POUDRE SCHOOL DISTRICT

EMPLOYEE BENEFITS GUIDE

AUGUST 1, 2025 – JULY 31, 2026



*Medical * Dental * Vision * Life Insurance*
*Employee Assistance Services * Flexible Spending Accounts*
*Deferred Compensation * Short-term Disability*
*Long-term Disability * Wellness * Legal Notices * More!*

Table of Contents

Introduction

Welcome to Poudre School District! 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 an array of benefit choices. 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.

Please contact Benefits Services via email at PSDBenefits@psdschools.org, if you have any questions. You may also reach us at 970-490-3382 or 970-490-3092.

If you (and/or your dependents) have or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please be sure to read the Medicare Part D Notice in the Legal Notices section of this booklet for information about your prescription drug coverage.

Benefits Contact Information

For Information or Questions Regarding:	Contact Information
Disability (short and long-term), Leaves of Absences and General Benefits including eligibility, benefit options, enrollment, and mid-year changes; life insurance claims and conversion/portability options	www.psdschools.org/staff (Departments, Benefits Services) Email: PSDbenefits@psdschools.org
Heather Fleming, Benefits Technician Last name A - O	970-490-3382, hfleming@psdschools.org
Genevieve Steensma, Benefits Technician Last name P - Z	970-490-3092, gsteensm@psdschools.org
Marissa Campos, Benefits Coordinator	970-490-3680, mcampos@psdschools.org
Melissa Johnson, Assistant Director of Benefits	970-490-3435, melj@psdschools.org
Medical Benefits	
Claims, ID cards, pre-authorizations, network providers	Simplified Benefits Administrators: 800-207-1018, simplifiedbenefitsadministrators.org
Prescription Benefits	
Medications, claims, ID cards, mail order	OptumRx: 1-800-880-1188, www.optumrx.com
Mental Health and Substance Use Benefits	eas.psdschools.org
Employee Assistance Services (EAS)	970-488-4925
Dental Benefits	Delta Dental – Group #DD000003050
Claims, pre-authorizations, network providers	Delta Dental: 1-800-610-0201, www.deltadentalco.com
Vision Benefits	VSP Choice Plan – Group #12058259
Claims, coverage, participating providers	Vision Service Plan: 1-800-877-7195, www.vsp.com
Flexible Spending Accounts (FSA)	
Dependent care and health care	Health Equity: 1-866-346-5800 https://my.healthequity.com/ClientLogin.aspx
Health Reimbursement Arrangement (HRA)	
Qualified medical and prescription reimbursement	Health Equity: 1-866-346-5800 https://my.healthequity.com/ClientLogin.aspx
Life Insurance	Policy #649750-A
Waiver of premium	Reliastar (Voya) Life Insurance Company: 800-955-7736
Wellness Program	www.psdschools.org/staff (Departments, Wellness)
Connor O'Rourke, Wellness Specialist	970-490-3532

HIPAA Special Enrollment Notice

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).

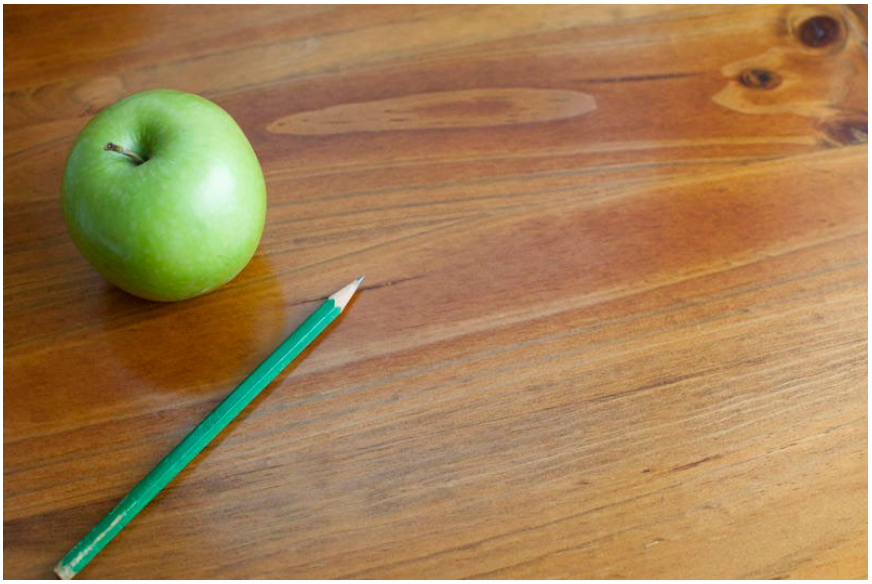
In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment with 31 days after the marriage, birth, adoption, or placement for adoption.

