccines/acip/index.html See your plan document for additional details, limitations and exclusions.

Mandatory Specialty Drug Program: Specialty drugs (including specialty diabetic medications) are limited to 31 Day supply at retail and through Magellan Rx's Specialty Pharmacy. Specialty drugs must be filled through Magellan Rx's Specialty Pharmacy. Members taking qualified specialty drugs are asked to participate in the Select Drugs and Products Program. You can reach the Magellan Rx Specialty team at (866) 554-2673.

SELECT DRUGS AND PRODUCTS PROGRAM

At Magellan Rx Management, we are partnering across the industry to provide a connected healthcare experience that truly leads humanity to healthy, vibrant lives. We are dedicated to giving you the best service and resources to help you and your family make better healthcare decisions.

The **Select Drugs and Products ProgramSM** is administered by *paydhealth* and is designed to improve access to specialty drugs. This program will assist you in reducing the cost of your medication by seeking sources of alternate funding for specialty drugs on the Select Drugs and Products List.

You must specifically enroll in the Select Drugs and Products Program in order to take advantage of these benefits. All specialty drugs listed on the Select Drugs and Products List require that you seek prior review and that your case be submitted to alternate funding before your benefit will apply. If you do not participate in the program, you will have a 100% reduction in your payable benefit for specialty medication.

If you are taking a specialty drug, you will be contacted by a Program Case Coordinator. Your Case Coordinator will provide you with further information regarding the Select Drugs and Products Program and walk you through the enrollment process and requirements. If you have any questions regarding the Select Drugs and Products Program, please call the Specialty Contact Center at 877.869.7772 (8:00 a.m. – 8:00 p.m. EST).

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Magellan Rx MANAGEMENT

8 WAYS TO MAKE YOUR BENEFITS WORK FOR YOU

1 **Call UMR Plan Advisors -** 800-207-3172. Advisors are available to help you with all your health care needs including identifying a participating provider, precertification, benefits and claims questions.

2 **Utilize Plan-Specific Primary Care and Pediatric Providers.** Office visits with affliliated CHP or MH primary care providers within your designated plan are free.

3 **Local Hospitals.** Colorado Canyons Hospital & Medical Center, Community Hospital and SCL Health St. Mary's Hospital are all in network on both plans and capture additional savings for the District.

4 **Participate in Prevention.** Each covered employee and each covered spouse that completed their annual routine preventative visit in the prior year receives a $300 deductible credit for the current year. Visits completed in the current year apply to next year's deductible credit.

5 **Clinical Programs.** All affiliated primary care providers have an assortment of services and programs available to support you in your health care journey. More info available in the medical section below.

6 **Urgent Care.** Visits in Urgent Care facilities affiliated with Community Hospital, St. Mary's Medical Center and Colorado Canyons Hospital and Medical Center are available for a $25 copay and capture additional District savings.

7 **Telehealth Visits.** Telehealth services offered by your providers are covered as regular office visits.

8 **Limited Basic Diagnostic Testing at No Cost.** When ordered by an affiliated primary care or pediatric provider in your designated plan and processed in an affiliated facility, the following tests are available at no cost to you: Comprehensive Metabolic Panel, Lipid Panel, Urinalysis, A1C, PSA, TSH, CBC, Strep Culture, and Pap Test.

DID YOU KNOW

All mammograms and the first colonoscopy of the plan year are covered at 100%. No age restrictions apply. Applicable for Preventative or Diagnostic/Therapeutic.

Contact your Primary Care Provider to get yours ordered today!

School District 51
MESA COUNTY VALLEY
Engage, Equip, and Empower

MEDICAL PLAN DESIGNS

Community Health Partnership

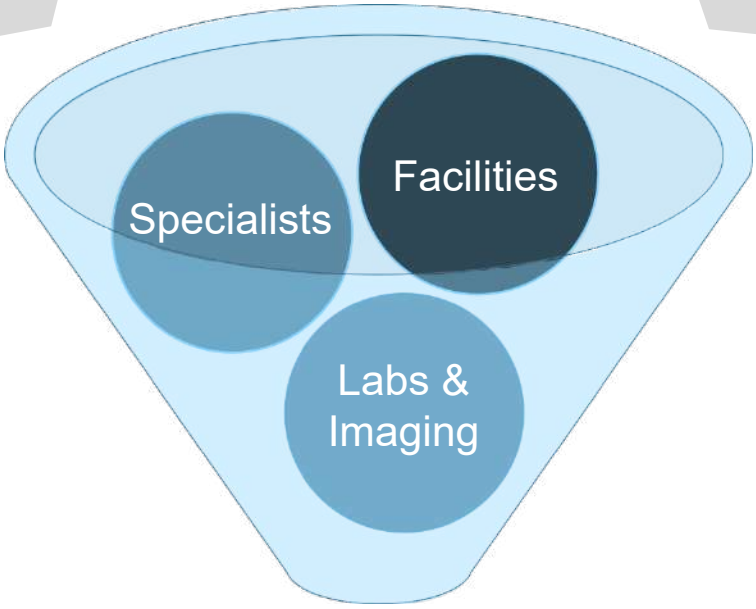
Monument Health

Community Health Partnership
Affiliated Primary Care Providers

$0 Copay Visits
Unique Clinical Services

Monument Health
Affiliated Primary Care Providers
$0 Copay Visits
Unique Clinical Services

Visits to primary care providers affiliated with the other plan are a $50 Copay



All United Healthcare Options PPO Network Providers

Note: The only difference between the Medical Plans are the primary care provider groups and their unique clinical services.

PRIMARY CARE PROVIDERS

Community Health Partnership

Community Medical Group Practices:
Fruita Family Medicine of the Grand Valley
Grand Valley Primary Care
Internal Medicine Associates of the Grand Valley
Grand Valley Pediatrics

Grand Junction Family Medicine

Juniper Family Medicine

Western Medical Associates

Western Valley Family Practice

Dino-Peds

Monument Health

Primary Care Partners Practices:
Western Colorado Physicians Group
Western Colorado Pediatric Associates
Tabeguache Family and Sports Medicine
Family Physicians of Western Colorado
Red Canyon Family Medicine

SCL Health Western Colorado Primary Care Practices:
St. Mary's Family Medicine Residency Clinic
SCL Health Medical Group - Patterson
Foresight Family Physicians

Western Valley Family Practice

Dr Lu Family Medicine

Dino-Peds

Delta Health Internal Medicine
Delta Health West Elk Hotchkiss
Delta Health Family Medicine
Delta Health West Elk Paonia
Delta Health Pediatrics

Surface Creek Family Medicine

PRIMARY CARE
UNIQUE CLINICAL PROGRAMS

Community Health Partnership Plan

Diabetes Medication Incentive Program (District Paid)
Health Coaching (District Paid)
Behavioral Health Services
Lifestyle Medicine Program
Diabetes Education
Nutrition Education

Monument Health Plan

Smoking Cessation Programs
Chronic Condition Management Programs
Behavioral Health Services
Nutritional Coaching
Stress Management
Substance Use and Addiction Programs
Chronic Pain Management
Integrated Pharmacy Services

FREE CLINICAL TESTS

Tests must be ordered by Affiliated Primary Care Provider and processed in aligned or owned local lab facility. (CHP to affiliated primary care provider labs or Community Hospital owned lab facilities; MH to affiliated primary care provider labs or SCL Health owned lab facilities)

Test Name	CPT Code
Comprehensive Metabolic Panel	80053
Lipid Panel	80061
Urinalysis U/A	81000,81001,81002,81003
Glycosylated Hemoglobin Test (A1C)	83036,83037
Prostate Specific Antigen	84153
Thyroid Stimulating Hormone (TSH)	84443
Complete Blood Count (CBC)	85025
Strep Culture/Confirm	87075,87081,87880
Pap Test	88142

PRE-CERTIFICATION

Before you receive certain medical services or procedures, your health plan requires a doctor to confirm that these requested services are considered medically necessary under your plan. This verification process is called "pre-certification." Even if some services or therapies are performed in your doctor's office, you may still need a pre-certification. Pre-certification requests must be submitted by your physician directly to UMR, follow the instructions on the back of your ID card.

