POUDRE SCHOOL DISTRICT

BENEFITS SERVICES

BENEFITS BOOKLET

AUGUST 1, 2016 – JULY 31, 2017

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Introduction

Poudre School District is committed to providing an environment that promotes a healthy employee population able to serve our students at the highest level. To help us achieve this goal, we offer a comprehensive benefits package that includes health, dental, and life insurance as well as other programs for our eligible employees.

Our benefit package offers you choices of benefits. Your benefits can play a significant role in your everyday life, especially when you understand their value and scope. You will want to take advantage of the benefits available to you.

This booklet contains important information regarding these benefits, eligibility, and how to enroll. Please take time to review the information in the booklet. If you have questions, we recommend you contact Benefits Services to have your questions answered.

The information contained in this booklet is a guide; the benefit decisions are yours.

The plan year runs August 1 through July 31.

You may make choices in these plans:

- ✓ Medical insurance
- ✓ Dental insurance
- ✓ Vision insurance
- ✓ Voluntary group term life insurance
- ✓ Flexible spending accounts (including medical reimbursement and dependent care)
- ✓ Tax-deferred plans (including 401(k), 403(b), and 457)

In addition, eligible employees are provided the following benefits at no cost:

- ✓ Basic life insurance/accidental death & dismemberment
- ✓ Short- and long-term disability

Please note that the Employee Benefits Booklet is not intended as a complete benefit description of all coverage. The complete details of each benefit plan are described in the applicable plan document. If there is any conflict between the information in this booklet and the legal plan documents, the plan will be administered according to the legal plan documents.

Contact Information

Benefits Services
2407 Laporte Avenue
Fort Collins CO 80521
Webpage: http://www.psdschools.org/department/benefits-services
Email: benefits-l@psdschools.org
Fax Number: 970-490-3624

Christina Erickson, Benefits/Wellness Technician
Phone Number: 970-490-3499
Email: christie@psdschools.org

Marissa Campos, Benefits Specialist
Phone Number: 970-490-3680
Email: mcampos@psdschools.org

Melissa Johnson, Benefits Manager
Phone Number: 970-490-3435
Email: melj@psdschools.org

Employee Assistance Services (EAS) – Mental Health & Substance Abuse Services
Webpage: http://eas.psdschools.org
Phone Number: 970-488-4925

Wellness Department
Webpage: http://www.psdschools.org/department/wellness

Ashley Schwader, District Wellness Manager
Phone Number: 970-490-3455
Email: aschwade@psdschools.org

Amanda Brantley, Wellness Coordinator
Phone Number: 970-490-3074
Email: abrantle@psdschools.org

Medical and Dependent Care Flexible Spending Plans
UCHealth Plan Administrators
1107 South Lemay Avenue, Suite 400
Fort Collins CO 80524
Phone Number: 970-224-4600
http://tpa.uchealth.org

Dental
MetLife Dental
PO Box 981282
El Paso TX 79998-1282
Phone Number: 800-942-0854
Group #302644
www.metlife.com/dental

Vision
Vision Service Plan
Phone Number: 800-877-7195
www.vsp.com

Life Insurance and Optional AD&D
Standard Insurance Company
900 SW Fifth Avenue
Portland, OR 97204-1282
Phone Number: 503-321-7000
Policy Number 649750-A

Pharmacy Benefits
OptumRX
Phone Number: 800-880-1188
www.mycatamaranrx.com

Employee Checklist

This checklist is provided to inform you of the items you **MUST** take care of within 31 days of your benefit eligibility date to ensure you enroll in the benefits you want before it's too late.

_____ Complete online enrollment for medical, dental, vision, and flexible spending plans using the UCHealth Plan Administrators online enrollment system at http://tpa.uchealth.org.

An eligibility notice will be sent to your PSD email from Benefits Services informing you to do this. This notice contains a specific Corporate Code that you will need to enroll. If you haven't received the notice, you can contact us.

_____ Complete the Standard Insurance Company Life Insurance Enrollment and Change Form. This form needs completed for beneficiary designation. It will also allow you to elect optional coverage for you and your eligible family members if you choose. Send completed form to PSD Benefits Services Department.

_____ Complete enrollment for voluntary cancer and intensive care coverage available through AFLAC. This can be done by accessing their website at www.aflac.com/psdschools.org.

_____ Complete enrollment for voluntary legal services available through ARAG. This can be done online at http://www.ARAGLegalCenter.com/home/index.htm?aragaccesscode=18085psd

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The following may be done outside 31 days of your eligibility for benefits:

_____ Enrollment in one of the deferred compensation plans (401k, 403b, 457)

_____ Enrollment in the voluntary auto and home owners insurance available through Horace Mann

_____ Enrollment in the voluntary pet insurance through VPI by contacting them at 877-738-7874.

_____ Enrollment in the voluntary identity theft and restoration services coverage through InfoArmor. This can be done online at https://orders.infoarmor.com/?customerid=poudresd

If you have any questions please contact:

Christina Erickson
christie@psdschools.org
970-490-3499

Who is Eligible?

You are eligible to enroll in the benefits described in this summary book if you meet the following criteria:

- Administrative employees contracted at 5.6 hours per day or more;
- Licensed employees contracted at 70% or more;
- Classified employees in an assignment normally scheduled for at least 1,041.55 hours (185 days at 5.63 hours per day) in an academic year.

(Refer to the Eligibility Chart in this booklet for specifics based on calendar length and exclusions.)

The following family members are eligible for medical, dental, vision and optional life insurance:

- Your legal spouse, including common law (a common law affidavit is required);
- Your domestic partner (a domestic partner affidavit is required);
- Your partner in a civil union (a civil union affidavit is required);
- All dependent children, regardless of student status or financial dependency, to the end of the month in which they turn 26;
- Children for whom you are the legal guardian;
- Any child of yours who is an alternate recipient under a qualified medical child support order;
- Disabled children of any age who are (or become) physically or mentally incapable of self-support.

If you request to enroll dependents in the medical, dental, life, and/or vision plans, you MUST provide proof of relationship confirming that the individual or individuals to be covered are eligible under the specific definitions of the plans. A list of acceptable documentation can be found at https://www.psdschools.org/employment/current-employees/benefits/psd-benefits-A-Z. These documents should be sent to PSD Benefits Services via email at benefits-l@psdschools.org or faxed to 970-490-3624.

Eligibility Criteria for Insurance and Other Benefits

Employees (excluding temporary, substitute, employees on the "S" Salary Schedule, any employees with variable working hours) are eligible for benefits as outlined in the charts below. Extra duty and extended contract assignments are not used to determine benefit eligibility.

Administrative and Licensed Employees

	Hours Per Day or Contract Percentage		
Admin Employees **Licensed Employees**	Less than 5.60 hrs Less than 70%	5.60 – 7.99 hrs 70% - 99.99%	8.00 hrs 100%

Classified Employees

Standard Assignment in Days	**Hours Per Day**		
141	Less than 7.39	7.39 – 8.00	-
174	Less than 5.99	5.99 – 8.00	-
175	Less than 5.96	5.96 – 8.00	-
177	Less than 5.89	5.89 – 8.00	-
180	Less than 5.79	5.79 – 8.00	-
181	Less than 5.76	5.76 – 8.00	-
182	Less than 5.73	5.73 – 8.00	-
185	Less than 5.63	5.63 – 7.99	8.00
186	Less than 5.60	5.60 – 7.95	7.96 – 8.00
190	Less than 5.49	5.49 – 7.78	7.79 – 8.00
195	Less than 5.35	5.35 – 7.58	7.59 – 8.00
200	Less than 5.21	5.21 – 7.39	7.40 – 8.00
205	Less than 5.09	5.09 – 7.21	7.22 – 8.00
210	Less than 4.96	4.96 – 7.04	7.05 – 8.00
215	Less than 4.85	4.85 – 6.88	6.89 – 8.00
220	Less than 4.74	4.74 – 6.72	6.73 – 8.00
225	Less than 4.63	4.63 – 6.57	6.58 – 8.00
230	Less than 4.53	4.53 – 6.43	6.44 – 8.00
261	Less than 4.00	4.00 – 5.67	5.68 – 8.00

Benefits			
Health Insurance	No	Yes	Yes
Dental Insurance	No	Yes	Yes
Life & AD&D Insurance	No	Yes	Yes
Optional Employee & Dependent Life Insurance	No	Voluntary	Voluntary
Vision	No	Voluntary	Voluntary
Short- and Long-Term Disability (PSD paid)	Yes - 15 or more scheduled hrs/wk	Yes	Yes
Flexible Spending Accounts	Optional	Optional	Optional
Tax Deferred Plans (401k, 403b, 457)	Optional	Optional	Optional

Benefits Effective Date

You must choose coverage for medical, dental, vision, and flexible spending plans during your initial 31-day enrollment period as a new employee, or when newly eligible (due to job change or increase in hours). Your coverage is effective the first (1st) of the month following your date of hire (which is your first day of actual work as a regular employee). This is also the first day of your initial 31-day enrollment period.

Important – you cannot change your elections during the plan year unless you experience a "qualified status change" as defined by the IRS. See the *Changing Elections During the Plan Year* section in this booklet for additional information.

All benefit eligible employees must enroll (or waive) coverage for medical, dental, vision, and flexible spending plans using the UCHealth Plan Administrators online enrollment system. You may access this website at http://tpa.uchealth.org.