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

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

For these enrollment opportunities, you will have 60 days – instead of 31 days – from the date of the Medicaid/CHIP eligibility change to request enrollment in the Poudre School District Health Plan. Note that this 60-day extension doesn't apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

To request special enrollment or obtain more information, contact benefits at PSDBenefits@psdschools.org.



Employee Action Items to Enroll in Benefits

You should have received a benefits eligibility notice via your PSD email from Benefits Services informing you of your eligibility and dates to enroll by. The email notice also contains the forms you will need to enroll. Although the notice should be received in your email inbox, please also check your clutter and junk email. If you haven't received the notice, please contact us at PSDbenefits@psdschools.org.

You MUST take care of the following items within 31 days of your benefit eligibility date to ensure you enroll in the benefits you want before it's too late.

IF	THEN
You want to enroll in the medical, dental, vision and flexible spending account plans	You must enroll by the date indicated on the benefits eligibility email sent to you. The enrollment forms are attached to the eligibility email. If you are adding dependents, proof of relationship is required.
You are requesting optional life for you and your eligible dependents. NOTE: If you request enrollment within the 31-day window, you and your eligible dependents are eligible for coverage to a certain limit without the Evidence of Insurability requirement by Reliastar (Voya) Life Insurance.	You must complete the Optional Life and AD&D Enrollment Form available on the PSD Benefits Services website at: **https://www.psdschools.org/staff** (Benefits -> PSD Benefits A – Z -> Forms)
You are NOT requesting optional life for you and your eligible dependents.	You must still complete the Voya Beneficiary Designation Form. This form needs to be completed for beneficiary designation of the $50,000 employee policy PSD pays on your behalf. The form is available on the PSD Benefits Services website at: **https://www.psdschools.org/staff** (Benefits -> PSD Benefits A – Z -> Forms)
You wish to enroll in the voluntary legal services plan available through ARAG	You must enroll via the online enrollment system at **https://www.araglegalcenter.com** (use access code **18085psd**)
You wish to enroll in the voluntary cancer and intensive care coverage available through AFLAC	You must contact AFLAC representative Tama Glazebrook-Hinckley at 719-487-8520 or via email at tama_glazebrookhinckley@us.aflac.com.

You may enroll in the following voluntary deductions outside 31 days of your eligibility for benefits. See the specific sections in this document which explains details of enrollment.

- Deferred compensation plans (401k, 403b, 457b)
- Pet insurance through Nationwide

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 (except vision which ends on the day the dependent turns 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/staff (Benefits -> PSD Benefits A-Z, Proof of Relationship). These documents should be sent to PSD Benefits Services via email at PSDbenefits@psdschools.org or faxed to 970-490-3624.

Required Information *– When you enroll, you will be required to enter a Social Security number (SSN) for all covered dependents. The Affordable Care Act (ACA) requires PSD to report this information to the IRS each year to show that you and your dependents have coverage.*

If you choose to enroll dependents, they will be enrolled on the same dental and medical plan as you. They cannot be on a different plan.

Benefit Eligibility Chart

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**		
151	Less than 6.90	6.90 – 8.00	-
177	Less than 5.89	5.89 – 8.00	-
178	Less than 5.86	5.86 – 8.00	-
180	Less than 5.79	5.79 – 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
188	Less than 5.54	5.54 – 7.87	7.88 – 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
209	Less than 4.99	4.99 – 7.08	7.09 – 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 Life Insurance	No	Voluntary	Voluntary
Vision	No	Voluntary	Voluntary
Short- and Long-Term Disability (PSD paid)	Yes – if working 3 or more scheduled hrs/wk	Yes	Yes
Flexible Spending Accounts	Optional	Optional	Optional
Tax Deferred Plans (401k, 403b, 457)	Optional	Optional	Optional

NOTE: Employees electing benefits requiring they pay any portion of the premium will be paid on a prorated basis.

ALEX – Benefit Education Tool

ALEX is an online educational tool available in audio and text versions to assist you in better understanding the benefit options available to you.

ALEX can help you determine which health plan might be best for you and your family depending on your medical needs/usage. ALEX also explains the many other benefits available to you as a PSD employee.

For a sneak peek, go to: **http://myalex.com/psdschools/newhire2025**

The audio-based module is currently available in English only. Employees can access this module to see all of their benefit offerings in-depth and get support in making selections that work for them through a guided audio experience.

The text-based module is available in both English and Spanish. To access the Spanish version, simply click on the EN box on the top left of the home screen and select ES Español. Employees can access this module to see all of their benefit offerings and utilize a family plan comparison tool.

It is recommended that you sign up before going through the tool, but you can also start as a guest. By signing up, your progress will be saved in the event that you need to leave the tool and come back at a later time. If you continue as a guest, your progress will not be saved.

Note: Due to the numerous classified work calendars we have, classified employees need to reach out to benefits at PSDBenefits@psdschools.org for assistance in determining which eligibility status should be selected from the dropdown menu when starting the module. This will help ensure you are receiving the most accurate information through the module.