Services Requiring Precertification			
Inpatient Hospitalizations & Skilled Nursing Facility Admissions	Home Health Care and Services	Oncology Care & Services (chemotherapy, radiation therapy, etc.)	MRI's, MRA's and PET Scans
Hospice Care	Dialysis	Transplants – Organ and Bone Marrow	Durable Medical Equipment (DME) over $1500
Out-Patient Surgeries (includes Colonoscopies)	Genetic Counseling	Mental Health Intensive Out-patient and Partial Hospitalization	
• A $500 penalty will be applied for all services rendered that do not have pre-certification completed.			

Get all your answers ***quick*** and ***easy*** @ **umr.com**

UMR
A UnitedHealthcare Company

Make umr.com your first stop

You want managing your health care to be fast and easy, right? You got it. At umr.com, you'll find everything you want to know – and need to do – as soon as you log in.

No hassles. No waiting. Just the answers you're looking for anytime, night or day!

Log in now to:

- View **My taskbar**, your personalized benefits to-do list
- Check your benefits and see what's covered
- Look up what you owe and how much you've paid
- Find a doctor in your network
- Learn about medical conditions and your treatment options
- Access tools and trusted resources to help you live a healthier life

WANT A QUICK TOUR?
Use the QR code reader on your smart phone to watch a short video.

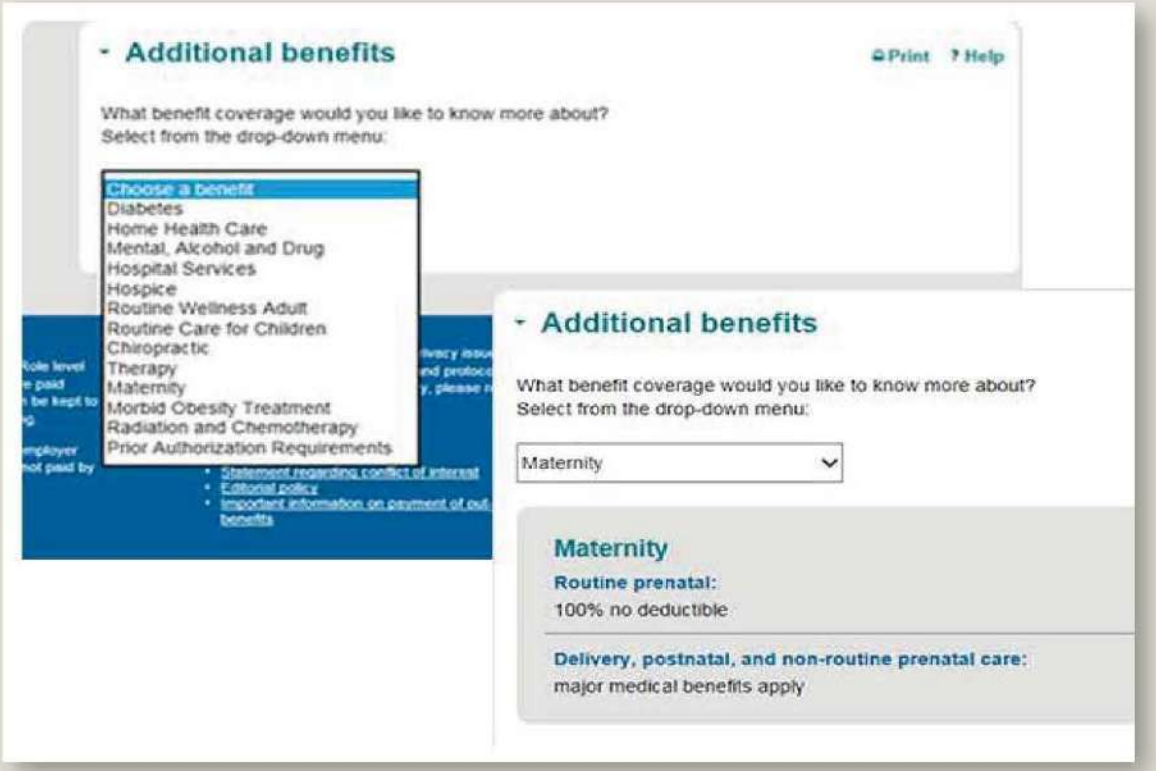
Note: *The images shown reflect available features within our desktop site. These features may or may not be available to all users, depending on your individual and/or company benefits.*

You don't need a Ph.D. to understand your benefits

We've made it easy to find the top things people want to know. Choose **Benefits & coverage** from myMenu to find out:

- What health care services are covered?
- What's the cost difference between an in-network and out-of-network service?
- What's your deductible, and are you close to reaching it?
- Is there a copayment for your office visit? If so, how much?

Get your answers at a glance on umr.com



Fictionalized data

Glossary

abc

Still confused about what a deductible is?

Just click the glossary tile shortcut on the member home page to find common health care terms (including benefit terms) defined in plain, clear language.

Fictionalized data

Did your dog eat your ID card?

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

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

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

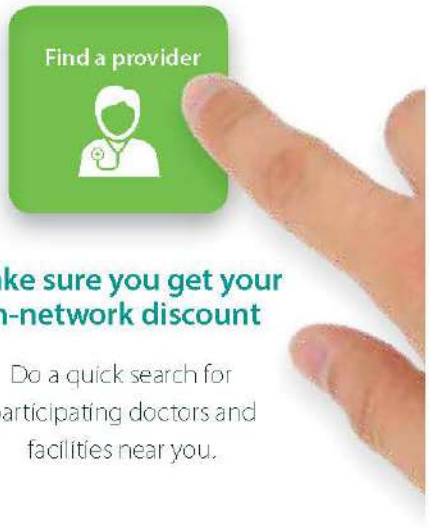
Don't be surprised by unexpected costs

Know the price you'll pay ahead of time

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

Quickly see what you spent on health care this year

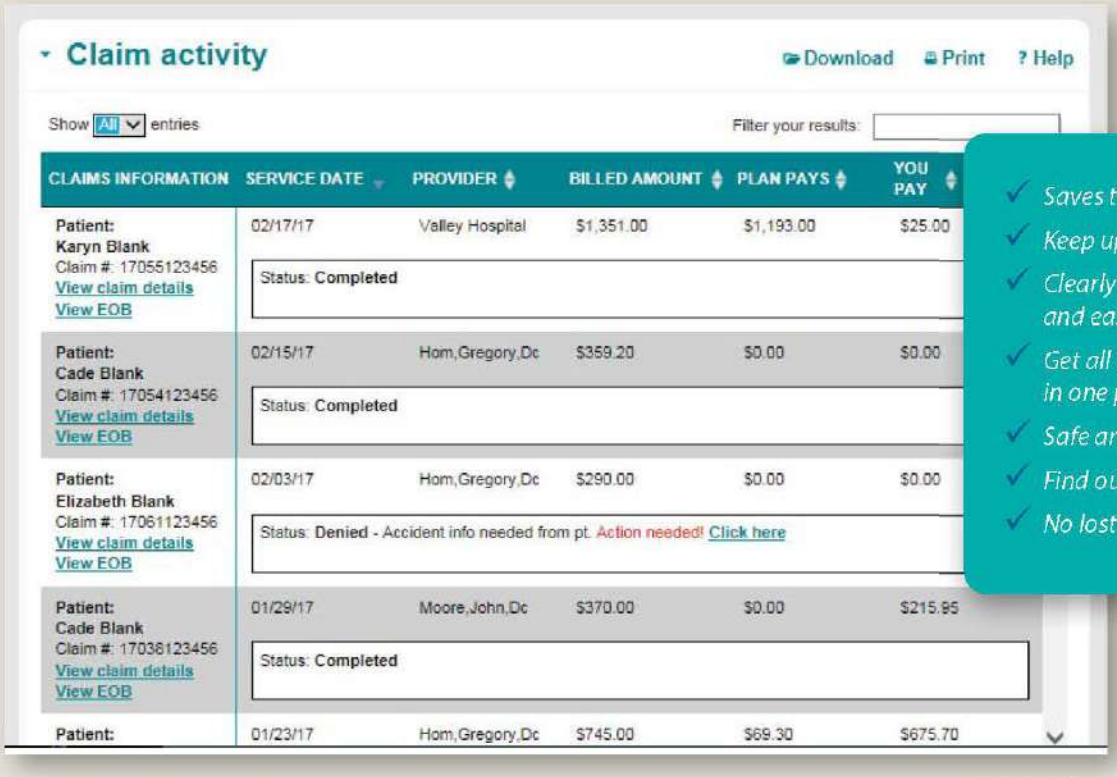
Get a breakdown by the types of services, so you can see where all your money went.