Benefit Stop Dates

Your insurance coverage ends on the earliest of the following events:

- ✓ The date the plan is terminated,
- ✓ The last day of the month in which your employment ends,
- ✓ The last day of the month in which you no longer make required contributions; including while on FMLA,
- ✓ The last day of the month in which you or your dependents are no longer eligible under the Poudre School District benefit plans,
- ✓ The end of the month after your FMLA ends, if you do not return to work (certain exceptions may apply),
- ✓ In the case where an Employee elects to drop coverage during Open Enrollment, the last day of the plan year.
- ✓ Life insurance benefits end on your date of termination

Open Enrollment Period

Open enrollment happens once a year – usually in July prior to the new plan year. It's a time to consider your benefit needs and make new choices. The benefits you choose will be effective from August 1 to July 31. At that time you may do the following:

Enroll or opt out of one of the medical;

Enroll or opt out of the dental or vision plan;

Add or drop eligible dependents;

Enroll or **Re-enroll** in the Flexible Spending Account plan

Changing Elections during the Plan Year

As you make your elections, please keep in mind in accordance with IRS regulations; once you make your elections, these may not be changed during the plan year (August 1 through July 31) unless you experience a qualified status change. *If you experience a qualified status change and wish to change your elections, you must complete the online enrollment process and submit proof of the status change to Benefits Services within 31 days of the status change.*

Currently, Federal law considers the following events to be examples of a change in status:

- a change in your legal marital status (including marriage, death of a spouse, divorce, legal separation and annulment);
- a change in the number of your dependents (including birth, death, adoption and placement for adoption);
- a change in the employment status of you, your spouse or dependent (including the termination or commencement of employment, a strike or lockout, commencement of or return from an unpaid leave of absence, a change in work site, or a change in your employment status that changes eligibility under the plan);
- a change in your dependent's ability to satisfy or cease to satisfy the requirements for coverage (due to attainment of age);
- a change in the place of residence of you, your spouse or dependent resulting in a change in eligibility for a particular plan;
- the amount of an election for your child or foster child who is a dependent is required to be changed by a judgment, decree, or order resulting from a divorce, legal separation or change in legal custody;
- you, your spouse, or dependent becomes enrolled or loses eligibility for Medicare (Part A or B) or Medicaid (other than coverage for pediatric vaccines);
- you, your spouse or dependent loses coverage under any group health coverage sponsored by a governmental or educational institution;
- coverage under a group health plan changes due to a special enrollment under HIPAA;
- you take a leave under the Family and Medical Leave Act (FMLA);
- you depart for or return from qualified military service under the Uniformed Services Employment and Reemployment Rights Act.

For a full description of a qualified status change refer to the specific Health Plan Document and Plan Summary.

Coverage under More Than One Policy

You and/or your dependents may have other medical, dental, or vision coverage available to you. Before you enroll in coverage under more than one policy (dual coverage), you should consider the cost of the coverage, the benefits provided under dual coverage and if there are any exclusion clauses. If you have coverage under more than one plan, the plans will coordinate benefits**. Under no circumstance should you receive benefit payments greater than the cost of care.**

In coordinating benefits, one plan is considered the primary plan and the other plan(s) become the secondary plan(s). If you are covered under your employer's plan and your spouse's plan, then your plan is primary and your spouse's is secondary. Likewise, if your spouse is covered under their employer's plan and yours, their plan is primary and yours is secondary. For dependent children with dual coverage, it is the parent whose birth date is first in the calendar year who provides the primary coverage. The primary plan pays benefits first, and then the secondary plan(s) pay benefits if appropriate. If the District plan is primary, it will pay benefits as it regularly would. If the District plan is secondary to another plan(s), you first must submit a claim to the primary plan. After the primary plan has paid benefits, or denied your claim, the District plan will calculate its payment, if any. The District plan will not pay more than it would have paid had it been the primary plan.

You should refer to the Summary Plan Description for specific information regarding coordination of benefits.

Pre-Tax versus Post-Tax Option

Employee paid elections for health, dental and/or vision benefits are automatically deducted as a pre-tax benefit through a premium-only cafeteria plan in accordance with Section 125 of the Internal Revenue Code. You pay no federal or state income tax or PERA contributions, and no Medicare tax (if applicable) on these dollars.

Pre-tax premiums reduce salary reported to PERA, which may affect salary averaging for retirement calculations. Therefore, the District offers the Post-Tax Premium Option to maximize benefits for all employees. You must complete the Post-Tax Premium Election Form as a new hire during your initial 31-day enrollment period or during the annual open enrollment to elect this option. Electing the post-tax premium option maximizes benefits to employees by not reducing salary reported to PERA. Post-tax benefits increase federal and state taxable income as well as PERA contributions.

How to Enroll/Waive Coverage Using the UCHealth Plan Administrators Online Enrollment System

The following instructions walk you through the steps to complete your online enrollment. You have thirty-one (31) days from your benefit effective date to enroll. You can enroll for medical, dental, and vision insurance along with medical and dependent care flexible spending accounts using the online system.

*****Failure to complete your online enrollment within the required 31 days will result in no medical, dental, vision, or flexible spending account coverage.**

You will need to be sure to have the following information in order to complete your online enrollment:

- Dependent Name(s), Social Security Number(s) and Date(s) of Birth; and
- the Corporate Code noted on the Benefit Eligibility Notice you received. If you have not received the notice, please contact Benefits Services at 970-490-3499.

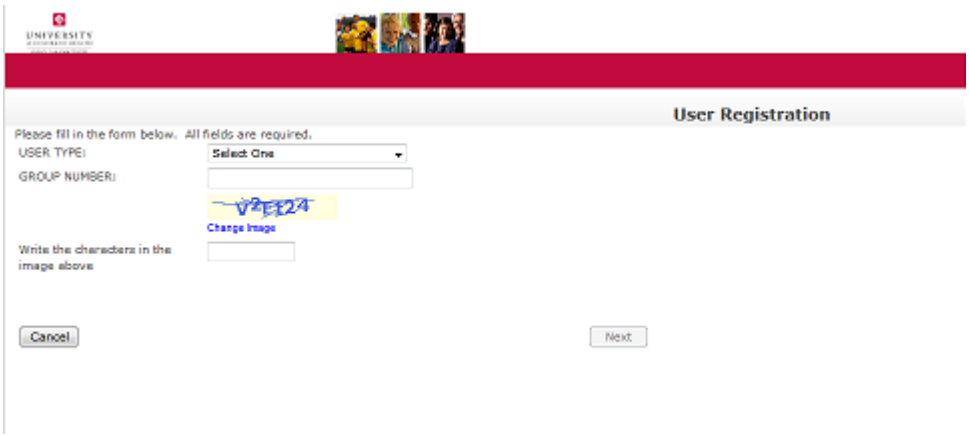
Be sure to read all instructions on each web page as you complete your online enrollment.

Go to the UCHealth Plan Administrators website: http://tpa.uchealth.org

In the middle-left hand side of the screen click on the Members "More Information" button. You will be directed to a "What would you like to do" page. Select the **Click Here** option after the question "**Poudre School District employees -** for **all** inquiries **EXCLUDING** Flexible Spending Accounts" - you will be redirected to UCHealth Plan Administrator's website.

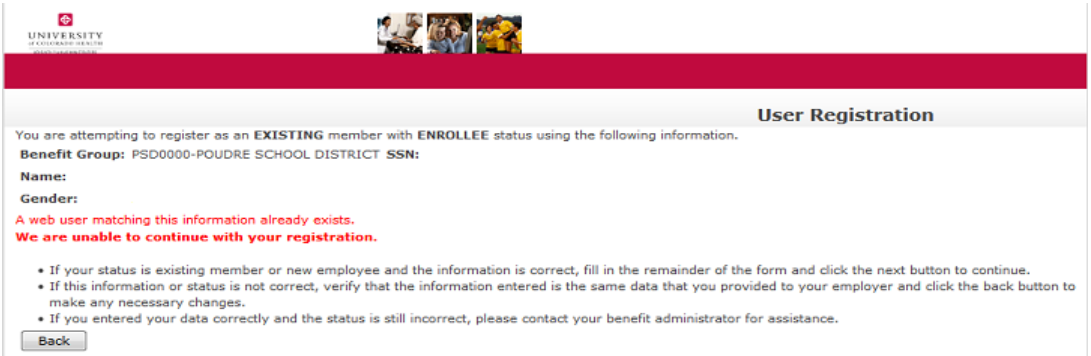
If you have never used the website, select New User Registration. If you have previously used the website, enter your User ID and Password and Submit. Entering your User ID and password will take you to the Welcome screen and you are ready to use the site. If you don't remember your User ID and password, contact UCHealth Plan Administrators at 970-224-4600.

Once you select New User Registration, a Registration Info box will appear -click on Register. On the next screen, Select User Type - Employee. The Group Number is PSD0000 (PSD followed by 4 zeros). Once the Group Number is entered, additional demographic questions will appear.

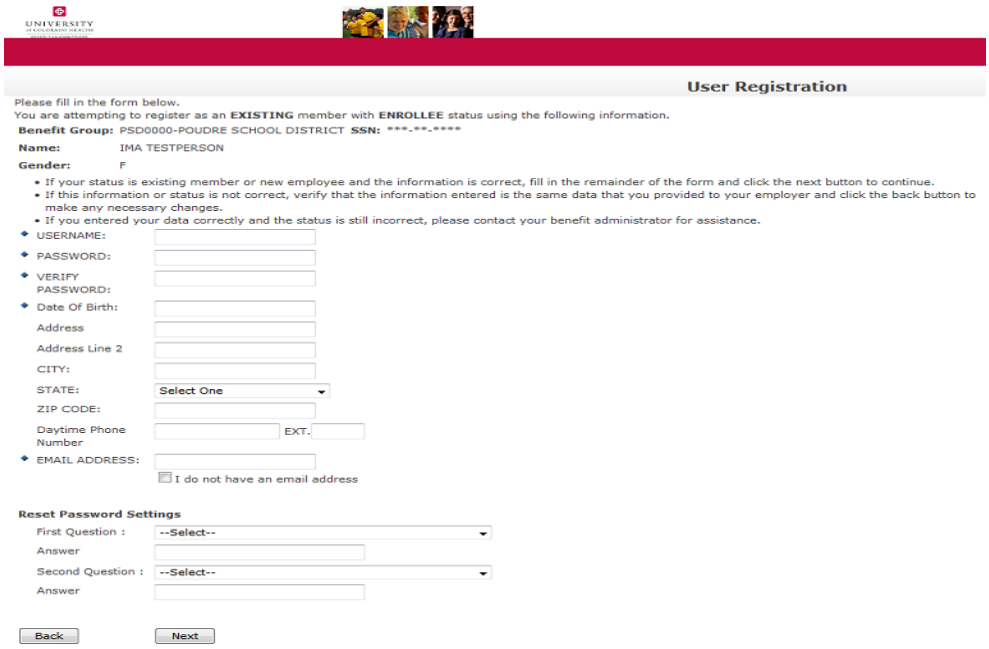


Enter the characters that appear in the image in the box provided (in this case V2E124). If the image is not clear, a new image can be requested by selecting Change Image. Next type in your Social Security Number.

If the website recognizes your information as a previous website user, you will receive an error screen. Please contact UCHealth Plan Administrators at (970) 224-4600 for further assistance.



The User Registration page is where you set up your User Name and Password for the website. The User Name can be any combination of letters and numbers. The Password is case sensitive and must be at least 6 characters. Enter the requested demographic information and select Next.