Please remember this is an educational tool only. You are still encouraged to review the materials posted on the benefits website as this is the most accurate information.

REMINDER: You must utilize the online enrollment system to make your enrollment elections. Making elections in ALEX does not complete the enrollment process!

Contact PSDBenefits@psdschools.org with any questions.

Public Employees' Retirement Association (PERA)

Employees of PSD do not pay into Social Security. Instead, employees participate in the Colorado PERA defined benefit pension fund. You contribute a mandatory 11% of your monthly gross salary into PERA and the district contributes an amount equivalent to 21.4% of your gross salary to help fund the PERA system.

After working five years under PERA covered employment, you become vested in the pension plan and are eligible to receive retirement payments once you reach retirement age. Retirement benefits are determined based on age and service. For additional information, contact PERA at 800-759-7372 or online at www.copera.org.

Pre-Tax Versus Post-Tax Insurance Premiums

Employee paid elections for medical, dental and 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 and no Medicare tax (if applicable) on these dollars. Whether or not you make PERA contributions on your pre-tax deductions, and whether it is an advantage to your future PERA benefit calculation to take your deductions on a post-tax basis in the years leading up to retirement, depends on when your PERA membership begins.

If your PERA membership begins prior to July 1, 2019

Pre-tax benefit deductions:

- You DO NOT pay federal or state taxes or PERA contributions on your medical, dental, vision, and flexible spending account deductions. You pay less taxes with this option.
- This option reduces the earnings reported to PERA.
- PERA calculates retirement benefits based on the average of your three highest years' salary. If you are not close to retirement age, electing the pre-tax option may be your best option. However, as you approach your final four years before retirement, you may wish to change your election to post-tax (or after-tax).

Post-tax benefit deductions:

- You DO pay federal, state taxes, and PERA contributions on your medical, dental, vision, and flexible spending account deductions. You pay more taxes with this option.
- This option increases the earnings reported to PERA.
- If you are within four years of retiring, this is often your best option since PERA calculates retirement benefits based on the average of your three highest years' salary (with a potential fourth year earnings limit).

Electing post-tax option: 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.

> **Important Update** – PERA regulations were updated with the adoption of Colorado SB 18-200. As a result, employees who begin PERA membership as of July 1, 2019, or later, will be subject to a different tax treatment that impacts their pre-tax deductions due to an amended definition of PERA-eligible earnings.

If your PERA membership begins July 1, 2019 or later

Pre-tax benefit deductions:

- You DO NOT pay federal or state taxes on your medical, dental, vision, and flexible spending account deductions. You pay less taxes with this option.
- This option does not reduce the earnings reported to PERA and you pay PERA contributions on your pre-tax earnings. Therefore, it is no longer necessary to adjust the tax status of your deductions to post-tax as you near retirement.
- Most people will keep the pre-tax option because PERA earnings will remain the same under either pre-tax or post-tax and you still get the tax benefit of paying less federal and state taxes.

Post-tax benefit deductions:

- You DO pay federal, state taxes, and PERA contributions on your medical, dental, vision, and flexible spending account deductions. You pay more taxes with this option.

Note: Health care and dependent care flexible spending account contributions are always made on a pre-tax basis. You don't have a choice.

Monthly Insurance Premiums

The cost of your 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 a significant part of the cost of employee-only medical coverage and 100% of the cost for employee-only dental 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 dependents, they must be enrolled in the same plan that you elect for yourself.

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.

Medical Premium Discount

The monthly employee share for medical premiums can be reduced by $25 per month for participating in PSD's wellness program on an annual basis.

What exactly do you need to do to receive the discount?

It's simple! You must be currently enrolled in a PSD medical plan then each year (August 1 – June 30) you must complete these 2 simple steps by the **June 30** deadline to start receiving the $25 per month discount beginning the following August.

Step 1 – Complete your annual preventative screening. This can be done one of two ways:

- accessing the onsite biometric screenings PSD offers during the year OR
- visiting your doctor and having them complete the Physician Results Form available on the wellness portal

Step 2 – Complete the Health Risk Assessment on the wellness portal

Watch for monthly emails from PSD's Wellness Specialist with additional details about the medical premium discount. You may also contact wellness at 970-490-3532 with questions.