Make sure you get your in-network discount

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

Buried in paperwork?
A single click lets you track all your claims



Claim activity — Download | Print | ? Help

Show All entries — Filter your results:

CLAIMS INFORMATION	SERVICE DATE	PROVIDER	BILLED AMOUNT	PLAN PAYS	YOU PAY
Patient: Karyn Blank Claim #: 17055123456 View claim details View EOB	02/17/17	Valley Hospital	$1,351.00	$1,193.00	$25.00
	Status: **Completed**				
Patient: Cade Blank Claim #: 17054123456 View claim details View EOB	02/15/17	Hom,Gregory,Dc	$359.20	$0.00	$0.00
	Status: **Completed**				
Patient: Elizabeth Blank Claim #: 17061123456 View claim details View EOB	02/03/17	Hom,Gregory,Dc	$290.00	$0.00	$0.00
	Status: **Denied** - Accident info needed from pt. Action needed! Click here				
Patient: Cade Blank Claim #: 17038123456 View claim details View EOB	01/29/17	Moore,John,Dc	$370.00	$0.00	$215.95
	Status: **Completed**				
Patient:	01/23/17	Hom,Gregory,Dc	$745.00	$69.30	$675.70

- ✓ *Saves time - no waiting!*
- ✓ *Keep up-to-date- 24/7*
- ✓ *Clearly organized and easy to sort*
- ✓ *Get all the details in one place*
- ✓ *Safe and secure*
- ✓ *Find out what you owe*
- ✓ *No lost paperwork*

Fictionalized data

Hassle-free access when you need it

Check in at your convenience to see if a claim has been processed and what you might owe. To get more details on a specific claim, click view claim details or view EOB. This will tell you the type of services provided, the amount billed and the amount paid, if any, and whether there's any action that needs to be taken before the claim can be processed.

You can choose to receive a secure e-mail any time you have a new EOB. And if you're not ready to give up paper completely, you can print out copies from our claims center.

Helpful apps, calculators, videos and health information all in one place

Online health information: up-to-date and ad-free

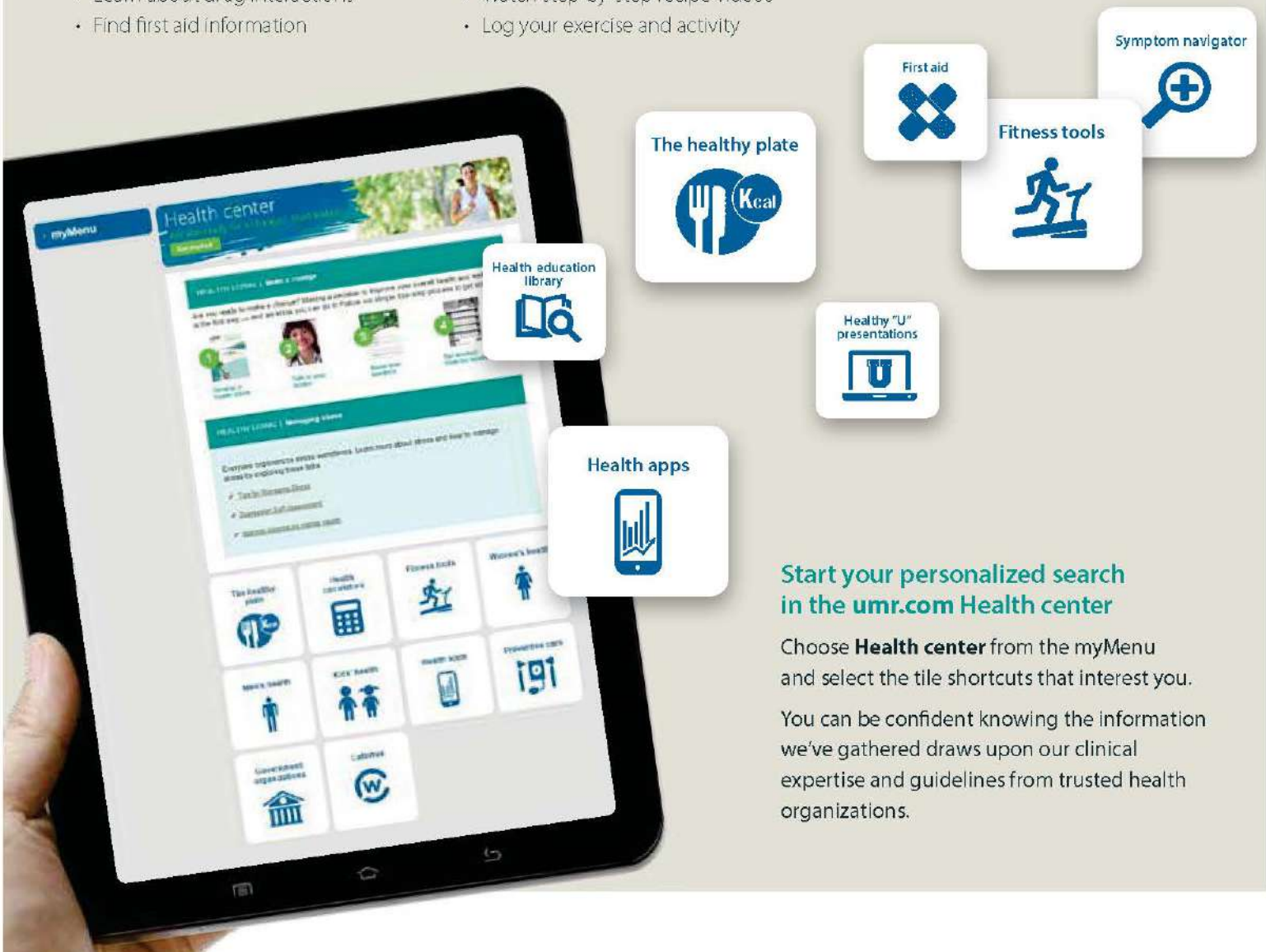
- Search your health symptoms
- Understand your treatment options
- Learn about drug interactions
- Find first aid information

Our top picks for healthy eating and exercise

- Get the essentials on men's, women's & kids' health
- Watch step-by-step recipe videos
- Log your exercise and activity

Free tools, apps and calculators

- Calculate your body-mass index (BMI)
- Download apps to help you stay healthy
- Track your nutrition and fitness goals



Start your personalized search in the umr.com Health center

Choose **Health center** from the myMenu and select the tile shortcuts that interest you.

You can be confident knowing the information we've gathered draws upon our clinical expertise and guidelines from trusted health organizations.

Logging in is easy

Ready to pop in and take our site for a spin? Visit **umr.com** on your desktop or tablet device. If you already have an account, simply click the **Login/Register** button in the upper-right corner.

If it's your first time visiting us, click the **Login/Register** button in the upper-right corner to open an account. Make sure you have your ID card handy and follow the steps to get started.

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YOUR PLAN ADVISOR

Ready to connect – and guide you to the answers you seek

Health care in the modern world calls for a sensitive, personal approach to service – one that's built on real relationships and trust.

Which is why Plan Advisor delivers an experience that's beyond traditional models of member support. Our advisors partner with you so you feel more confident in the decisions you make about your health, and comforted by the steps you're taking to get there.

Because we all need a person we can rely on.
Let your Plan Advisor be yours.

Connecting you to the care you need

Whether your question is common or complex, we make it easier for you to get answers by ensuring you have the information you need.

Keeping it real

Your plan advisor is an actual person who's focused on serving you, equipped with knowledge and options to support and anticipate your unique needs and goals.

We're in it with you

If you need something that's out of our reach, we'll connect you to the resources your need – and we'll even stay on the call as long as you need.

Dedicated to **YOU**

To connect with your Plan Advisor, call the number on the back of your member ID card.

Plan Advisor
Your personal guide to all things health care

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VISIT US ANYTIME ONLINE AT UMR.COM

Sign up for online services and get quick and easy access to your claims and benefit information.

With **umr.com**, you can:

- Look up network providers
- Check your claims activity
- Review your financial activity
- Find tools for improving your health

You can even log in on the go with your smart phone or mobile device.

We're ready when you are

Here are some of the ways we can help:

Finding the right fit is important. We can help

Finding the right provider can feel daunting. We'll match you to high-quality health care providers and the highest level of benefits – right where you live – to avoid paying more than you need to. We can schedule appointments with providers, and identify possible health screenings or preventive care.