Successful completion of the User Registration form will take you to the Welcome screen where you can do such things as enroll in benefits, view claims, check your coverage, and search for a provider.

Medical Benefits

The Poudre School District health plan is a self-funded plan administered by UCHealth Plan Administrators. You can access your personal medical information and find a medical provider by going to the UCHealth Plan Administrators website at http://tpa.uchealth.org.

For specific questions regarding plan coverage and individual claims, you should contact UCHealth Plan Administrators at 970-224-4600.

The address for submitting medical claims is:
UCHealth Plan Administrators
1107 South Lemay Avenue, Suite 400
Fort Collins, CO 80524

The plan year runs August 1 through July 31.

Enrollment
You are NOT required to enroll in the medical benefits. If you do not enroll within the required 31-days, you will NOT have medical benefits.

You may enroll in one of the following tiers:

- ✓ Employee-only
- ✓ Employee and spouse (domestic partner/partner in a civil union)
- ✓ Employee and child(ren)
- ✓ Employee and family, OR
- ✓ You may elect to waive coverage entirely

Newborn Coverage
Newborns are covered from the moment of birth for the first 31 days under the mother's policy provided the mother is covered under one of the health plans.

- ✓ To continue coverage beyond the first 31 days, the dependent MUST be added to the health plan by completing the online enrollment process within the first 31 days of the baby's date of birth.
- ✓ If both parents of the newborn are employed and benefit eligible through PSD, the father of the newborn is NOT given an additional 31 days to add the newborn following the initial 31 days of coverage under the mother's plan.

The following three (3) medical insurance plan options are available:

- ✓ EPO (Exclusive Provider Organization - similar to an HMO plan)
- ✓ PPO-1 (Preferred Provider Organization)
- ✓ PPO-2 (Preferred Provider Organization)

Medical Plan Comparisons

These benefit summaries are intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If these Benefit Summaries conflict in any way with the Plan Document and Plan Summary, the Plan Document and Plan Summary shall prevail. It is recommended that you review your Plan Document and Plan Summary for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

Note: Plan Year refers to the time period August 1, 2016 through July 31, 2017

EPO Plan

The Exclusive Provider Organization (EPO) is a plan similar to an HMO. Participants must select a Primary Care Physician and pay a co-payment for services received. Participants are responsible for obtaining referrals to see specialists. The network area is limited to Fort Collins, Loveland, Wellington, and Windsor. There are no out-of-network benefits.

EPO plan participants may utilize urgent care in addition to emergency care when out of the network coverage area.

Benefit Description	In-Network You Pay
Plan Year Deductible	Single $70, Family $210
Plan Year Out-of-Pocket (OOP) Maximums	Medical: Individual $2,000, Family $4,000 Mental Health/Substance Abuse: Individual $1,200, Family $2,400
Lifetime Maximum	No lifetime maximum
Office Visits	Primary Care Physician: $35 per visit Specialist: $50 per visit with referral
Preventive Care Mammograms, routine prostate exam	No copay; covered at 100%
Maternity Prenatal Delivery	 $35 per visit $500 per admission
Laboratory, X-Ray and Diagnostic	$35 per visit
MRI/PET/CAT scan	$100 per visit
Emergency Care	$100 per visit
Ambulance	$100 per visit
Urgent Care	$50 per visit
Inpatient Services	$500 per admission
Outpatient Services	$300 per visit
Physical, Occupational and Speech Therapy	$50 per visit with referral; 30 sessions per acute care
Body Organ Transplant	$500 per admission
Home Health Care	100% coverage
Durable Medical Equipment	100% coverage
Breast Pumps and Supplies	100% coverage for rental or purchase; limit 1 per birth; must be obtained within 60 days of baby's date of birth
Hospice Care	100% coverage, 180 day maximum
Non-surgical treatment of chronic foot conditions, including orthotics	$50 with referral

PPO-1 Plan

The Preferred Provider Organization (PPO-1) plan offers employees freedom to obtain services from in-network or out-of-network providers. Participants in this plan pay a coinsurance, or a percentage of the charges, with a higher level of benefits for services provided by in-network providers. This plan has a $500 individual in-network deductible and a $750 individual out-of-network deductible. The plan offers a "wrap" network through the Cofinity Network including in-network coverage in Larimer, Weld, Adams, and Boulder counties. However, not all facilities and/or services are available as in-network. Questions on the Cofinity Network should be addressed to UCHealth Plan Administrators at 970-224-4600.

Benefit Description	In-Network You Pay	Out-of-Network You Pay
Plan Year Deductible	Single: $500, Family: $1,500	Single: $750, Family: $2,250
Plan Year Out-of-Pocket (OOP) Maximums	Medical: Individual $2,000 Family $4,000 Mental Health/Substance Abuse: Individual $1,200 Family $2,400	Medical: Individual $5,000 Family $10,000 Mental Health/Substance Abuse: Individual $1,200 Family $2,400
Lifetime Maximum	No lifetime maximum	
Office Visit PCP/Specialist	25% per visit	50% per visit
Preventive Care Well Exam to age 2; Well Exam over age 2; Mammograms and routine prostate exam	Nothing; covered at 100%	50%; Plan pays 100% up to $300 50%; Plan pays 100% up to $200 50%; Plan pays 100% up to $100
Maternity	25% per visit	50% per visit
Laboratory, X-Ray and Diagnostic	25% per visit	50% per visit
MRI/PET/CAT scan	25% per visit	50% per visit
Emergency Care	25% per visit	50% per visit
Ambulance	25% per visit	50% per visit
Urgent Care	25% per visit	50% per visit
Inpatient Services	25% per visit	50% per visit
Outpatient Services	25% per visit	50% per visit
Physical, Occupational and Speech Therapy	25% per visit, 30 sessions per acute care	50% per visit, 30 sessions per acute care
Body Organ Transplant	25%	50%
Home Health Care	100% coverage	
Durable Medical Equipment	25%	50%

Breast Pumps and Supplies	100% for rental or purchase; limit 1 per birth within 60 days of date of birth	Subject to deductible then 50%
Hospice Care	100% coverage, 180 day maximum	
Non-surgical treatment of chronic foot conditions, including orthotics	25%	50%

PPO-2 Plan

The Preferred Provider Organization (PPO-2) plan offers employees to obtain services from in-network providers only. Participants in this plan pay a coinsurance, or a percentage of the charges, with a higher front-end deductible. This plan has a $1,000 individual in-network deductible. The plan offers a "wrap" network through the Cofinity Network including in-network coverage in Larimer, Weld, Adams, and Boulder counties. However, not all facilities and/or services are available as in-network. Questions on the Cofinity Network should be addressed to UCHealth Plan Administrators at 970-224-4600.

Benefit Description	In-Network You Pay
Plan Year Deductible	Single: $1,000, Family: $3,000
Plan Year Out-of-Pocket (OOP) Maximums	Combined Medical and Mental Health/Substance Abuse: Individual $5,400 Family $10,800
Lifetime Maximum	None
Office Visit PCP/Specialist	25% per visit
Preventive Care Well Exams; Mammograms and routine prostate exam	Nothing; covered at 100%
Maternity	25% per visit
Laboratory, X-Ray and Diagnostic	25% per visit
MRI/PET/CAT scan	25% per visit
Emergency Care	25% per visit
Ambulance	25% per visit
Urgent Care	25% per visit
Inpatient Services	25% per visit
Outpatient Services	25% per visit
Physical, Occupational and Speech Therapy	25% per visit, 30 sessions per acute care

Body Organ Transplant	25%
Home Health Care	Covered at 100%
Durable Medical Equipment	25%
Breast Pumps and Supplies	100% coverage for rental or purchase; limit 1 per birth; must be obtained within 60 days of baby's date of birth
Hospice Care	Covered at 100%; 180 day maximum
Non-surgical treatment of chronic foot conditions, including orthotics	25%

Prescription Benefits

You are automatically enrolled in the prescription benefit when you enroll in the EPO, PPO-1, or PPO-2 plans. The benefits are the same for all plans.

OptumRx administers the prescription benefits for the Poudre School District Health Plan. You can access your personal prescription information, price medications, and find participating pharmacies by visiting their website at www.mycatamaranrx.com.

OptumRx provides online access called *My Catamaran Rx*. The program can help you save money on your prescriptions by showing you a prescription drug comparison of alternative medications that may be available to you. The program shows you the list of drugs you take on an ongoing basis, the cost of those drugs, and potential lower-cost alternatives. You then have the option of asking your doctor about whether or not these medication alternatives are right for you. If so—you could save money by changing prescriptions! Changes are not made without your doctor's approval.

To access *My Catamaran Rx* and see how much you can save, go to www.mycatamaranrx.com, login with your personal information, and click on the *My Rx Choices* line in the left toolbar.

You may contact OptumRx at 1-800-880-1188

Prescription Summary:

Benefit Description	In-Network You Pay
Retail Plan Year Out-of-Pocket Maximum	Individual $1,200 Family $2,400
Retail (up to 34-day supply)	10% generic (minimum $10 not to exceed cost of drug) 20% preferred (minimum $20 not to exceed cost of drug) 30% non-preferred (minimum $40 not to exceed cost of drug)

Home Delivery (up to 90-day supply)	$25 generic $50 preferred $100 non-preferred

Home Delivery – What it is and how to use it.

- Home Delivery offers you and your eligible dependents the convenience and savings of having your long-term medications (those taken for 3 months or more) delivered to your home or office and standard shipping is free.
- You receive up to a 90-day supply (compared with a typical 34-day supply at retail) of each covered medication for just one (1) mail order co-payment.
- Co-payment (up to a 90-day supply):
  - Generic $25
  - Preferred $50
  - Non-preferred $100
- Getting started is simple
  - Ask your doctor to write a prescription for up to a **90-day supply** of each medication (plus refills for up to 1 year, if appropriate).
  - Complete an *OptumRx Home Delivery Form*. Available on the PSD website under the Employment tab then Benefits or by contacting Benefits Services as benefits-l@psdschools.org.
  - Send the completed form, your prescription, and your payment to OptumRx.
  - Your medication will usually be delivered within 7-10 days after they receive your order. If you are currently taking a medication, be sure to have at least a 14-day supply on hand when ordering. If you don't have a 14-day supply, ask your doctor to give you a second prescription for a 14-day supply and fill it at a participating retail pharmacy while your mail-order prescription is being processed.
  - You can also choose to sign up for **OptumRx By Mail** online at **www.mycatamaranrx.com.**
  - If you choose, you may also call OptumRx at 1-800-880-1188 and they will contact your doctor to transfer your current prescriptions to **OptumRx By Mail** for you.