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

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	$901.00	$848.00	$53.00	$747.00	$154.00
Employee/Spouse	$1907.00	$848.00	$1059.00	$747.00	$1160.00
Employee/Child(ren)	$1584.00	$848.00	$736.00	$747.00	$837.00
Employee/Family	$2108.00	$848.00	$1260.00	$747.00	$1361.00

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	$799.00	$747.00	$52.00	$747.00	$52.00
Employee/Spouse	$1676.00	$747.00	$929.00	$747.00	$929.00
Employee/Child(ren)	$1392.00	$747.00	$645.00	$747.00	$645.00
Employee/Family	$1849.00	$747.00	$1102.00	$747.00	$1102.00

Poudre Consumer Driven Health 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	$735.00	$735.00	$0.00	$735.00	$0.00
Employee/Spouse	$1326.00	$735.00	$591.00	$735.00	$591.00
Employee/Child(ren)	$1138.00	$735.00	$403.00	$735.00	$403.00
Employee/Family	$1444.00	$735.00	$709.00	$735.00	$709.00

Dental DPPO 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	$53.00	$53.00	$0.00
Employee/Spouse	$120.00	$53.00	$67.00
Employee/Child(ren)	$120.00	$53.00	$67.00
Employee/Family	$166.00	$53.00	$113.00

Dental DPPO Buy-Up 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	$62.00	$53.00	$9.00
Employee/Spouse	$139.00	$53.00	$86.00
Employee/Child(ren)	$139.00	$53.00	$86.00
Employee/Family	$193.00	$53.00	$140.00

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	$8.34	$0.00	$8.34
Employee plus one	$15.99	$0.00	$15.99
Employee plus 2 or more	$25.81	$0.00	$25.81

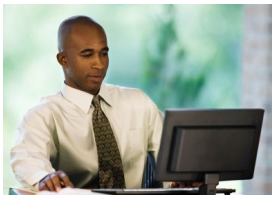
* Based on standard 185-day (9-month) contract. See eligibility chart in this booklet for other contract lengths.

Benefits Start Date

You must choose coverage for medical, dental, vision, flexible spending plans, and the legal services plan 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 by completing the appropriate forms. These forms will be included in your eligibility email.



Benefits Stop Date

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 (optional life insurance coverage for dependents turning 26 terminates on the day the dependent turns 26),
- ✓ 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 in July prior to the new plan year. It's the 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 plans;
- 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
- Enroll or drop the legal services plan through ARAG

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. Benefit changes must be consistent with the situation. *If you experience a qualified status change and wish to change your elections, you must complete the Benefits Enrollment Form and submit proof of the status change to Benefits Services within 31 days of the status change*. **Exception:** Unlike other qualifying events, you have 60 days from the date of the qualifying Medicaid/CHIP event to request enrollment in the PSD medical plan.

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;
- your spouse or dependent gains or loses coverage during their employer's open enrollment;
- 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);
- your spouse or dependent is eligible for a special enrollment in a public exchange or seeks to enroll in a public exchange during the public exchange's annual open enrollment period;
- 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) pays 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.

How to Enroll for Coverage

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 enrollment forms that were attached to your eligibility notice. If you have not received the notice, please contact Benefits Services at 970-490-3382.

Return completed forms to PSDbenefits@psdschools.org or fax to 970-490-3624 within 31 days of your noted effective date

If you enroll your spouse or eligible dependent children on your medical, dental or vision plans, you will be required to submit proof of relationship documents to Benefits Services before your enrollment is approved. A list of acceptable proof of relationship documents is attached to the Eligibility Notice that was e-mailed to you by Benefits Services. Email the necessary documents to PSDbenefits@psdschools.org.

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

You will need to be sure to have the following information to complete your enrollment forms:

- Dependent Name(s), Social Security Number(s) and Date(s) of Birth; and

Medical Benefits

The Poudre School District health plan is a self-funded plan administered by Simplified Benefits Administrators. You can access your medical claim information and find medical providers by going to the Simplified Benefits Administrators website at https://simplifiedbenefitsadministrators.org.

For specific questions regarding plan coverage and individual claims, you should contact Simplified Benefits Administrators at 800-207-1018.

The address for submitting medical claims is:

Simplified Benefits Administrators
PO Box 4718
Englewood, CO 80155

The plan year runs August 1 through July 31.

Mental Health and Substance Use Benefits

Mental Health and Substance Use benefits are available under the PSD medical plans. Additional details are included in this section.

Employee Health Clinic

Employees with regular scheduled work hours/contract and their eligible dependents enrolled in one of the PSD medical plans are eligible to use the Employee Health Clinic at no additional cost (for most services). Information about the employee clinic is available in the Employee Health and Wellness section of this booklet.

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

The following medical insurance plan options are available:

- ✓ PPO-1 (Preferred Provider Organization)
- ✓ PPO-2 (Preferred Provider Organization)
- ✓ Consumer Driven Health Plan with Health Reimbursement Arrangement (HRA)

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.

Routine preventive services are covered at 100% under all plans when utilizing a network provider. A preventive health visit can help identify any current or potential medical issues before they develop into something more serious. Some well child, well man, and well woman screenings, vaccinations, and tests have specific age requirements. Please be sure to check with Simplified Benefits Administrators prior to obtaining these services to determine whether it will be considered preventive and covered at 100%.