Know your coverage – and costs

Navigating health care can be tricky, which is why no question is a bad one. Your plan advisor is ready to go over your benefit details with you, or connect you to the right person to find the answer you need, so you won't be caught by surprise.

We'll help you:

- Look into a recent medical claim to make sure it was paid correctly
- Check to see what your out-of-pocket costs are for services
- See how much you have paid – and how much you have left – of your individual or family deductible
- Understand reward programs available to you
- Discover what services are available to you based on your plan

Let's talk

Our plan advisors are available weekdays from 7 a.m. to 7 p.m. Central time. During off hours or weekends a representative can assist you with claims or benefits questions, and your plan advisor can follow up during the regular business hours.

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UMR CARE

A valuable part of your medical benefits

Few things in life are more important than the health of you and your family. Fortunately, you have UMR CARE on your side to help you understand all your medical care options.

UMR CARE has a staff of experienced, caring nurses (RNs) who help you get the most out of your health plan benefits. They work with you, your doctors and other medical advisors to get the services that best meet your needs.

Our expert CARE nurses can guide you before, during and after your medical care. They will listen to your concerns, answer questions and explain your options.

Helpful support in any situation

Whether you're having a baby, have an emergency hospitalization or need non-emergency care, our CARE nurses are there for you.

For example, we can assist you during a hospital stay, after you are released and with your home care. You can concentrate on getting well knowing your CARE nurse will review your progress with your doctor.

As an added bonus, our services can save you money and prevent delays in your medical claim processing.

You will also learn about quality medical services and become a more informed health care consumer.

Here for you in times of crisis

Hopefully, you or a family member never experience a serious injury or long-term illness. But if you do, we will have UMR CARE nurses on the case at no cost to you.

In fact, we call them CARE nurse managers. They will assist with your medical care and treatment by:

- Helping negotiate treatment from the beginning of your care to recovery
- Helping you look at treatment needs and options under the direction of your doctor
- Serving as your advocate with your benefits administrator
- Providing an understanding of any complex issues to your claims payer
- Helping you better understand your health benefits

Questions

If you have questions about your CARE benefits or upcoming health care services, call UMR CARE at the phone number provided on your member ID card.

IMPORTANT NOTE...

Your doctor remains solely responsible for decisions concerning your medical treatment and care.

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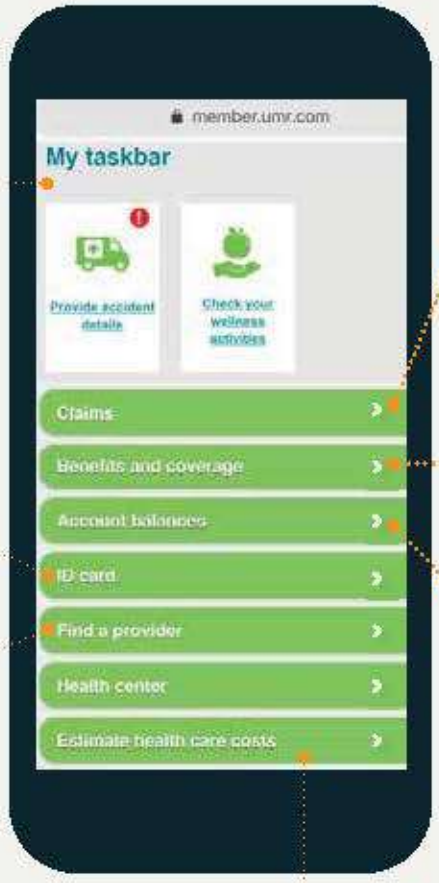
Welcome to
umr.com on the go

As a UMR member you can access your benefits and claims information anytime, anywhere using your mobile device. There's no app to download. Simply log in to **umr.com**

My Taskbar
View upcoming tasks right from the homepage.

Share your ID card with your provider
Now, there's no need to carry it with you, it's at your finger tips

Find a provider
Find an in-network provider while you are "**on the go**."



Look up claims
Look up a claim for yourself or an authorized dependent.

Check your benefits
View medical/dental benefits. And, see who's covered under your plan.

Access account balances
Look up balances for your special accounts including HRAs and FSAs.

Estimate health care costs
See what you can expect to pay before receiving care with the Health Cost Estimator tool.

Want to bookmark umr.com on your mobile device?

iPhone: Touch and hold the open book icon to add **umr.com**

Android: Tap on the menu. Then select "Add Bookmark."

Note: The images above reflect available features within our mobile site. These features may or may not be available to all users depending on your individual and company benefits. If you are having trouble accessing or logging into our mobile site, contact the 800 number on the back of your ID card for fastest service. You can click the 'Contact us' link on the home screen.

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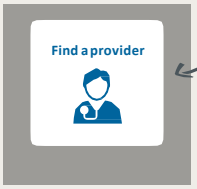
Find a provider

Finding a network provider on umr.com has never been easier

1 Go to **umr.com** and select **"Find a provider"**



2 Search for **UnitedHealthcare Options PPO Network** using our alphabet navigation or type **UnitedHealthcare Options PPO** into the search box

Find a provider on-the-go using our umr.com mobile site

continued on back »

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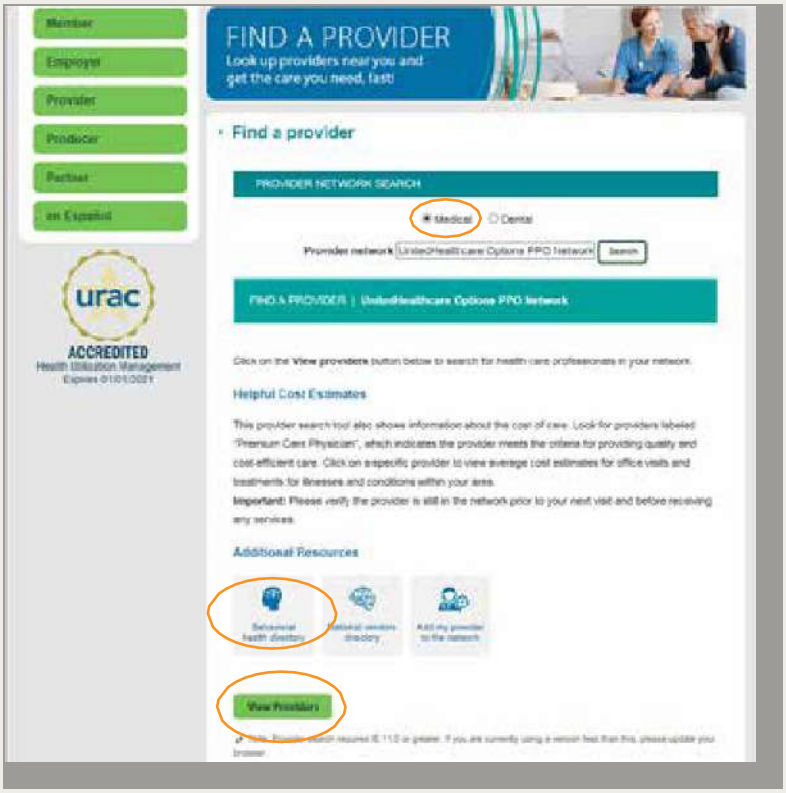
REMEMBER:
Get the most from your benefit plan – use participating network health care providers whenever possible.

3 For medical providers, choose **View Providers**. For behavioral health providers (including counseling and substance abuse), select **Behavioral health directory**.



UnitedHealthcare Options PPO:

The UnitedHealthcare online provider directories include network hospitals, primary physicians and specialists. The following information is available:

- Provider name, address and phone number
- Hospital affiliation
- Board certification
- UnitedHealth Premium® Quality & Cost Efficiency designations that highlight physicians by quality of care and cost standards in their specialty
- Average costs for care in your area and how different providers compare to the local average
- Provider ID number
- Office language capabilities (English, Spanish, etc.)
- Map and directions to each office

WHAT IS TELEMEDICINE & TELEHEALTH?

With the onset of Covid-19, telehealth has become an increasingly popular way for individuals to receive medical treatment and diagnosis without visiting a physical, clinical location such as a doctor's office or hospital.

Telemedicine and telehealth are sometimes used interchangeably to describe both clinical and non-clinical interactions with health professionals through technology. While telemedicine focuses on remote clinical assistance, telehealth also includes educational and non-clinical remote interactions through the use of various technologies such as webcams, apps, and mobile devices.