Retail Refill Allowance Program

- This program allows you and your eligible dependents to fill your long-term prescriptions two (2) times at the retail pharmacy.
- Beginning on the third refill, you will pay a higher cost for the covered medications you take on a long-term basis if you continue to purchase them at a participating retail pharmacy. This cost is the Home Delivery co-payment cost. You will pay this higher cost for a 34-day supply at retail unless you utilize Home Delivery.
- Long-term prescriptions are medications used for treatment of a chronic condition whose duration of therapy is reasonably expected to exceed one year.
- To receive your long-term prescriptions at the most efficient cost to you, you should utilize the Home Delivery Pharmacy Service. You are not required to use Home Delivery, but it will save you money.
- In addition, you should continue to get all of your short-term prescriptions, such as antibiotics, at the regular retail pharmacy.

Medical Premiums for August 1, 2016 – July 31, 2017

The employee portion of the insurance premium coverage is automatically deducted as pre-tax within the Section 125 Plan unless the employee elects "after-tax" deductions on the Post-Tax Election Form. If you are in your last three to five years of employment prior to retirement, you may want to select the post-tax option in order to maximize your PERA retirement benefits.

The cost of your medical coverage varies by the plan and the tier you select. As health care costs increase, each year Poudre School District will evaluate the cost of health care benefits and may find it necessary to increase employee contributions and/or make changes to the plan design. It is our goal to maintain a competitive benefit program.

Employer Contribution
Depending on your eligibility, Poudre School District makes a premium contribution toward the cost of employee-only benefit coverage. This contribution represents all or a significant part of the cost of employee-only coverage. Regardless of the plan you choose, you are responsible for 100% of any spouse/domestic partner/partner in a civil union and/or child dependent coverage elected. If you enroll your spouse/domestic partner/partner in a civil union and/or child dependents, they must be enrolled in the same plan that you elect for yourself.

The costs of coverage for the Poudre School District benefit plans are listed in the charts following.

If you elect coverage and are required to pay a monthly cost, your pay will be prorated to cover the cost of premiums over the summer months.

If you decline medical or dental coverage, you will NOT receive a taxable cash contribution (in lieu of the benefits) from the District.

EPO Plan					
		Eligibility Requirements *8 hours per day (classified) or 100% (admin/licensed)		**Eligibility Requirements** *5.63 – 7.99 hours per day (classified) or 70 – 99.99% (admin/licensed)	
	Total Premium	**PSD Monthly Contribution**	**Employee Monthly Cost**	**PSD Monthly Contribution**	**Employee Monthly Cost**
Employee Only	$572.00	$521.00	$51.00	$457.00	$115.00
Employee/Spouse	$1260.00	$521.00	$739.00	$457.00	$803.00
Employee/Child(ren)	$1044.00	$521.00	$523.00	$457.00	$587.00
Employee/Family	$1396.00	$521.00	$875.00	$457.00	$939.00

* Based on standard 185-day (9-month) contract. See eligibility chart in this booklet for other contract lengths.

PPO-1 Plan					
		Eligibility Requirements *8 hours per day (classified) or 100% (admin/licensed)		**Eligibility Requirements** *5.63 – 7.99 hours per day (classified) or 70 – 99.99% (admin/licensed)	
	Total Premium	**PSD Monthly Contribution**	**Employee Monthly Cost**	**PSD Monthly Contribution**	**Employee Monthly Cost**
Employee Only	$521.00	$521.00	$0.00	$457.00	$64.00
Employee/Spouse	$1146.00	$521.00	$625.00	$457.00	$689.00
Employee/Child(ren)	$949.00	$521.00	$428.00	$457.00	$492.00
Employee/Family	$1270.00	$521.00	$749.00	$457.00	$813.00

* Based on standard 185-day (9-month) contract. See eligibility chart in this booklet for other contract lengths.

PPO-2 Plan					
		Eligibility Requirements *8 hours per day (classified) or 100% (admin/licensed)		**Eligibility Requirements** *5.63 – 7.99 hours per day (classified) or 70 – 99.99% (admin/licensed)	
	Total Premium	**PSD Monthly Contribution**	**Employee Monthly Cost**	**PSD Monthly Contribution**	**Employee Monthly Cost**
Employee Only	$457.00	$457.00	$0.00	$457.00	$0.00
Employee/Spouse	$1005.00	$457.00	$548.00	$457.00	$548.00
Employee/Child(ren)	$831.00	$457.00	$374.00	$457.00	$374.00
Employee/Family	$1110.00	$457.00	$653.00	$457.00	$653.00

* Based on standard 185-day (9-month) contract. See eligibility chart in this booklet for other contract lengths.

Dental Plan

The Poudre School District dental plan is a self-funded plan administered by MetLife. You may access your personal dental information including plan coverage, claims, obtain claims forms, and find a MetLife provider by going to MetLife's website at www.metlife.com.

This website also offers a Planning Tool including Life Events and Life Advice to help guide you through important events or situations in your life to make sure you are making informed choices regarding benefits.

PSD has contracted with Metropolitan Life Insurance. MetLife's Preferred Dentist Program (PDP) provides a higher level of benefits if a preferred provider is chosen, yet also allows a free choice of dentist.

You may contact MetLife at 1-800-942-0854.

The group number is 302644.

The address for submitting dental claims is:

MetLife Dental
PO Box 981282
El Paso, TX 79998-1282

The plan year runs August 1 through July 31.

Enrollment
You are NOT required to enroll in the dental benefits. If you do not enroll within the required 31-days, you will NOT have dental benefits.

You may enroll in one of the following tiers:

- ✓ Employee-only
- ✓ Employee and spouse (domestic partner/partner in a civil union)
- ✓ Employee and child(ren)
- ✓ Employee and family, OR
- ✓ You may elect to waive coverage entirely

Schedule of Benefits

This benefit summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflict in any way with the Plan Document and Plan Summary, the Plan Document and Plan Summary shall prevail. It is recommended that you review your Plan Document and Plan Summary for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

Note: Plan Year refers to the time period August 1, 2016 through July 31, 2017

It is recommended to obtain a pre-treatment estimate for any services that will exceed $400. Dependent children are eligible for coverage under the plan until the end of the month they reach age 26. Only dependent children to age 19 are eligible for orthodontic benefits.

Benefit Description	In-Network You Pay	Out-of-Network You Pay*
Plan Year Deductible Applies to major and ortho services only	Single: $50 Family: $100	Single: $50 Family: $100
Diagnostic & Preventive Care	Nothing; covered at 100%	Nothing; covered at 100%
Basic & Implant Services	20%	20%
Major Services	50%	50%
Orthodontic Services	50%	50%
TMJ	20%	20%

*If you use a non-network provider, covered charges will be paid based on the reasonable and customary rate. You may be responsible for the balance not covered by the plan.

Maximum Benefits

Benefit Description	Maximum Paid by the Plan
Diagnostic, Preventive, Major, and Basic Services	$1,500 per patient per plan year
Orthodontic Services	$2,000 per patient lifetime
Implant Services	$3,000 per patient lifetime
Temporomandibular Joint/Myofacial Pain Dysfunction	$1,200 per patient lifetime

Dental Premiums for August 1, 2016 – July 31, 2017

The employee portion of the insurance premium coverage is automatically deducted as pre-tax within the Section 125 Plan unless the employee elects "after-tax" deductions on the Post-Tax Election Form. If you are in your last three to five years of employment prior to retirement, you may want to select the post-tax option in order to maximize your PERA retirement benefits.

Employer Contribution
If eligible for benefits, Poudre School District pays 100% of employee-only dental coverage. You are responsible for 100% of any spouse/domestic partner/partner in a civil union and/or child dependent coverage elected. The costs of coverage for the Poudre School District dental plan is listed in the chart following.

If you elect coverage and are required to pay a monthly cost, your pay will be prorated to cover the cost of premiums over the summer months.

If you decline dental coverage, you will NOT receive a taxable cash contribution (in lieu of the benefits)

from the District.

Dental Plan			
		Eligibility Requirements *5.63 – 8 hours per day (classified) or 70 – 100% (admin/licensed)	
	Total Premium	**PSD Monthly Contribution**	**Employee Monthly Cost**
Employee Only	$40.00	$40.00	$0.00
Employee/Spouse	$91.00	$40.00	$51.00
Employee/Child(ren)	$91.00	$40.00	$51.00
Employee/Family	$127.00	$40.00	$87.00

* Based on standard 185-day (9-month) contract. See eligibility chart in this booklet for other contract lengths.

Vision Plan

Voluntary group vision coverage is provided through Vision Service Plan (VSP) at the employee's expense. The plan offers participants the option to select in-network or out-of-network providers. Benefits are paid at a higher level for services provided by in-network providers. This is a pre-tax benefit unless you waive the pre-tax option.

Vision Service Plan administers the voluntary vision plan. You can contact Vision Service Plan Member Services at 1-800-877-7195. You can find a vision provider by visiting Vision Service Plan's website at www.vsp.com.

Enrollment
Vision is voluntary and therefore, if you do not enroll within the required 31-days, you will NOT have vision benefits.

You may enroll in one of the following tiers:
- ✓ Employee-only
- ✓ Employee plus one dependent
- ✓ Employee plus two or more dependents

Schedule of Benefits

This benefit summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. Vision Service Plan makes the determination of benefit coverage. It is recommended that you contact them for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

Benefit Description	In-Network You Pay	Out-of-Network Plan Pays
Exam Copayment Frequency	 $15 Once every 12 months	Reimbursement Up to $50 Once every 12 months
Materials Copayment	$15	N/A
Lenses Single Bifocal Trifocal Frequency	 $15 $15 $15 Once every 12 months	Reimbursement Up to $50 Up to $75 Up to $100 Once every 12 months
Frames Benefit Frequency	 $175 retail frame allowance Once every 24 months	Reimbursement Up to $70 Once every 24 months
Contacts (in lieu of glasses) Exam Lenses	 Plan reimbursement up to $60 $175 allowance	 N/A Reimbursement up to $110

Vision Premiums for August 1, 2016 – July 31, 2017

The insurance premium is automatically deducted as pre-tax within the Section 125 Plan unless the employee elects "after-tax" deductions on the Post-Tax Election Form. If you are in your last three to five years of employment prior to retirement, you may want to select the post-tax option in order to maximize your PERA retirement benefits.