The following are common terms used to understand medical coverage.

- Coinsurance: Percentage of the charge that you pay for covered services **after** you've met your deductible.
- Copay/Copayment: An amount you pay for a covered service each time you utilize that service. It does **not** apply toward the deductible.
- Deductible: The amount that you pay for covered services before you start paying any applicable coinsurance and the plan begins to pay. For example, if you have a $500 plan year deductible, you will pay 100% of your medical bills until you've reached the $500.

- In-network: Refers to the inclusion of a provider within the health care network
- Out-of-Network: Refers to a provider that is not part of the health care network
- Plan Year Out-of-Pocket Maximum (OOPM): The maximum amount you pay for covered services within a given plan year. After you reach the OOPM, the health plan pays 100% of covered services for the remainder of the plan year.

Note: Plan Year refers to the time period August 1, 2025 through July 31, 2026

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 coinsurance, or a percentage of the charges, with a higher level of benefits for services provided by in-network providers. This plan has a $750 individual in-network deductible and a $1,125 individual out-of-network deductible. Questions on the Network should be addressed to Simplified Benefits Administrators at 800-207-1018.

The following is a summary and is not inclusive of all covered services available under the plan. Refer to the PPO1 Plan Document and Plan Summary for additional details.

Benefit Description	In-Network	Out-of-Network
Plan Year Deductible	Individual: $750 Family: $2,250	Individual: $1,125 Family: $3,375
Plan Year Out-of-Pocket Maximum	Individual: $4,750 Family: $9,500	Individual: $7,750 Family: $15,500
Primary Care Office Visit	$35 copayment; services billed outside office services are subject to deductible and 30% coinsurance	Plan pays 50%; You pay 50% after deductible
Specialist Office Visit	Plan pays 70%; You pay 30% after deductible	Plan pays 50%; You pay 50% after deductible
Preventive Care Annual Well Exam (age 2 and up)	Plan pays 100%	Plan pays 100% up to $200/plan year; You pay 50% after deductible
Well Child (to age 2)	Plan pays 100%	Plan pays 100% up to $300/plan year; You pay 50% after deductible
Mammograms/Routine Prostate Exams	Plan pays 100%	Plan pays 100% up to $100/plan year; You pay 50% after deductible

Urgent Care	$100 copayment; services billed outside of office services are subject to deductible and 30% coinsurance	If immediate care is required: $100 copayment; services billed outside office services are subject to deductible and 30% coinsurance paid by you. If immediate care is not required: Plan pays 50%; You pay 50% after deductible
Inpatient Hospital	Plan pays 70%; You pay 30% after deductible	Plan pays 50%; You pay 50% after deductible
Outpatient/Ambulatory Surgery	Plan pays 70%; You pay 30% after deductible	Plan pays 50%; You pay 50% after deductible
Laboratory and X-Ray – Diagnostic	Plan pays 70%; You pay 30% after deductible	Plan pays 50%; You pay 50% after deductible
Mental Health and Substance Use - Inpatient	Plan pays 70%; You pay 30% after deductible	Plan pays 50%; You pay 50% after deductible
Mental Health and Substance Use - Outpatient	Plan pays 70%; You pay 30% no deductible	Plan pays 50%; You pay 50% no deductible
MRIs, CAT and PET Scans	Plan pays 70%; You pay 30% after deductible	Plan pays 50%; You pay 50% after deductible
Emergency Care	Plan pays 70%; You pay 30% after deductible	If immediate care is required: Plan pays 70%; You pay 30% after deductible If immediate care is **not** required: Plan pays 50%; You pay 50% after deductible
Ambulance	Plan pays 70%; You pay 30% after deductible	Plan pays 50%; You pay 50% after deductible
Durable Medical Equipment	Plan pays 70%; You pay 30% after deductible	Plan pays 50%; You pay 50% after deductible; $2,000 plan year max

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 coinsurance, or a percentage of the charges, with a higher front-end deductible. This plan has a $1,500 individual in-network deductible. Questions on the Network should be addressed to Simplified Benefits Administrators at 800-207-1018.

The following is a summary and is not inclusive of all covered services available under the plan. Refer to the PPO2 Plan Document and Plan Summary for additional details.