Telemedicine and telehealth provide options for meeting virtually with a healthcare provider when you are not feeling well. Using technology and apps, it is now easier than ever to meet with a physician from your home, office, or while traveling. Additionally, physicians are available outside of normal business hours and on weekends.

Meeting with a doctor through an app like Teladoc or Doctor on Demand is very similar to visiting your primary care physician in an office, except your interactions with the physician are through your mobile device. The doctor can give you a diagnosis based on your symptoms and even provide a prescription that can be picked up from your local pharmacy.

You can contact a doctor at any time using this benefit and there is no need to contact your Plan Advisor prior to using this service. We recommend you download the app to your phone now so that you can use this option when needed. More information is available on the next page.

24/7 doctor visits via phone or mobile app

Teladoc gives you round-the-clock access to U.S. board-certified doctors, from home or on the go. Call or connect online or using the Teladoc mobile app for affordable medical care, when you need it.

Talk to a doctor anytime, anywhere you happen to be

Receive quality care via phone, video or mobile app

Prompt treatment, median call back, in 10 minutes

A network of doctors that can treat every member of the family

Prescriptions sent to pharmacy of choice if medically necessary

Teladoc is less expensive than the ER or urgent care

Talk to a doctor anytime!

visit **Teladoc.com**
or call
1-800-Teladoc

Get the care you need

Teladoc doctors can treat many medical conditions, including:

- Cold & flu symptoms
- Allergies
- Pink eye
- Respiratory infections
- Sinus problems
- Skin problems
- And more

With your consent, Teladoc is happy to provide information about your Teladoc visit to your primary care physician.

TELADOC

MONTHLY DENTAL & VISION PREMIUMS

Delta Dental Plan

Delta Dental Plan	Employee Monthly Premium
Employee	$37.04
Employee + 1	$63.03
Family	$111.63

VSP Vision Plan

VSP Vision Plan	Employee Monthly Premium
Employee	$9.91
Employee + Spouse	$18.75
Employee + Children	$17.35
Family	$29.08

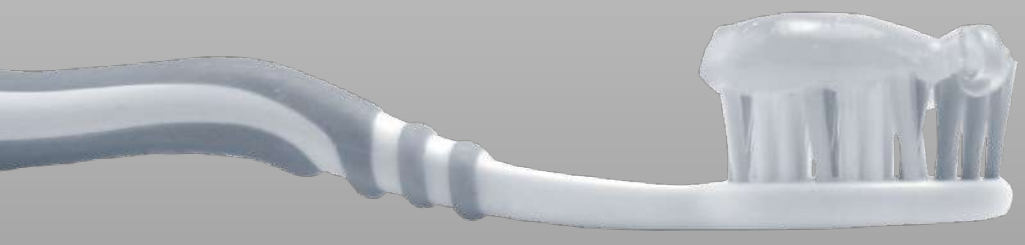
DENTAL BENEFITS

Mesa County Valley School District 51 offers voluntary dental benefits through Delta Dental. This dental plan balances affordability with the freedom to go outside the network. You may choose a participating or a non-participating provider. This Summary of Dental Plan Benefits should be read in conjunction with your Certificate of Insurance which will provide you with additional information about your Delta Dental plan, including information about plan exclusions and limitations. To find a participating provider, visit www.DeltaDentalco.com.

DENTAL PLAN	In-Network	Out-of-Network
Deductible per Calendar Year	$50/single $100/family	
Calendar Year Maximum	$1,500/person	
Preventive Services • Oral exams – 2 per calendar year • X-rays • Cleanings – 2 per calendar year • Sealants – thru age 14 • Fluoride Treatment – thru age 15	100% deductible waived	
Basic Services • Fillings • Simple Extractions • Complex Oral Surgery • Endodontics (Root Canals) • Periodontics (Gum Disease Treatment)	80% after deductible	
Major Services • Denture Repair/Reline/Rebase • Prosthodontics (Dentures, Bridges) • Special Restorative (Crowns, Inlays, Onlays) • Implants	50% after deductible	
Orthodontia (children only to Age 19) Lifetime Maximum	50% deductible waived $1,500	

There are three levels of dentists to choose from:

PPO Dentist:	Payment is based on the PPO dentist's allowable fee, or the actual fee charged, whichever is less.
Premier Dentist:	Payment is based on the Premier Maximum Plan Allowance (MPA), or the fee actually charged, whichever is less.
Non-Participating Dentist:	Payment is based on the non-participating Maximum Plan Allowance. Members are responsible for the difference between the non-participating MPA and the full fee charged by the dentist
Right Start 4 Kids	Covers children up to their 13th birthday at 100% with no deductible (for the same services outlined in the plan, up to the annual maximum, and subject to limitations and exclusions). The child must see a Delta Dental PPO or Premier Provider to receive the 100% coinsurance. If an out-of-network provider is seen, the adult coinsurance levels will apply. Orthodontics is not covered at 100%.



DELTA DENTAL®

The Right Start for a Bright Future
Right Start 4 Kids℠ from Delta Dental of Colorado

100% COVERAGE*

NO DEDUCTIBLE

IN-NETWORK PROVIDERS

HEALTHY SMILES & BRIGHT FUTURES

Did you know that cavities are the most chronic childhood disease? Cavities are five times more common than asthma. Children with pain from tooth decay typically miss more school and have lower grades than their peers, not to mention the lost work hours for parents. But cavities are nearly 100% preventable, and it's easy to protect your child's oral health and ensure better overall health.

RIGHT START 4 KIDS (RS4K) FROM DELTA DENTAL OF COLORADO is a unique plan design enhancement that removes most of the cost barriers to dental care by providing coverage for children up to their 13th birthday at 100% coinsurance for diagnostic & preventive, basic, and major services, with no deductible, when in-network providers are seen.* **If an out-of-network provider is seen, the adult coinsurance levels will apply.** Orthodontic services are available but are not eligible for the RS4K 100% coverage level.

Want to learn more about your child's oral health and why it's so important to take care of it from an early age? Go to the Oral Health & Wellness page on our website at www.deltadentalco.com/wellness.aspx.

*Right Start 4 Kids is subject to limitations, exclusions, and annual maximum. Check your benefits booklet for specific plan coverage as it varies from group to group.

deltadentalco.com

VOLUNTARY VISION BENEFITS

Mesa County Valley School District 51 offers voluntary vision benefits through VSP. The vision plan through VSP provides access through a national network including both private practice and retail chain providers. To find a participating provider, visit www.vsp.com.

BENEFITS	In-Network	Out-of-Network (Reimbursement)
WellVision Exam		
• Once every 12 months	$15 Copay	Up to $45
• Digital Retinal Exam - **NEW**	Up to $39 additional Copay	N/A
Lenses		
• Single Vision	$15 copay	Up to $30
• Polycarbonate Lenses (dependent children only)	$15 copay	N/A
• Lined Bifocal	$15 copay	Up to $50
• Lined Trifocal	$15 copay	Up to $65
• Standard Progressive	Included	Up to $50
• Premium Progressive	$95 - $105 additional copay	N/A
• Custom Progressive	$150 - $175 additional copay	N/A
• Frequency	Once every 12 months	Once every 12 months
Lens Options		
Tint (Solid or Gradient)	$0 Copay	Up to $5
Photochromic - **NEW**	$0 Copay	N/A
Frames	Included in Prescription Glasses Copay	Up to $70
Allowance Based on Retail Pricing	$140 allowance for a wide selection of frames $160 allowance for featured frame brands 20% savings on the amount over your allowance $75 Costco & **Walmart** frame allowance (**NEW**)	
Frequency	Once every 12 months	Once every 12 months
Contact Lenses (In Lieu of Glasses)	No Copay / $140 allowance every 12 months	Up to $105
Lens Fitting & Evaluation **- NEW**	Maximum $60 Copay	N/A
Medically Necessary	Covered 100%	Up to $210
Frequency	Once every 12 months	Once every 12 months
LightCare - **NEW**	Members without a need for prescription eyewear can use their LightCare benefit to purchase ready-made non-prescription blue light filtering glasses or ready-made non-prescription sunglasses. When they select this option, both their frame and lens benefits will be exhausted for the year.	N/A
PREMIER PROGRAM	Maximize your coverage with bonus offers and additional savings that are exclusive to Premier Program locations (located on VSP.com)	N/A

Note: When using a non-network provider, the participant pays the full fee to the provider, and VSP reimburses the customer for services rendered up to the maximum allowance after the application of the applicable copay. All receipts must be submitted at the same time.