If you elect coverage, your pay will be prorated to cover the cost of premiums over the summer months.

Vision Plan			
		Eligibility Requirements *5.63 – 8 hours per day (classified) or 70 – 100% (admin/licensed)	
	Total Premium	**PSD Monthly Contribution**	**Employee Monthly Cost**
Employee Only	$8.51	$0.00	$8.51
Employee plus one	$16.32	$0.00	$16.32
Employee plus 2 or more	$26.32	$0.00	$26.32

* Based on standard 185-day (9-month) contract. See eligibility chart in this booklet for other contract lengths.

Life and Accidental Death and Dismemberment Insurance

Policy Information
The current life insurance company information and policy number is:

Standard Insurance Company
900 SW Fifth Avenue
Portland, OR 97204-1282
503-321-7000
Policy #649750-A

This benefit summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. For all details, please see the policy certificate available by contacting Benefits Services at 970-490-3499 or 970-490-3680

Basic Coverage

Eligible employees are automatically enrolled in a basic life insurance policy in the amount of $50,000.00 paid by the District. The policy terminates when you no longer meet the eligibility requirements of the plan.

Your amount of Basic and Accidental Death and Dismemberment Insurance reduces to 65% when you reach age 70, to 50% when you reach age 75 and to 20% when you reach age 80.

It is recommended you complete a beneficiary designation form for the $50,000 policy provided to you. If a designation form is not completed, any benefits payable will be made to the employee's estate.

Optional Coverage

You have the option to purchase optional life insurance for yourself and your spouse/domestic partner/partner in a civil union and dependent children. A dependent child can be covered to age 26 provided he/she depends on you for 50% or more of his/her support.

If you do not enroll in the optional life insurance at the time of eligibility, you will be subject to Evidence of Insurability by the life insurance carrier for the full amount.

You must elect Optional Life coverage for yourself in order to cover your spouse/domestic partner/partner in a civil union and/or dependent children.

If you are electing coverage for your spouse/domestic partner/partner in a civil union and/or children, you are the beneficiary of the benefits provided for your spouse/domestic partner/partner in a civil union and/or children.

Coverage Options	
Yourself	
Increments	$10,000
Guaranteed Issue	$100,000 if enrolled within 31 days of initial eligibility
Maximum	$300,000
Coverage Reduction	To 65% age 70; 50% age 75; 20% age 80
Spouse/Domestic Partner/Partner in a Civil Union	
Increments	$5,000
Guaranteed Issue	$20,000 if enrolled within 31 days of initial eligibility
Maximum	50% of employee's optional coverage not to exceed $100,000
Coverage Reduction	To 65% age 70; 50% age 75; 20% age 80
Dependent Children	
Increments	$2,500
Maximum	50% of employee's optional coverage not to exceed $10,000
Coverage Reduction	Coverage ends at age 26

Optional Rates

Premiums for the voluntary optional life and AD&D are based on age.

EMPLOYEE	
Age	**Monthly cost per $1,000 of coverage****
Under 25	$ 0.061
25 – 29	$ 0.070
30 – 34	$ 0.086
35 – 39	$ 0.095
40 – 44	$ 0.103
45 – 49	$ 0.144
50 – 54	$ 0.211
55 – 59	$ 0.376
60 – 64	$ 0.567
65 – 69	$ 1.072
70 +	$ 1.726

SPOUSE	
Age	**Monthly cost per $1,000 of coverage**
Under 25	$ 0.041
25 – 29	$ 0.050
30 – 34	$ 0.066
35 – 39	$ 0.075
40 – 44	$ 0.083
45 – 49	$ 0.124
50 – 54	$ 0.191
55 – 59	$ 0.356
60 – 64	$ 0.547
65 – 69	$ 1.052
70 +	$ 1.052

CHILD(REN)	
Monthly cost per $1,000 of coverage	
All eligible children	$ 0.123

** Includes Optional AD&D

Additional Features

Accelerated Death Benefit
If you are diagnosed as terminally ill with a 12 month life expectancy, you may receive payment of a portion of your life insurance. The remaining amount of your life insurance would be paid to your beneficiary when you die.

Conversion and Portability
Life insurance coverage terminates for you and any dependents you had enrolled in the plan on your last employed day. You may be eligible to convert or port your group life insurance or the optional life insurance coverage upon termination. You may request the necessary application from Benefits Services. If you choose to convert the policy, the application and the first premium payment must be submitted within 60 days of your termination date to Standard Insurance Company. If you choose to port the policy, the application must be submitted to Standard Insurance Company within 60 days of your termination date. If you exceed these deadlines, you will NOT be eligible for life insurance conversion or porting.

Waiver of Premium
If you become totally disabled while insured and before your 60th birthday, this option may continue your life insurance without any further payment by you or Poudre School District. Premium is waived to age 70 or retirement.

Emergency Travel Assistance
This service is provided by FrontierMEDEX, Inc. and provides emergency coverage for you and your family 24 hours per day, 365 days a year anywhere in the world when you travel more than 100 miles from home.

Employee Assistance Services

EAS is a confidential problem-solving consultation service available to help employees and their immediate family members solve personal issues before they may affect family or work relationships, health, or job performance.

EAS services are available at no cost and regardless of whether the employee or family member is enrolled in a PSD Health Plan.

No enrollment is necessary for Employee Assistance Services (EAS). However, only participants enrolled in the EPO, PPO-1, or PPO-2 are eligible for Mental Health and Substance Abuse benefits.

You may visit the EAS website at http://eas.psdschools.org for additional information or contact them at 970-488-4925.

Wellness and the Integrated Health Management System

PSD is committed to supporting employees and promoting a healthy work/life balance in every way. PSD provides an Integrated Health Management System (IHMS) combining all aspects of health and wellness into one cohesive, connected approach. With accessible, affordable care, the IHMS focuses on the whole person through coordination between medical providers, lifestyle support, wellness, and mental health services.

The key services of the IHMS include:

- Walk-in Employee Health Clinic – PSD has partnered with the University of Colorado Health, Associates in Family Medicine, and Miramont Lifestyle Fitness to provide benefited employees and their dependents with increased access to care through an employee health clinic. Employees and dependents must be enrolled in a PSD health plan to access the clinic. Clinic services are located at:

  University of Colorado Health Walk-in Clinic
  2211 South College Avenue
  Fort Collins CO 80525
  970-237-6339

- Lifestyle Health Services – This program is available to benefited employees and dependents on a referral basis. This program assists those at risk for a chronic condition such as hypertension, asthma, diabetes, arthritis, and bipolar disorders. Services are completely voluntary and confidential. Support tools may be provided to improve nutrition, fitness, and overall health. Lifestyle Health Services are located at:

  Miramont Lifestyle Fitness
  2211 South College Avenue
  Fort Collins CO 80525
  970-776-8333

- Wellness Classes and Support – PSD provides comprehensive wellness programming to all employees regardless of their benefit status. Examples of wellness offerings include biometric screenings, health assessments, fitness assessments, wellness classes, flu shots, discounts at local fitness centers, and much more. In addition, an employee wellness portal is available to employees. The portal is a great place to access wellness programs, recipes, and many more items. You can access the portal as follows:
  - Go to www.wellworksforyoulogin.com
  - Click the link to create an account as a New Member
  - Enter your COMPANY ID: 10479
  - Create a Username and Password
  - Accept the terms of the Consent Form
  - Enter the required Personal Information

    Please note: You may register on the portal using your Poudre email address and password to keep your login information easy to remember!

- Employee Assistance Services – Provides access to cope with the demands and stresses of life. Staff is available with problem-solving strategies and confidential mental health counseling services. Services are available to all employees and their dependents, regardless of benefit status.

You may visit the Wellness website at http://www.psdschools.org/department/wellness for additional information.

Flexible Spending Accounts (FSA)

Section 125 of the Internal Revenue Code allows you to defer a portion of your gross income into a tax free spending account for:

- ✓ Health Care FSA – used to pay for medical, dental and vision related expenses for you and your eligible dependents.
- ✓ Dependent Care FSA – used to pay for eligible daycare expenses

You will not pay federal, state or Medicare taxes, or PERA contributions on the portion of your gross income you elect to deposit to your medical and/or dependent care spending account(s).

Eligible expenses must be incurred during the plan year (August 1-July 31).

NOTE: You are required to re-enroll each year during the open enrollment period to continue participation.

Plan carefully! Any account balance after July 31 of each year will be forfeited. You do have 90 days from the end of the plan year (July 31) to submit qualified expenses incurred through July 31 for reimbursement.

Plan Administrator:
The FSA plan is a benefit administered through UCHealth Plan Administrators. The address for submitting FSA claims is:

UCHealth Plan Administrators
1107 South Lemay Avenue, Suite 400
Fort Collins, CO 80524
970-224-4600

Health Care FSA

The expenses you claim must not be eligible for reimbursement elsewhere (i.e., insurance plans) and you will not be able to claim the reimbursed expenses as a medical deduction on your tax return.

When you participate in the health flexible spending account, you will receive a "Benny" card to use as payment to providers. The card acts as a credit card with your annual health flexible spending balance on the card. Each time the card is used, the applicable charge is deducted from the balance. You must keep your receipts as backup for the charges on the card, but you are not required to submit them for reimbursement.

The health care FSA lets you set aside a predetermined amount divided into equal monthly installments, from your paycheck, to pay for medically necessary medical, dental and vision care expenses which are not covered by a health care plan.

The maximum amount you may set aside is $2,550 per year ($212.50 per month) and the minimum is $120 per year ($10 per month) for health care expenses. The maximum amount is pro-rated if your first paycheck is after August 31.

In general, you can use your health care FSA for the same type of health care expenses the IRS lets you claim as a deduction on your personal income tax returns. Additionally, you can claim certain over-the-counter medications as prescribed by your doctor. However, you cannot claim these FSA expenses on another FSA or your personal income tax return. You can submit your deductibles, coinsurance payments and co-payments for reimbursement under the FSA. Health care FSAs must be continued while you are on a leave of absence, unless participation is waived within 31 days of the "qualifying event".

Eligible Expenses
A complete list of eligible health expenses is available from the IRS Publication 502 – Medical and Dental Expenses (www.irs.ustreas.gov).

If you have any questions about whether a procedure or an item is eligible for FSA reimbursement, please contact UCHealth Plan Administrators at 970-224-4600 prior to establishing your medical FSA. Plan carefully for all known expenses, since failure to receive eligible services during the plan year will result in unspent monies that are lost to you.