Benefit Description	In-Network Only
Plan Year Deductible	Individual: $1,500 Family: $4,500
Plan Year Out-of-Pocket Maximum	Individual: $7,700 Family: $15,400
Primary Care Office Visit	Plan pays 70%; You pay 30% after deductible
Specialist Office Visit	Plan pays 70%; You pay 30% after deductible
Preventive Care Annual Well Exam (age 2 and up)	Plan pays 100%
Well Child (to age 2)	Plan pays 100%
Mammograms/Routine Prostate Exams	Plan pays 100%
Urgent Care	You pay $100 copayment; services billed outside office services are subject to deductible and 30% coinsurance paid by you
Inpatient Hospital	Plan pays 70%; You pay 30% after deductible
Outpatient/Ambulatory Surgery	Plan pays 70%; You pay 30% after deductible
Mental Health and Substance Use – Inpatient	Plan pays 70%; You pay 30% after deductible
Mental Health and Substance Use - Outpatient	Plan pays 70%; You pay 30%, no deductible
Laboratory and X-Ray – Diagnostic	Plan pays 70%; You pay 30% after deductible
MRIs, CAT and PET Scans	Plan pays 70%; You pay 30% after deductible
Emergency Care	Plan pays 70%; You pay 30% after deductible
Ambulance	Plan pays 70%; You pay 30% after deductible
Durable Medical Equipment	Plan pays 70%; You pay 30% after deductible

Consumer Driven Health Plan with Health Reimbursement Arrangement

This plan offers employees the freedom to obtain services from in-network or out-of-network providers. You pay a lower premium, but a significantly higher deductible and out-of-pocket maximum. You are responsible for all healthcare costs (including medical and pharmacy), except preventive (annual well exam) until you reach the deductible. Since the deductible and OOPM are the same for an individual, once you reach the deductible/OOPM, the plan pays 100% for covered services for the remainder of the plan year.

The plan includes an employer funded health reimbursement arrangement (HRA). PSD will fund $1,000 annually to the HRA for employee only coverage and $2,000 annually for employee/spouse, employee/child(ren) or employee/family coverage which can be applied toward the medical deductible or pharmacy copayments or coinsurance. You may also want to consider participating in the medical flexible spending plan as another way to set aside money to pay the deductible. See details starting on page 34.

Questions on the Network should be addressed to Simplified Benefits Administrators at 800-207-1018.

The following is a summary of covered services available under the plan. Refer to the CDH Plan Document and Plan Summary for additional details.

Benefit Description	In-Network	Out-of-Network
Plan Year Deductible	Individual: $7,700 Family: $15,400	Individual: $15,400 Family: $30,800
Plan Year Out-of-Pocket Maximum	Individual: $7,700 Family: $15,400	Individual: $15,400 Family: $30,800
Preventive Care	Plan pays 100%	You pay 100% up to deductible
Urgent Care	$100 copayment; services billed outside office services are subject to the deductible	If immediate care is required: $100 copayment; services billed outside office services are subject to deductible. If immediate care is not required: all services subject to deductible.

Mental Health and Substance Use Coverage

Mental health and substance use coverage is available to all medical plan participants. Employee Assistance Services (EAS) contracts rates directly with mental health and substance use providers and provides recommendations, eligibility, and pre-certification requirements for mental health services. EAS referral authorizations are not required, but you are strongly encouraged to consult with EAS for assistance when searching for a network provider to meet your specific needs.

All inpatient services MUST be pre-certified through EAS for any benefits to be covered.

For specific questions regarding coverage, you should contact EAS at 970-488-4925.
The address for submitting mental health service claims is:

Employee Assistance Services
3350 Eastbrook Drive, Suite 200
Fort Collins, CO 80525

The following is a summary of coverage for PPO1 and PPO2 participants. CDHP participants are responsible for meeting the plan year deductible before the plan will pay 100%.

Benefit Description	PPO1 In-Network	PPO1 Out-of-Network	PPO2 In-Network
Lifetime Maximum	None	None	None
Plan Year Out-of-Pocket Maximum (combined with medical)	Individual: $4,750 Family: $9,500	Individual: $7,750 Family: $15,500	Individual: $7,700 Family: $15,400
Inpatient Services **Deductible (combined with medical)**	Individual: $750 Family: $2,250	Individual: $1,125 Family: $3,375	Individual: $1,500 Family: $4,500
Coinsurance	Plan pays 70%; Plan Participant pays 30%	Plan pays 50% of Usual & Customary; Plan Participant pays 50%	Plan pays 70%; Plan Participant pays 30%
Outpatient Services **Deductible**	None	None	None
Coinsurance	Plan pays 70%; Plan Participant pays 30%	Plan pays 50% of Usual & Customary; Plan Participant pays 50%	Plan pays 70%; Plan Participant pays 30%

Prescription Benefits

You are automatically enrolled in the prescription benefit when you enroll in one of the medical plans. You must use an in-network pharmacy to receive benefits under the plan. Most national pharmacy chains and local pharmacies participate in the network.

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 the OptumRX website at www.optumrx.com. You may contact OptumRx at 1-800-880-1188.