Coverage with a participating retail chain may be different. Visit VSP.com for details

VSP DISCOUNTS: HEARING AIDS

TruHearing® is making hearing aids affordable by providing exclusive savings to all VSP® Vision Care members. You can save up to 60% on a pair of hearing aids with TruHearing pricing. What's more, your dependents and even extended family members are eligible, too.

In addition to great pricing, TruHearing provides :

- Three provider visits for fitting, adjustments, and cleanings
- 45-day trial
- Three-year manufacturer's warranty for repairs and one-time loss and damage
- 48 free batteries per hearing aid

Plus, with TruHearing you'll get:

- Access to a national network of more than 6,000 licensed hearing aid professionals
- Straightforward, nationally fixed pricing on a selection of more than 90 digital hearing aids in 400 styles
- Deep discounts on replacement batteries shipped directly to your door

Best of all, if you already have a hearing aid benefit from your health plan or employer, you can combine it with this program to maximize the benefit and reduce your out-of-pocket expense.

Learn more at: truhearing.com/vsp

How it Works:

1. **Call TruHearing.** Call 877.396.7194. You and your family members must mention VSP.
2. **Schedule Exam.** TruHearing will answer your questions and schedule a hearing exam with a local provider.
3. **Attend Appointment.** The provider will make a recommendation, order the hearing aids through TruHearing, and fit them for you.

Learn more about this VSP Exclusive Member Extra at vsp.truhearing.com or, call 877.396.7194 with questions.

vsp Vision care for life

PUT YOUR EYES AT EASE WITH VSP LIGHTCARE

WHY UV AND BLUE LIGHT COVERAGE?

Even if you don't wear prescription glasses, an annual eye exam is an easy and cost-effective way to take care of your eyes and overall health.

With VSP LightCare™, you can use your frame and lens benefit to get non-prescription eyewear from your VSP® network doctor. Sunglasses or blue light filtering glasses may be just what you're looking for.

KEEP YOUR EYES PROTECTED OUTDOORS AND IN:

Always wear sunglasses outdoors. Protect your eyes from the sun's ultraviolet rays that can damage your corneas and cause eye related diseases like cataracts. 100% UVA and UVB protection is the best choice for your sunglasses.[2]

Wear blue light filtering glasses indoors to combat digital eye strain. Digital screens and fluorescent lighting emit blue light that can contribute to headaches, blurred vision and sore eyes—all possible symptoms of digital eye strain.

PROVIDER CHOICES YOU WANT

PREMIER PROGRAM

Visionworks

The VSP Premier Program includes thousands of private practice doctors and over 700 Visionworks® retail locations nationwide.

eyeconic®

Prefer to shop online?

At Eyeconic.com, you'll be shopping at the preferred online retailer for VSP members where you can connect and use your benefits.[3]

vsp® Vision care for life

YOUR LIGHTCARE COVERAGE WITH A VSP NETWORK DOCTOR*

EYE EXAM
A fully covered comprehensive WellVision Exam®[1].

EYEWEAR
Visit a VSP network doctor and choose either prescription eyewear coverage, or use your frame and lens allowance toward ready-to-wear:

- non-prescription sunglasses *or*
- non-prescription blue light filtering glasses

*Register and log in to **vsp.com** to review your benefit information. Based on applicable laws; benefits may vary by location.

Questions? vsp.com | 800.877.7195

1. Less any applicable copay **2**. American Academy of Ophthalmology **3.** To find out whether your employer participates in Eyeconic, log into vsp.com to check your vision benefits.

Classification: Public

EMPLOYER-PAID LIFE INSURANCE

Life Insurance Amount	2x Basic Yearly Earnings, rounded to the nearest $1,000, to a maximum benefit of $250,000 (earnings are updated August 1 each year and benefits are recalculated based on those earnings)
Reduction Schedule	Benefits will reduce by 35% at age 70; and to 50% of the original amount at age 75
Conversion	If your insurance terminates because you are no longer employed full-time, all or part of your insurance may be converted to an individual policy if you apply within 31 days of termination. Conversion does not require proof of medical insurability.
Accelerated Benefits	If you become terminally ill with a life expectancy of 12 months or less, you may elect to receive a portion of your life insurance benefit up to 80% in advance. Upon death, your beneficiary will receive the balance of your benefit.
Travel Assistance	Travel Assistance is a valuable benefit that is provided and administered by AXA Assistance USA, Inc. through an arrangement with MetLife. This service offers you and your dependents medical, travel, legal, financial and concierge services, 24 hours a day, 365 days a year, while traveling internationally or domestically. With one quick toll-free phone call to the alarm center, you will receive assistance in obtaining the help you need through more than 600,000 pre-qualified providers worldwide. Please visit www.metlife.com/travelassist to set up your unique profile via the registration process for first time access.
GRIEF COUNSELING & WILLS CENTER	You and your dependents have 24/7 access to a work/life counselor. Sessions can either take place in person, or by phone. You can have 5 face-to-face sessions per event. Additional assistance from research specialists is also available at the same toll-free number –and at no cost. These specialists can refer funeral planning services and providers as well as offer additional helpful information such as locate back-up care for children or elderly; locate cemetery options, identify monument and headstone vendors; locate funeral homes in your area; obtain cost estimates, services offered, and planning options; and identify other service providers such as florists, caterers and hotels. **www.willscenter.com** **1-888-7819** **VISIT: METLIFEGC.LIFEWORKS.COM** **User Name: MetLifeAssist Password: support**

VOLUNTARY SUPPLEMENTAL LIFE INSURANCE

Your employer provides you with Basic Term Life and Accidental Death & Dismemberment insurance coverage in the amount of 2x earnings to a maximum of $250,000. You may purchase additional amounts as follows:

For You	$10,000 increments, to the lesser of $500,000 or 5x earnings.
For Your Spouse	$5,000 increments to the lesser of 50% of employee selection or $100,000
For Your Dependent Unmarried Children	Life: 15 days to age 26 – increments of $1,000 to $10,000 AD&D: Live Birth to age 26 equal to Life Benefit if elected

*Guarantee Issue Amounts	
Employee	$150,000
Spouse	$ 25,000
Children	$10,000

*You may purchase up to the guarantee issue amount when you are first eligible, without underwriting. If you waive voluntary life insurance, then any amounts you elect in the future will be subject to evidence of insurability and you might be declined coverage. **For Employee Coverage, if you elect a minimum of one increment when you are first eligible, you will be able to increase your life amount by one increment each year, no questions asked, until you reach the guaranteed issue amount shown. (only available for employees)**

You can elect Life Insurance with AD&D or Life Insurance without AD&D. There is no age-reduction schedule on voluntary life. Includes waiver of premium, accelerated benefit, and portability.

	Employee Cost per $1,000 Benefit	Spouse Cost per $1,000 Benefit
< 29	.037	.031
30 - 34	.047	.035
35 - 39	.061	.045
40 - 44	.089	.062
45 - 49	.142	.097
50 - 54	.219	.152
55 - 59	.331	.292
60 - 64	.454	.547
65 - 69	.857	1.394
70 +	1.403	2.765
AD&D/$1,000	.014	.017
Child(ren) Life / $1,000 (includes all children)		0.134
Child(ren) AD&D/$1,000		0.05

Sometimes you can feel lost or overwhelmed

WE CAN HELP YOU FIND YOUR WAY

EMPLOYEE **ASSISTANCE** PROGRAM

Mesa School District 51 provides you and your family with Triad's Employee Assistance Program that can help you turn it around. You now have four free, confidential counseling sessions per year per incident to help you:

- Enhance relationships
- Conquer stress & depression
- Improve anxiety
- Overcome grief, loss, trauma
- Improve workplace relations
- Balance work and home life
- Feel better; sleep better
- Trounce addictions
- Tackle legal or financial challenges

School District 51
MESA COUNTY VALLEY
Achieving Monumental Success

Triad
EMPLOYEE ASSISTANCE PROGRAM

CALL toll-free to speak live with a consultant.

PHONE: **970-242-9536**

TOLL-FREE: **877-679-1100**

LOG ON to your employee support website to access articles, tips, links, and tools.

www.triadeap.com
USERNAME: **d51**
PASSWORD: **eap**

E-MAIL Triad EAP to request assistance.

info@triadeap.com

ASK your HR or benefits manager about additional programs available to you and your family.