The following list is not intended to be a complete list of eligible expenses. The IRS regulations regarding eligible expenses that may be included in Section 125 Flexible Spending Accounts is the final determination. All expenses must be eligible under IRS Code Section 213. Any expense not listed that you believe may be eligible should be discussed with the administrator prior to enrollment.

Abortion (legal only)
Acupuncture (excluding remedies/treatments prescribed)
Alcoholism; Drug Addiction
Ambulance
Artificial limb
Artificial teeth
Blood Pressure Monitor
Braille books
Childbirth classes
Chiropractors
Co-payments & Co-insurance amounts
Contraceptives (prescription only)
Contact lenses & cleaning solutions
Crutches
Deductibles
Dental care including dentures
Diabetic supplies
Ear plugs
Eye exams, eyeglasses, contacts
Fertility treatments
Flu shots
Hearing aids & batteries
Immunizations
Insulin
Lasik vision correction

Learning disabilities
Medical records charges
Nicotine chewing gum
Occlusal guards
Orthodontia services
Over-the-counter medications such as pain relievers, allergy medications, cold/flu medications and antacids if prescribed by a physician
Patterning exercises
Physical exams
Prescription drugs
Prescription sunglasses
Pregnancy tests
Psychiatric care
Physical therapy
Smoking Cessation (prescription only)
Speech training
Sterilization
Transplants
Vaccines
Wheelchair

Non-prescription, over-the-counter medications that may be reimbursed through a Flexible Spending Account with a physician prescription:

PAIN RELIEVERS

Aspirin
Tylenol
Motrin
Advil
Ibuprofen
Generic equivalents

ALLERGY MEDICATIONS

Claritin
Sinutab
Benadryl
Actifed
Allerest
Dilosos
Tavist
Generic Equivalents
Alavert
Chlor-Trimeton

COLD/FLU MEDICATIONS

Sudafed
Nyquil
Theraflu
Vicks
Aleve
Alka-Seltzer
Contac
Comtrex
Coricidin
Delsym
Dristan
Drixoral
Triaminicin
Generic equivalents

ANTACIDS

Alka-Seltzer
Gaviscon
Tagamet
Prilosec
Maalox
Mylanta
Pepcid
Pepto Bismol
Philips
Rolaids
Tums
Zantac
Generic Equivalents

MISCELLANEOUS

Creams & Ointments such as BenGay, Neosporin etc.
Band-aids and bandages
Wart removers such as Compound W
Condoms and spermicidal foams
Hemorrhoid relieving products such as Tucks
Sunburn relief such as Solarcain

Ineligible Expenses

The following list is not intended to be a complete list of ineligible expenses.

Air purifier*
Alternative medicines
Breast pumps*
Cosmetic surgeries & procedures
COBRA insurance premiums
Child care expenses
Controlled substances
Exercise equipment
Funeral expenses
Genetic testing**
Hair transplants
Hair growth medications (i.e. Rogaine)
Hair removal treatments
Health club dues
Herbs*
Herbal supplements*
Illegal services
Insurance premiums
Lodging***
Long term care insurance/services
Massage therapy*
Medicare premiums
Meals
Monitoring and testing devices*
Nutritional supplements*
Personal trainer
Pre-payments or pre-treatments
Specialty foods*
Storage fees (sperm, blood etc.)
Sundries; toothpaste, face creams etc.
Sunscreen
Supplies*
Surrogate expenses
Tanning salon
Teeth bleaching/whitening

Varicose vein treatments*
Vitamins*
Weight loss programs/medications*

*Must be prescribed for a specific medical condition.
**Only to determine possible defects.
***Subject to IRS daily limits.

Qualified Status Change for Medical FSA

If you have a qualified status change, you must submit the change to Benefits Services within 31 days of the status change on the appropriate enrollment or change form. *The change you elect must be consistent with the status change.* For example, should you have a child during the plan year, it is consistent if you elect to increase your medical care FSA deduction. It would not be consistent to reduce your deduction, as expenses should increase with the addition of a baby.

- ✓ You must be enrolled in the FSA plan to make a change.
- ✓ A qualified status change will ***NOT*** allow you to join the plan mid-year.

Dependent Care FSA

The Dependent Care FSA lets you set aside a predetermined amount, divided into equal monthly installments, from your paycheck, to pay for dependent care expenses. An eligible dependent may be a child under age 13 or a disabled adult you claim as a deduction on your personal taxes. You can use this FSA for day care expenses when you work outside your home.

When you participate in the dependent care flexible spending account, you will receive a "Benny" card to use as payment to providers. The card acts as a credit card with your annual dependent care flexible spending balance on the card. Each time the card is used, the applicable charge is deducted from the balance. You must keep your receipts as backup for the charges on the card, but you are not required to submit them for reimbursement.

The maximum is $5,000 per year ($416.67 per month) and the minimum is $120 per year ($10 per month) for Dependent Care expenses. The maximum amount is pro-rated if your first paycheck is after August 31st. If you and your spouse are both PSD employees, the maximum is $2,500 per year each if filing jointly.

All-day kindergarten does not qualify for dependent care reimbursement under Section 125.

Expenses eligible for reimbursement include the same type as those for which you may claim a deduction on your personal taxes. You should consult with your tax professional to determine whether the dependent care FSA is the best way to pay for your dependent expenses. Remember that you cannot claim these FSA expenses on another FSA or your personal income tax return.

Plan carefully for all known expenses, since failure to receive eligible services during the plan year will result in unspent monies that are lost to you.

Qualified Status Change for Dependent Care FSA

If you have a qualified status change, you must submit the change to Benefits Services within 31 days of the status change on the appropriate enrollment or change form. *The change you elect must be consistent with the status change.* For example, should you have a child during the plan year, it is consistent if you elect to enroll in or increase your dependent care FSA deduction. It would not be consistent to reduce your deduction, as expenses should increase with the addition of a baby.

- ✓ You may enroll in, change, or drop the dependent care FSA plan if you have a qualified status change. **The change must be consistent with the status change.**

Short Term/Long Term Disability

PSD offers short- and long-term disability coverage for eligible employees scheduled to work 15 or more hours per week. There is no cost to the employee. Should you become disabled and unable to work, this coverage would provide a benefit to help replace your salary. This is especially important if you do not have at least five years of service credit with PERA. After you have earned five years of service credit, PERA provides some disability protection.

Standard Insurance Company makes the medical determination for disability benefits.

This benefit summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. For all details, please see the policy certificate available by contacting Benefits Services at 970-490-3680.

Disability Summary

Benefit	Short-Term Disability	Long-Term Disability
Benefit	70% of pre-disability earnings up to $1,000 per week	60% of pre-disability earnings up to $6,000 per month
Waiting Period	Benefits start after the later of: • All projected sick and flex/floating leave is exhausted, or • On the 16th working day of a disabling illness, pregnancy, or accident	Greater of: • 105 working days (including 15-day waiting period); or • The exhaustion of all projected sick and flex/floating leave; or • Any period of salary continuation (e.g. pay during summer months for wages already earned but not paid)

Maximum Benefit Period	Greater of: • 105 working days (including 15-day waiting period); or • The exhaustion of all projected sick and flex/floating leave; or • Any period of salary continuation (e.g. pay during summer months for wages already earned but not paid)	To age 65

401(k), 403(b), and 457 Information

Internal Revenue Service (IRS) regulations allow employees to put part of their salary into special accounts without paying taxes on that money or on the earnings it generates until it is withdrawn (usually at retirement). Because this money is taken out of your pay before taxes (tax-deferred), you pay lower federal and state income taxes now. The District offers three programs for you to select from if you decide to set aside some of your compensation on a tax-deferred basis.

Tax Sheltered Annuities and Custodial Accounts – 403(b) The Internal Revenue Code Section 403(b) permits employees of educational institutions to exclude a portion of their salary from current taxable income through purchase of an annuity or custodial account. The District has several approved providers who offer 403(b)'s to PSD employees.

457 Plan– Flexible Tax-Deferred Savings Plan – Empower Retirement is the sole provider for this plan which allows an employee to increase the tax-deferred amount each year by combining the contribution limits of a 401(k) account and/or a 403(b) account with a 457 account. The 457 Plan has a separate contribution limit then the 401(k)/403(b) limit.

PERA's 401(k) The PERA 401(k) Plan was established on July 1, 1985, to enhance the retirement savings opportunities of PERA members. The 401(k) Plan provides all Colorado PERA members the option to voluntarily invest some of their income tax-deferred.

Any active and contributing member of PERA or retiree working in a PERA-covered position is eligible to contribute to the Plan from his or her PERA employer income.

Contact Information

401(k) Plan

The 401(k) plan is available through PERA and administered by Voya Financial. Enrollment kits and information are available at www.copera.org or by calling 1-800-759-7372.

457(b) Plan

The 457(b) plan is available through Empower Retirement. Enrollment information is available at www.empower-retirement.com/participant or by calling 1-866-467-7756.

403(b) Plans

Approved 403(b) plans are available through the following providers:

• AXA Financial	Max Shaffer	719-352-8756
• Met Life Resources	Kelly Pachelo-Forehand	303-886-8904
• Security Benefit	Jonathan Neher	970-222-3561
	Randy Petrilli	970-215-6149
• Valic	Jeff Bauer	970-430-9745
	Jeff Kopina	720-732-9903

Enrollment

Participants in any of the deferred compensation plans are required to elect to defer (contribute) to the plan prior to the month in which the contribution is effective. For example, if an employee wishes to change a contribution amount or elect to contribute to a deferred compensation plan effective on the July payroll, the election must be made by June 30.

This requirement is based on IRC 457 regulations. For consistency, the District is applying this regulation to the 403(b) and 401(k) plans as well.

You may enroll in a deferred compensation plan anytime during the year as long as you meet the requirement stated above.

To enroll in PERA's 401(k) plan, you may obtain an enrollment kit from PERA.

To enroll in a 403(b) plan, you must contact one of PSD's Approved Providers listed above. The forms for enrolling are available through the representative, PSD Benefits Services, or online from the PSD website at www.psdschools.org -> Staff > PSD Intranet -> S.A.F.E. School Accounting Financial E-Tools -> Payroll Forms -> Voluntary Deductions Election.

To enroll in the 457(b) plan, you must enroll by using the Empower Retirement online system at www.empower-retirement.com/participant or by calling 1-866-467-7756.

Changes

Changes in contribution elections to the 457(b) plan must be made using the Empower Retirement online system at www.empower-retirement.com/participant or by calling 1-866-467-7756 toll-free.