Prescription Summary:

	PPO1 Plan		PPO2 Plan
Benefit Description	**In-Network**	**Out-of-Network**	**In-Network**
Prescription Drugs			
Out-of-Pocket Maximum	Individual: $1,500 Family: $3,000	Not Applicable	Individual: $1,500 Family: $3,000
Retail	Generic: You pay 10% Preferred: You pay 20% Non-Preferred: You pay 30%	No Benefit	Generic: You pay 10% Preferred: You pay 20% Non-Preferred: You pay 30%
Mail Order (90-day supply)	Generic: You pay $30 Preferred: You pay $150 Non-Preferred: You pay $250	No Benefit	Generic: You pay $30 Preferred: You pay $150 Non-Preferred: You pay $250

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 $30
  - Preferred $150
  - Non-preferred $250
- 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 Staff tab then Benefits, Benefits A-Z, and Forms or by contacting Benefits Services as PSDbenefits@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.optumrx.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 your short-term prescriptions, such as antibiotics, at the regular retail pharmacy.

Dental Plan

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

You have two options to choose from including the basic DPPO plan and the DPPO buy-up plan. ***Both plans include a Right Start for Kids Program which offers 100% coverage with no deductible for covered diagnostic, preventive, basic and major services up to age 13 when in-network providers are used. These services are still subject to annual maximums.***

You may contact Delta Dental at 1-800-610-0201.

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

We offer only a DPPO plan and utilize Delta Dental's PPO plus Premier network.

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, 2025 through July 31, 2026

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.

Dental PPO (DPPO) Plan

You can visit any licensed dentist in the United States for your care, but you will save money by seeing a network dentist. For services provided by a PPO plus Premier Network dentist, Delta will pay based on contracted fees. If you utilize non-network dentists, Delta will pay based on the maximum reimbursable charge for the geographic area. You are responsible for the difference and the dentist may balance bill up to their usual fees. For assistance in finding a PPO plus Premier Network dentist, visit their website or give them a call.

All costs shown in the chart are the member's portion of payment for services rendered unless otherwise noted.

Only dependent children to age 19 are eligible for orthodontic benefits on this plan.

The following is a summary and is not inclusive of all covered services available under the plan.

Benefit Description	PPO and Premier Providers	Out-of-Network Providers*
Plan Year Deductible **Does not apply to diagnostic & preventive**	Individual: $50 Family: $100	
Plan Year Maximum	$1,500	
Lifetime Maximums	Orthodontia: $2,000 Implant Services: $3,000 TMJ: $1,200	
Diagnostic & Preventive Services Exams, x-rays, cleanings	Plan pays 100%	Plan pays 100%
Basic Restorative Services	Plan pays 80%; You pay 20% after deductible	Plan pays 50%; You pay 50% after deductible

Major Restorative Services	Plan pays 50%; You pay 50% after deductible	Plan pays 25%; You pay 75% after deductible
Orthodontia (dependent children only to age 19)	Plan pays 50%; You pay 50% after deductible	Plan pays 25%; You pay 75% after deductible
Temporomandibular Joint/Myofacial Pain (TMJ)	Plan pays 80%; You pay 20% after deductible	Plan pays 50%; You pay 50% after deductible
Implant Services	Plan pays 80%; You pay 20% after deductible	Plan pays 50%; You pay 50% after deductible

*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.

Dental PPO (DPPO) Buy-Up Plan

You can visit any licensed dentist in the United States for your care, but you will save money by seeing a network dentist. For services provided by a PPO plus Premier Network dentist, Delta will pay based on contracted fees. If you utilize non-network dentists, Delta will pay based on the maximum reimbursable charge for the geographic area. You are responsible for the difference and the dentist may balance bill up to their usual fees. For assistance in finding a PPO plus Premier Network dentist, visit their website or give them a call.

All costs shown in the chart are the member's portion of payment for services rendered unless otherwise noted.

This plan has an increased plan year maximum and covers adult orthodontia.

The following is a summary and is not inclusive of all covered services available under the plan.

Benefit Description	PPO and Premier Providers	Out-of-Network Providers*
Plan Year Deductible **Does not apply to diagnostic & preventive**	Individual: $50 Family: $100	
Plan Year Maximum	$3,000	
Lifetime Maximums	Orthodontia: $2,000 Implant Services: $3,000 TMJ: $1,200	
Diagnostic & Preventive Services Exams, x-rays, cleanings	Plan pays 100%	Plan pays 100%

Basic Restorative Services	Plan pays 80%; You pay 20% after deductible	Plan pays 50%; You pay 50% after deductible
Major Restorative Services	Plan pays 50%; You pay 50% after deductible	Plan pays 25%; You pay 75% after deductible
Orthodontia (includes adult coverage)	Plan pays 50%; You pay 50% after deductible	Plan pays 25%; You pay 75% after deductible
Temporomandibular Joint/Myofacial Pain (TMJ)	Plan pays 80%; You pay 20% after deductible	Plan pays 50%; You pay 50% after deductible
Implant Services	Plan pays 80%; You pay 20% after deductible	Plan pays 50%; You pay 50% after deductible

*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.