FLEXIBLE SPENDING ACCOUNTS – JAN 1 THROUGH DEC 31, 2022

Flexible Spending Account
The Health Flexible Spending Account allows you to set aside up to $2,750 in pre-tax dollars to pay most out-of-pocket medical, dental or vision expenses, including deductibles and copayments, eyeglasses, dental and orthodontic work not covered by insurance.

You decide how much to deposit into your account. Your election amount is evenly deducted pre-tax from your paycheck throughout the plan year. When you have an expense that qualifies, you pay the bill, submit a claim, and you are reimbursed with tax-free dollars from your account.

If you don't use all the money you deposited in your account, you will forfeit any balance in the account at the end of the plan year. You have 90 days after the plan year ends to submit claims for expenses incurred during that plan year. Note: If you don't use all the money you deposited in your account, you may **roll-over up to $550** to use in the following plan year.

Dependent Care
The Dependent Care account allows you to set aside tax-free income to pay for qualified dependent care expenses, such as day care, that you would normally pay with after-tax dollars. Qualified dependents include children under age 13 and/or dependents who are physically or mentally unable to care for themselves. If your spouse is unemployed or doing volunteer work, you cannot set up a dependent care account. You must meet one of the following criteria in order to set up this account:

- *You and your spouse both work;*
- *You are the single head of household;*
- *Your spouse is disabled or a full-time student.*

Each calendar year the IRS allows you to contribute the following amounts, depending on your family status:

- *If you are single, the lesser of your earned income or $2,500*
- *If you are married, you can contribute the lowest of*
    - *Your (or your spouse's) earned income*
    - *$5,000 if filing jointly or $2,500 if filing separately*

Once Enrolled, You May Not Change Your Election
You cannot change your annual election after the beginning of the plan year. However, there are certain limited situations when you can change your elections if you have qualified change in status.

Accessing Your FSA Funds

Claim Submission -
Participants may file requests for reimbursement directly to Rocky Mountain Reserve through fax, mail, e-mail, mobile application, or by uploading them directly through the participant website. Disbursements are issued by **check** or **direct deposit**. Claim Forms and Direct Deposit Authorization Forms are online at **www.RockyMountainReserve.com**.

Fax: (866.557.0109) **E-mail:** claims@rmrbenefits.com **Mail:** PO Box 631458 Littleton, CO 80163

FLEXIBLE SPENDING ACCOUNT ELIGIBLE EXPENSES

ELIGIBLE EXPENSES
These are only examples, and this list is not all-inclusive – it only provides some of the more common expenses. Additional information is available in IRS Publication 502.

Common Eligible Medical Expenses:
- Eyeglasses, eye exams, sunglasses
- (prescription)
- Over-the-counter drugs
- Menstrual care products
- Eye surgery
- Fertility enhancement
- HMO expenses
- Hearing aids, batteries, and exams
- Hospital services
- Immunizations, vaccines, flu shots
- Laboratory fees
- LASIK eye surgery
- Medicines (prescribed)
- Obstetric services
- Optometrist
- Orthodontia
- Prescription drugs
- Psychiatric care
- Psychologist
- Speech therapy
- Stop smoking programs
- Surgery/operations
- Therapy
- Vasectomy
- Wheelchair
- X-rays

Dual Purpose Expenses That Potentially Qualify:
The expense *must* be for a specific medical reason and be accompanied by a prescription.
- Vitamins
- Supplements
- Massage therapy
- Herbal supplements
- Natural medicines
- Aromatherapy
- Weight-loss program
- Health club dues

Health Care Reform & Over-the-Counter Items:
Over-the-Counter Medicine and Drugs do not require a prescription to be eligible for reimbursement under the plan.

- Allergy medications
- Antacids
- Anti-diarrhea medicine
- Bug-bite medication
- Cold medicine
- Cough drops and throat lozenges
- Diaper rash ointments
- Hemorrhoid medication
- Incontinence supplies
- Laxatives
- Muscle/joint pain products/rubs
- Nicotine medications, gum, patch-es
- Pain relievers
- Sinus medications, nasal sprays, nasal strips
- Sleep aids
- Wart removal medication
- Band-aids/bandages
- Cold/hot packs for injuries
- Condoms
- Contact lens solutions
- Diabetic supplies
- First aid kits
- Medical alert bracelets/necklaces
- Pregnancy test kits
- Thermometers

Ineligible Expenses:
- Cosmetic surgery
- Long term care
- Hair transplant/re-growth
- Maternity clothes
- Nutritional supplements
- Personal use items: such as toiletries, cotton swabs, toothbrush, toothpaste, facial care, shampoo
- Teeth whitening
- Drunk driving classes

Dependent Care Eligible Expenses:
- A dependent receiving care must be a child under the age of 13, or a tax dependent unable to provide for their own care, who resides with you. The care must be necessary for you or your spouse to be gainfully employed or to go to school. Care may be provided by anyone other than your spouse or your children under the age of 19. Expenses for schooling, kindergarten, over-night care, and nursing homes are not reimbursable. See IRS Publication 503.

- The maximum you can elect, in a calendar year, is equal to the smallest of the following:

- $5,000 – Married and filing federal taxes jointly or a single parent
- $2,500 – Married and filing separate federal tax return

- The amount contributed year-to-date, is available for reimbursement.

AVAILABLE VOLUNTARY BENEFIT OPTIONS:

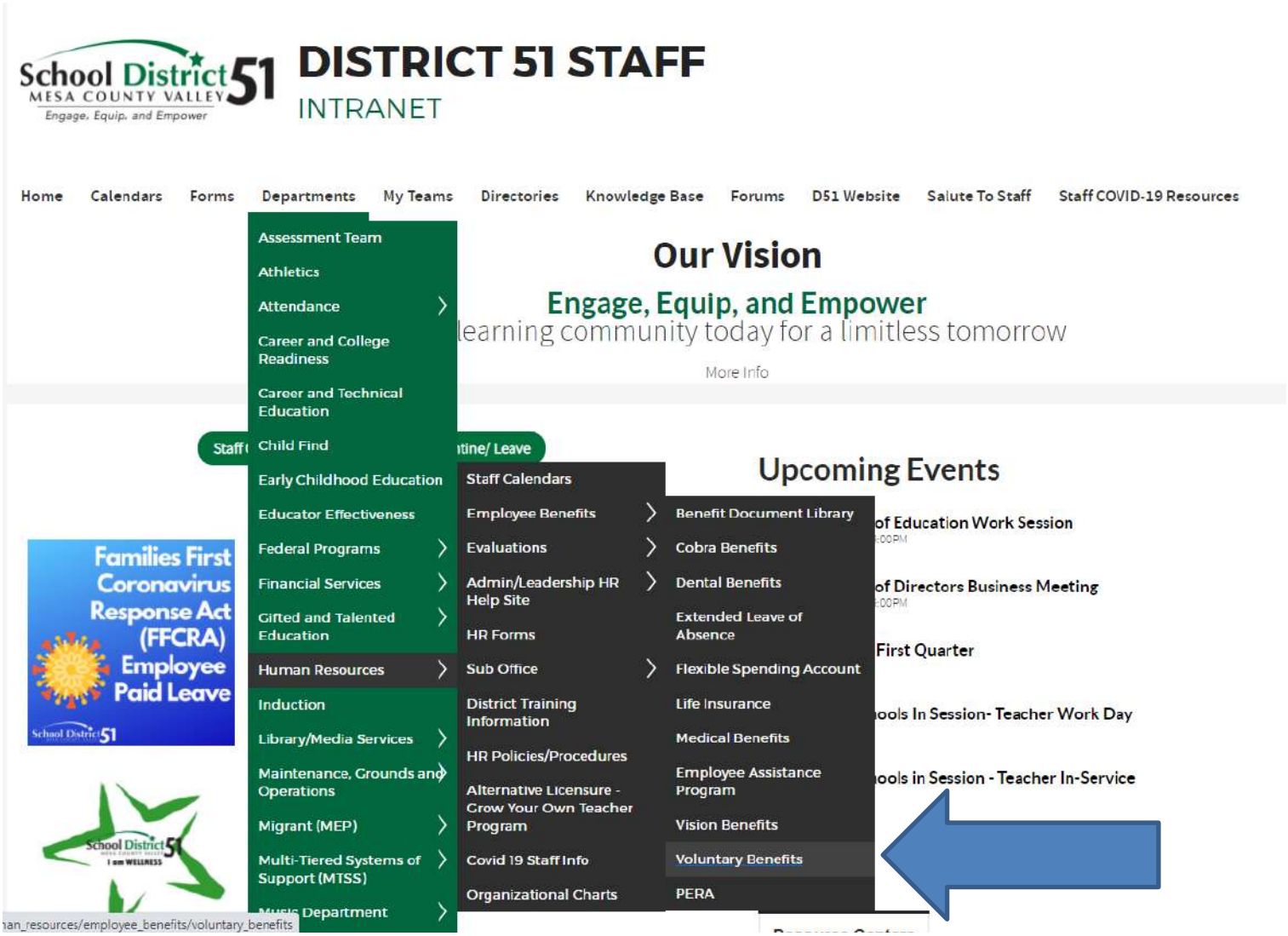
Accident – Pays a cash benefit directly to you in the event of a serious injury, including organized sports injuries for your children.