To make changes to your PERA 401(k) or 403(b) contribution election, use the *PSD Voluntary Deductions Election Form* available from the PSD Payroll Department.

Contribution Limits

The following charts show a brief summary of the limits and catch-up provisions for each plan for the 2016 calendar year. Many of these provisions have specific limitations, and some provisions can be used in combination while others cannot. PSD cannot give financial or tax advice and strongly recommends that you discuss specific aspects of a plan with the respective plan representatives or a financial advisor. Employees using the catch-up provisions available under the 457(b) or 403(b) plans are required to submit a new calculation each calendar year. Please consult your plan representative to complete this form.

Annual Contribution Limit	2016
401(k)	$18,000
403(b)	$18,000
457(b)	$18,000
Age 50+ catch-up	$6,000

Combined Annual Limits	2016
401(k) and 403(b)	$18,000
401(k) and 457(b)	$36,000
403(b) and 457(b)	$36,000

Combine Annual Limits with Age 50+ Catch-Up	2016
401(k) and 403(b)	$24,000
401(k), 403(b) and 457(b)	$53,000

"Standard" Catch-Up Elections	401(k)	403(b)	457(b)
15 years of services with the same employer	Not available	Up to $20,000 lifetime	No
3 years before normal retirement age	Not available	Not available	Up to twice the annual contribution limit

Access to Retirement Savings	401(k)	403(b)	457(b)
10% early withdrawal penalty for withdrawals prior to age 59½	Yes	Yes	Not applicable
Rollover to other plans allowed	Yes	Yes	Yes

Other Voluntary Benefits

Auto and Home Owners Insurance and Disability Income through Horace Mann

Horace Mann offers discounted auto and home owners insurance rates for PSD employees. In addition, should you become disabled and unable to work, the voluntary disability income coverage would provide a benefit to help replace your salary. This is especially important if you do not have at least five years of service credit with PERA. After you have earned five years of service credit, PERA provides some disability protection.

This plan is separate from the disability coverage offered by PSD for eligible employees.

Information is available by calling Horace Mann Representative, Steve Tracy at 970-460-0729.

Cancer and Intensive Care Coverage through AFLAC

Cancer and intensive care insurance is available to employees as a payroll deduction. This coverage pays cash to you over and above any other insurance to help you pay for non-medical or medical related expenses.

Information is available by calling AFLAC representative, Tama Glazebrook Hinckley at 970-669-9379 or via email at tama@edhyperlinks.com. You may also access AFLAC's online enrollment system at www.aflac.com/psdschools.

Identity Theft Protection and Restoration Services through InfoArmor

Identity theft protection and restoration services from InfoArmor help assess your risk, deter theft attempts, detect fraud, and manage the restoration process in the event of an identity theft. Your identity will be monitored to uncover fraud at its inception. You will be offered an annual credit report, monthly credit scores, and monitoring of your credit file.

InfoArmor offers privacy advocates that are certified and trained in identity restoration. If they detect suspicious activity, a privacy advocate can act as a dedicated case manager on your behalf and resolve the issue.

Monthly Premium – all paid by employee

- Employee only coverage - $7.95
- Employee and family - $13.95

Information and online enrollment can be found at
https://orders.infoarmor.com/?customerid=poudresd

You may also contact InfoArmor at 1-800-789-2720.

Legal Services through ARAG

We're excited to offer you the opportunity to enroll in a legal insurance plan from ARAG. It provides you with affordable, reliable legal coverage to help with everyday life matters – like a dispute with a contractor, getting your will done, or an auto repair that doesn't go as planned. Legal advice will be just a phone call away. A knowledgeable client service representative can help you locate a plan attorney in your area.

Monthly Premium – all paid by employee - $17.50

Enrollment

You MUST enroll during your initial 31-day eligibility period, during the annual open enrollment period or within the required 31-days of a qualified status change.

For additional information:

- Visit http://www.ARAGLegalCenter.com/home/index.htm?aragaccesscode=18085psd

- Call the ARAG Customer Care Center toll-free from 6:00 a.m. to 6:00 p.m. Mountain time, Monday through Friday at 800-247-4184.

Pet Insurance through Veterinary Pet Insurance (VPI)
Pets can take a bite out of your budget. VPI® Pet Insurance can help. This paw-pular benefit is available to PSD employees, so what are you waiting for?

From regular preventive care to unexpected illnesses, you can be reimbursed for veterinary expenses with coverage from Veterinary Pet Insurance®. Plus, PDS employees receive a 5%* special employee discount. Pet Parents with multiple pets receive additional discounts.

Choose the amount of coverage that's right for you
Major Medical: Coverage for accidents and illnesses, including cancer. Reimburses for exam fees, testing, surgeries, specified hereditary conditions and more. Low $250 annual deductible.

Wellness: Coverage for the routine care your pet needs every year. Reimburses for wellness exams, vaccinations, flea/heartworm preventives and more. No deductible.

Major Medical + Wellness: Bundled coverage for maximum protection. Nose-to-tail coverage at its very best.

Plus every VPI plan includes access to Vet Helpline. This **free** service gives you access to a veterinarian 24/7 to help manage your pets care and make optimal healthcare decisions.

*5% yearly discount on base medical plan or standalone wellness plan only, with continuous coverage.

For additional information:
- Visit http://www.petinsurance.com/psdschools
- Call 1-877-738-7874

Simply mention you are an employee of Poudre School District!

COBRA Continuation of Coverage

PHSA Continuation of Benefits (similar to COBRA):
Depending on when you terminate employment with Poudre School District, Poudre School District's group health plan may provide continuation coverage for you and your family. A special notice on continuation of benefits is sent upon termination of employment.

You will be required to pay the full premium cost of this continued coverage, plus a 2% administrative charge. Detailed information is available from UCHealth Plan Administrators at (970) 224-4600.

Legal Notices

Newborns' and Mothers' Health Protection Act of 1996

- ✓ The Newborns' and Mother's Health Protection Act of 1996 (NMHPA), which was signed into law in the fall of 1996, became effective September 1, 1997. This law provides certain protection for mother and infants, and specifically requires that:
  - "Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother of newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods."
- ✓ Newborns meeting the definition of a dependent are covered by Poudre School District's health plan from the moment of birth for the first 31 days under the mother's policy. The dependent must be added to the health plan to continue coverage beyond the first 31 days.
- ✓ If you need to add a newborn to your health plan, you must:
  - Complete the online enrollment available through UCHealth Plan Administrators at http://tpa.uchealth.org within 31 days of the baby's date of birth.
  - You must complete this enrollment to add your newborn even if you already have other dependent children on your health plan.

Women's Health and Cancer Rights Act

- ✓ On October 21, 1998, Congress passed a bill called the Women's Health and Cancer Rights Act. In accordance with this federal law, the Plan shall provide benefits for reconstructive surgery following a mastectomy, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of all stages of mastectomy, including lymphedemas.
- ✓ In addition, the Plan may not interfere with a woman's rights under the Plan to avoid these requirements, or offer inducements to the health provider, or assess penalties against the health provider, in an attempt to interfere with the requirements of the law.
- ✓ However, the Plan may apply deductibles, co-payments, and coinsurance consistent with other coverage provided by the Plan.

Family and Medical Leave Act of 1993

Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements
Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections
During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a

chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

Notice of Privacy Practices (HIPAA)

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

You are receiving this Privacy Notice because you are enrolled in the Poudre School District (PSD) Health Plan. "The Plan" (reference to the PSD health plan) and its administrators are committed to protecting the confidentiality of any health information we collect about you. This Notice describes how The Plan may use and disclose your "protected health information" (PHI). PHI is information that identifies you and is about your health care, health status, or payment for your health care.

Employees of the plan sponsor, who administer and manage The Plan, and third party administrators such as UCHealth Plan Administrators, OptumRx or Met Life, may use your PHI only for appropriate Plan purposes (such as for payment or health care operations), but not for employment-related purposes of PSD. These organizations must comply with the same confidentiality requirements that apply to The Plan.

The Plan is required by the Health Insurance Portability and Accountability Act (HIPAA) to provide this Notice to you. Additionally, the Plan is required by law to:

- maintain the privacy of your "protected health information" (PHI), and
- provide you with a Privacy Notice of its legal duties and privacy practices with respect to your PHI, and
- follow the terms of the Privacy Notice that is currently in effect.

If you have questions about any part of this Privacy Notice or if you want more information about the privacy practices of the Plan, please contact the Privacy Officer listed at the end of this Notice.

USE AND DISCLOSURE OF HEALTH INFORMATION

The Plan is permitted by law to use and disclose your PHI in certain ways. These are described below, with examples of permitted uses. This Notice does not list every permitted use or disclosure that The Plan may make. However, all the ways The Plan is permitted to use or disclose PHI will fall within one of the categories below.

For Treatment Purposes. The Plan may disclose PHI to a health care provider in order for the health care provider to be able to treat you, although it is more likely a health care provider would receive your PHI from another health care provider than from The Plan. For example, if your Primary Care Physician (PCP) or your treating medical provider refers you to a specialist for treatment, The Plan can disclose your PHI to the specialist to whom you have been referred so (s)he can become familiar with your medical condition, prior diagnoses and treatment, and prognosis.

To Make or Obtain Payment. The Plan may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, The Plan may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

To Conduct Health Care Operations. The Plan may use PHI for its own health care operations and may disclose PHI to another health plan, health care provider, medical group or hospital for the health care operations purposes of The Plan, or for the other entity's health care operations purposes (subject to certain limitations). Examples of The Plan's "health care operations" include underwriting, premium rating and other activities related to plan coverage; conducting quality assessment and improvement activities; submitting claims for stop-loss coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; and business planning, management and general administration of The Plan.

Uses and Disclosures that Require The Plan to Give You an Opportunity to Object. Unless you object, we may provide relevant portions of your PHI to a family member, friend or other person you indicate is involved in your care or in helping you get payment for your health care. In an emergency or when you are not capable of agreeing or objecting to these disclosures, we will disclose PHI as we determine is in your best interest.

To a Business Associate of The Plan. The Plan may disclose PHI to a Business Associate of The Plan, if a Business Associate Agreement is in place between the Business Associate and The Plan. A Business Associate is any entity that performs a function on behalf of The Plan and that uses PHI in doing so. Examples of Business Associates include The Plan's Third-Party Administrators (TPAs) such as UCHealth Plan Administrators, OptumRx, and Met Life.