Hospital Indemnity – Pays a fixed cash payment to you when you are admitted to a hospital or ICU.

Critical Illness – Provides lump-sum cash payment for a range of conditions including Cancer, Heart Disease, and Organ Failure. In addition, it covers other conditions that are not included under the Aflac plans including Parkinson's, Huntington's Disease, ALS, and Alzheimer's disease, to name a few.

Short-Term Disability – Provides income replacement when you cannot work full time due to a disability. You elect the amount of insurance you want, up to a maximum, and total disability is not required.

For more information on each option, go to:
District 51 Staff site/ Departments / Human Resources / Employee Benefits / Voluntary Benefits



GUARDIAN®

IMPORTANT NOTICES

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 or your dependents in this plan if you or your dependents lose eligibility for that other coverage, or if the employer stops contributing towards your or your dependents' other coverage. However, you must request enrollment within 31 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). To be eligible for these Special Enrollment rights you must have completed a waiver when you were first eligible stating that you were declining because of other group health insurance coverage.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. In the case of marriage, eligible individuals must submit their enrollment forms prior to the Effective Dates of coverage in order for salary reductions to have preferred tax treatment from the date coverage begins.

Women's Health & Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, benefits under this Plan are provided for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). If you are receiving benefits in connection with a mastectomy, benefits are also provided for the following Covered Charges, as you determine appropriate with your attending Physician: 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; and Prostheses and treatment of physical complications of the mastectomy, including lymphedema. The amount you must pay for such Covered Charge (including Copayments and any Deductible) are the same as are required for any other Covered Charge. Limitations on benefits are the same as for any other Covered Charge.

Patient Protection Notice

Mesa County Valley School District 51 generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact UMR at the number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from UMR or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact UMR at the number on the back of your ID card.

Wellness Program Disclosure

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at 970-254-5176 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
This Notice of Privacy Practices (the "Notice") describes the legal obligations of Mesa County Valley School District 51 and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, from which it is possible to individually identify you and that relates to:
(1) your past, present, or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present, or future payment for the provision of health care to you.

If you have any questions about this Notice or about our privacy practices, please contact Human Resources at 970-254-5176.

Effective Date
This Notice is effective September 23, 2013.

Our Responsibilities
We are required by law to:
- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices by internal company email.

How We May Use and Disclose Your Protected Health Information
Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if prior prescriptions contraindicate a pending prescription.

For Payment. We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations. We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. However, we will not use your genetic information for underwriting purposes.

Treatment Alternatives or Health-Related Benefits and Services. We may use and disclose your protected health information to send you information about treatment alternatives or other health-related benefits and services that might be of interest to you.

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use, and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to process your claims for Plan benefits or to provide support services, such as utilization management, pharmacy benefit management, or subrogation, but only after the Business Associate enters into a Business Associate contract with us.

As Required by Law. We will disclose your protected health information when required to do so by federal, state, or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors. For the purpose of administering the plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations
In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information without your specific authorization. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation. If you are an organ donor, we may release your protected health information after your death to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military. If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your protected health information for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your protected health information for public health activities. These activities generally include the following:
- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone involved in a legal dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.

Law Enforcement. We may disclose your protected health information if asked to do so by a law-enforcement official-
- in response to a court order, subpoena, warrant, summons, or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct; and
- about criminal conduct.

Coroners, Medical Examiners, and Funeral Directors. We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors, as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or are in the custody of a law-enforcement official, we may disclose your protected health information to the correctional institution or law-enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research. We may disclose your protected health information to researchers when:
(1) the individual identifiers have been removed; or
(2) when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information and approves the research.

Required Disclosures
The following is a description of disclosures of your protected health information we are required to make.
Government Audits. We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You. When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Other Disclosures
Personal Representatives. We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:
(1) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; or
(2) treating such person as your personal representative could endanger you; and
(3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members. With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations. Other uses or disclosures of your protected health information not described above will only be made with your written authorization. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your protected health information for marketing; and we will not sell your protected health information, unless you give us a written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Your Rights You have the following rights with respect to your protected health information:
Right to Inspect and Copy. You have the right to inspect and copy certain protected health information that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy.

To inspect and copy your protected health information, you must submit your request in writing to Human Resources. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to Human Resources.

Right to Amend. If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to Connie Mack at 2115 Grand Avenue, Grand Junction, CO 81501. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.
- If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to Human Resources. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.
Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

We will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid in full by you or another person.

To request restrictions, you must make your request to Human Resources at 970-254-5176. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply-for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request to Human Resources at 970-254-5176. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to Be Notified of a Breach. You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact Human Resources at 970-254-5176.

Complaints. If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact Human Resources at 970-254-5176 or 2115 Grand Avenue, Grand Junction, CO 81501. All complaints must be submitted in writing. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be 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 employmentbased 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 2013 for coverage starting as early as January 1, 2014.

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 9.5% 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]

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 check your summary plan description or contact Human Resources at (970) 254-5176

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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.

[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.

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 Mesa County Valley School District 51			4. Employer Identification Number (EIN) 84-6002839
5. Employer address 2115 Grand Avenue			6. Employer phone number 970-254-5176
7. City Grand Junction	8. State CO	9. ZIP code 81501	
10. Who can we contact about employee health coverage at this job? Connie Mack			
11. Phone number (if different from above)	12. Email address connie.mack@d51schools.org		

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

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

☒ All employees. Eligible employees are:

legally employed and working 20 or more hours per week

☐ Some employees. Eligible employees are:

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

a legal spouse (and civil union spouse) and dependent children until the end of the month of their 26th birthday. In addition, unmarried disabled children over the age of 26 if approved.

☐ We do not offer coverage.

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

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

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

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your State for more information on eligibility –

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

GEORGIA Medicaid	MASSACHUSETTS Medicaid and CHIP
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131	Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840
INDIANA Medicaid	**MINNESOTA Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA Medicaid and CHIP (Hawki)	**MISSOURI Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS Medicaid	**MONTANA Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KENTUCKY Medicaid	**NEBRASKA Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA Medicaid	**NEVADA Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE Medicaid	**NEW HAMPSHIRE Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY Medicaid and CHIP	SOUTH DAKOTA 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: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK Medicaid	**TEXAS Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA Medicaid	**UTAH Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA Medicaid	**VERMONT Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA Medicaid and CHIP	**VIRGINIA Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON Medicaid	**WASHINGTON Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA Medicaid	**WEST VIRGINIA Medicaid**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND Medicaid and CHIP	**WISCONSIN Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA Medicaid	**WYOMING Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2023)

MEDICARE PART D NOTICE

Important Notice from Mesa County Valley School District 51 About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Mesa County Valley School District 51 and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. If neither you nor any of your dependents are eligible for or have Medicare, this notice does not apply to your or the dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

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

2. Magellan Rx has determined that the prescription drug coverage offered by the Mesa County Valley School District 51 Employee Benefit Plan is on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current coverage, you and your dependents will be able to get this coverage back at the next annual open enrollment period.

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 Mesa County Valley School District 51 and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Mesa County Valley School District 51 changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook.
You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

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

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

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

Date: October 1,2021
Mesa County Valley School District 51
Connie Mack
2115 Grand Avenue, Grand Junction, CO 81501
970-254-5176

School District 51
MESA COUNTY VALLEY
Engage, Equip, and Empower

novo benefits