For Treatment Alternatives. The Plan may use and disclose your PHI to tell you about or recommend possible treatment options or alternatives that may be of interest to you, for example, if you were receiving benefits for a diabetic condition we might advise you of a new diabetic product or treatment on the market.

For Distribution of Health-Related Benefits and Services. The Plan may use or disclose your PHI to provide you with information about health-related benefits and services that may be of interest to you.

For Disclosure to The Plan Sponsor. In some circumstances The Plan may disclose your PHI to The Plan's sponsor, PSD, which may perform administrative services on behalf of The Plan such as the review of claims appeals by PSD's benefits committee. In these circumstances, PSD is required to comply with the provisions of a Business Associate agreement, and is forbidden from using your PHI for employment purposes. The Plan may also provide summary health information to PSD so that PSD may solicit premium bids from other health plans or TPAs, or for the purpose of modifying, amending or terminating The Plan.

When Legally Required and for Public Health Purposes. The Plan will disclose your PHI when it is required to do so by any federal, state or local law. In addition, The Plan may notify state or local health authorities regarding particular communicable diseases, or regarding suspected child or adult abuse or neglect.

To Conduct Health Oversight Activities. The Plan may disclose your PHI to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action.

In Connection With Judicial and Administrative Proceedings. As permitted or required by state or federal law, The Plan may disclose your PHI in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order. The Plan may also disclose your PHI in response to a subpoena, discovery request or

other lawful process, but only when The Plan makes reasonable efforts to either notify you about the request or to obtain an order protecting your PHI.

For Law Enforcement Purposes and to Medical Examiners. As permitted or required by state or federal law, The Plan may disclose your PHI to law enforcement officials for certain law enforcement purposes, and to coroners, medical examiners and funeral directors.

In the Event of a Serious Threat to Health or Safety. The Plan may, consistent with applicable law and ethical standards of conduct, disclose your PHI if The Plan believes in good faith that such a disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of another person or the public.

For Specified Government Functions. In certain circumstances, federal regulations require The Plan to use or disclose your PHI to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and to correctional institutions (regarding inmates).

For Worker's Compensation. The Plan may release your PHI to the extent necessary to comply with laws related to worker's compensation or similar programs.

In general, we may disclose a minor patient's PHI to a parent or guardian, but we may deny the parent's access to the minor patient's PHI in some situations.

For some types of PHI, there may be additional restrictions on our uses or disclosures described above. For example, the following Colorado laws may apply:

10-3-1104.5 (HIV testing)
10-3-1104.7 (Genetic testing)
12-43-218 (Psychotherapy records)
19-1-308 (Parentage information/genetic testing information)
19-4-106 (Artificial insemination)
25-1-122.5 (Genetic testing)
25-1-312 (Records of alcoholics)
25-1-1108 (Records of drug abusers)
27-10-120 (Records re mental health services)
27-10-120.5 (Mental health information)

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as stated above, The Plan will not disclose your health information other than with your written authorization. If you authorize The Plan to use or disclose your health information, you may revoke that authorization in writing at any time. However, a revocation will not apply to uses and disclosures that have already been made.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that The Plan maintains:

Right to Request Limits On Uses and Disclosures of Your Health Information. You have the right to ask The Plan to limit how we use and disclose your PHI, as long as you are not asking us to limit uses and disclosures that we are required or authorized to make to the Secretary of the Federal

Department of Health Services. Any such request must be submitted in writing to **PSD Privacy Official at 2407 LaPorte Ave, Fort Collins, CO 80521.** We are not required to agree to your request. If we do agree, we will put it in writing and will abide by the agreement except when you require emergency treatment.

Right to Choose How We Communicate With You. You have the right to ask that The Plan send information to you at a specific address (for example, at work rather than at home) or in a specific manner (for example, by e-mail rather than by regular mail, or never by telephone). You must make any such request in writing, to **PSD Privacy Official at 2407 LaPorte Ave, Fort Collins, CO 80521.** The Plan will attempt to honor your reasonable requests for confidential communications.

Right to See and Copy Your Health Information. You have the right to see and copy your PHI that is held by The Plan. If you wish to do so, a request to inspect and copy records containing your health information must be made in writing to **PSD Privacy Official at 2407 LaPorte Ave, Fort Collins, CO 80521.**

If you request a copy of your PHI, The Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request. In certain situations we may deny your request, but if we do, we will tell you in writing of the reasons for the denial and explain any appeal rights you may have under law.

Right to Correct Or Update Your Health Information. If you believe that the PHI that The Plan has about you is incomplete or incorrect, you may ask The Plan to amend it. That request may be made as long as The Plan maintains the information. A request for an amendment of records must be made in writing to **PSD Privacy Official at 2407 LaPorte Ave, Fort Collins, CO 80521.**

The Plan may deny the request if you do not state why you believe the amendment is appropriate. The request may also be denied in certain circumstances if the PHI at issue was not created by The Plan, is not part of The Plan's records, falls within an exception to the health information you are permitted to inspect and copy, or if The Plan determines that it is accurate and complete. The Plan will inform you in writing as to whether the amendment will be made or denied. If The Plan agrees to make the amendment, The Plan will ask you whom else you would like us to notify of the amendment.

Right to Get a List of The Disclosures We Have Made. You have the right to get a list of instances in which The Plan has disclosed your PHI. However, the list will not include, for example, disclosures that have been made for treatment, payment and health care operations purposes, or those made directly to you or your family. Neither will the list include disclosures we have made with your written authorization, for national security purposes or to law enforcement personnel (in certain circumstances), disclosure of any "limited data set" of information, or disclosures made before April 14, 2003. The request must be made in writing to **PSD Privacy Official at 2407 LaPorte Ave, Fort Collins, CO 80521.**

The request should specify the time period you want the list to cover, but may not go back before **April 14, 2003,** or cover a period of more than six (6) years. The Plan will provide the first list of disclosures you request during any 12-month period without charge. Subsequent requests may be subject to a reasonable cost-based fee. The Plan will inform you in advance of the fee, if applicable.

Right to a Paper Copy of this Notice. You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the

Notice electronically. To obtain a paper copy, please contact **Benefits Services of Poudre School District at benefits-l@psdschools.org** or **970-490-3680. You may also obtain a copy of the current version of The Plan's Notice at its website, www.psdschools.org under Benefits Services.**

THE PLAN'S RESPONSIBILITIES REGARDING YOUR HEALTH INFORMATION

The Poudre School District's health plan is a "covered entity" (CE) and has responsibilities under HIPAA regarding the use and disclosure of PHI. The Plan is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. The Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Plan reserves the rights to change the terms of this Notice and to make the new Notice provisions effective for all PHI that it or its administrators maintain. If The Plan changes its policies and procedures in a way that would make this Notice inaccurate, The Plan will revise this Notice. If this Notice is revised in a significant or material way, we will provide a copy of the revised Notice to you within sixty (60) days of the revision. You have the right to make complaints to The Plan, and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to The Plan should be made in writing to **PSD Privacy Official at 2407 LaPorte Ave, Fort Collins, CO 80521.** The Plan encourages you to ask any questions and express any concerns you may have regarding the privacy of your PHI. You will not be retaliated against in any way for filing a complaint.

CONTACT PERSON

The Plan (Poudre School District's health plan) has designated the **Benefits Manager** as its contact person and Privacy Official for all issues regarding patient privacy and your privacy rights. You may contact this person *by phone at 970-490-3435, by e-mail at melj@psdschools.org, or by mail at 2407 LaPorte Ave. Fort Collins, CO 80521.*

EFFECTIVE DATE

THIS NOTICE IS EFFECTIVE APRIL 14, 2003.

IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE, PLEASE CONTACT BENEFITS SERVICES OR E-MAIL AT benefits-l@psdschools.org.

Medicare Part D Notice – Creditable Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Poudre School District Health Plan (including the EPO, PPO1, and PPO2 plans) and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

2. Poudre School District has determined that the prescription drug coverage offered by the Poudre School District Health Plan (including the EPO, PPO1, and PPO2 plans) 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 Poudre School District Health Plan coverage will not be affected. You can keep this coverage and it will act as your primary plan for prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your current Poudre School District Health Plan coverage, be aware that you and your dependents will be able to get this coverage back provided eligibility requirements are met.

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 the Poudre School District Health Plan 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 or call OptumRx at 1-800-880-1188. **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 the Poudre School District Health Plan 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:	June 23, 2016
Name of Entity/Sender:	Poudre School District
Contact--Position/Office:	Melissa Johnson, Benefits Manager Benefits Services
Address:	2407 Laporte Avenue Fort Collins Colorado 80521
Phone Number:	970-490-3435

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

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 Sate 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-KIDSNOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2016. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**GEORGIA – Medicaid**
Website: www.myalhipp.com Phone: 1-855-692-5447	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ALASKA – Medicaid	**INDIANA – Medicaid**
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Medicaid	**IOWA – Medicaid**

Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: https://www.flmedicaidtplrecovery.com/hipp Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	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
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: www.eohhs.ri.gov Phone: 401-462-5300
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/ index.aspx Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**

Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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

OMB Control Number 1210-0137 (expires 10/31/2016)

HIPAA Exemption - Notice to Enrollees in the Poudre School District Self-Funded Nonfederal Government Group Health Plan

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must generally comply with the requirements listed below. However, the law also permits State and local governmental employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. Poudre School District has elected to exempt the Poudre School District Health Plan (including EPO, PPO1, and PPO2, from the following requirements:

1. Parity in the application of certain limits to mental health benefits. Group health plans (of employers that employ more than 50 employees) that provide both medical and surgical benefits and mental health or substance use disorder benefits must ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applicable to substantially all medical and surgical benefits covered by the plan.

The exemption from these Federal requirements will be in effect for the 2016-2017 plan year, beginning August 1, 2016 and ending July 31, 2017. The election may be renewed for subsequent plan years.

HIPAA also requires the Plan to provide covered employees and dependents with a "certificate of creditable coverage" when they cease to be covered under the Plan. There is no exemption from this requirement. The certificate provides evidence that you were covered under this Plan, because if you can establish your prior coverage, you may be entitled to certain rights to reduce or eliminate a preexisting condition exclusion if you join another employer's health plan, or if you wish to purchase an individual health insurance policy. If you have questions regarding this notice, please contact Barb Fisher, Employee Assistance Services Manager at 970-488-4925 or Melissa Johnson, Benefits Manager at 970-490-3435.

Notice of HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (of if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment with 31 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Christina Erickson, Benefits Technician, 970-490-3439 or at christie@psdschools.org.