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. Reference the "Choice" network to find an in-network VSP provider.

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	In-Network You Pay	Out-of-Network Plan Pays
Exam (once every 12 months)	$15	Up to $50
Prescription Glasses Frames (once every 24 months) Lenses (once every 12 months) Single Vision Lined Bifocal Lined Trifocal	$15 Included in prescription glasses copay; $175-$195 allowance Included in prescription glasses Included in prescription glasses Included in prescription glasses	 Up to $70 Up to $50 Up to $75 Up to $100
Lens Enhancements (once every 12 months) Standard Progressive Premium Progressive Custom Progressive	 $55 $95-$105 $150-$175	 Up to $75 Up to $75 Up to $75
Contacts (in lieu of glasses) – once every 12 months Exam Lenses	 Up to $60 depending on exam $200 allowance; copay does not apply	 Up to $110 total for exam and lenses

Additional benefits are available for diabetic eyecare and care for individuals with severe vision problems that are not correctable with regular lenses. Discounts are available for non-covered services such as additional glasses and sunglasses, contact lenses, and laser vision correction surgery.

Life and Accidental Death and Dismemberment Insurance

PSD provides eligible employees with life and accidental death and dismemberment insurance coverage through Reliastar Life Insurance Company (Voya). In addition to basic coverage for eligible employees, employees can purchase optional coverage for themselves and eligible dependents.

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

Reliastar Life Insurance Company (Voya)
20 Washington Avenue South
Minneapolis, Minnesota 55401
800-955-7736
Policy #68948-3GAT2

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.

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 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	$150,000 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	$25,000 if enrolled within 31 days of initial eligibility
Maximum	50% of employee's optional coverage not to exceed $150,000
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 and level of coverage and increase the first of the month following when the employee/spouse enters a new age band.

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

Note: To calculate your cost for coverage, take your desired insurance amount divided by 1,000 and multiply your age banded rate which equals the monthly premium. Example: 41-year old wanting $50,000 of life insurance: $50,000/1,000 = 50 x $0.103 = $5.15 per month.

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 Reliastar Life Insurance Company. If you choose to port the policy, the application must be submitted to Reliastar Life 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 IMG 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 Health and Wellness

Our Commitment to Health and Wellness
PSD is committed to supporting employees and promoting a healthy work/life balance in every way. As part of these efforts, PSD is proud to provide all aspects of health and wellness into one cohesive and innovative approach. With accessible, affordable care, the focus is on the whole person through coordination between medical providers, lifestyle support, mental health services, and wellness.

We give you the tools you need to reach your health goals. Take control and do your part – a healthy diet, exercise, get enough sleep, reduce stress, and be sure you and your family get an annual well exam and recommended screenings according to United States Preventive Services Task Force (USPSTF) guidelines, because wellness works!

Employee health and wellness key services include:
- Employee Assistance Services
- Employee Health Clinic
- Lifestyle Health Program
- Wellness Classes and Support

Employee Assistance Services (EAS)
PSD offers its employees and their eligible family members free and confidential mental health/substance use counseling services through Employee Assistance Services (EAS). EAS offers up to five visits per problem per plan year to help with personal issues and to minimize their impact on health, family, work relationships, work performance, and more.

You do not need to participate in PSD's health plan to be eligible for EAS services.

EAS is available to help with any concern you may have, including (but not limited to):

- Work/life balance
- Relationship issues (spouse/partner; family conflicts; parent/child; friends; coworkers, etc.)
- Work related issues
- Life changes and transitions
- Grief and loss
- Depression and anxiety
- Physical health
- Stress
- Substance use and other addictions
- Mental health/substance use medically certified leave of absence

EAS is available 24/7 for crisis support.

To learn more about these services and/or to make an appointment, call EAS at 970-488-4925, or email EAS@psdschools.org.

For PSD health plan members, EAS provides assessments, pre-certifications, treatment planning, care coordination, and recommendations to the EAS Preferred Provider Network, ensuring you are getting the most out of your health plan coverage. You can also find information on their website at eas.psdschools.org.

EAS is located at: 3350 Eastbrook Drive, Suite 200, Fort Collins CO 80525

Employee Health Clinic Services through Banner Health

Be a wise health care consumer! If you have a non-life-threatening medical issue, **you can save time and money when you use one of the Employee Health Clinics!**

The employee health clinics are available to all employees with an assignment that has a set contract percentage or scheduled number of hours they work per week regardless of whether they are enrolled in a PSD health plan. Dependents must be enrolled in a PSD health plan to access the clinic.

The walk-in clinics are open 7 days per week, 7:30 a.m. to 7:30 p.m. There is no charge for a visit to one of the clinics. However, some covered services during the visit may be billable to your insurance including, but not limited to, labs that are sent out of the office for processing.

The clinics are designed as an alternative for many non-life-threatening symptoms and services and are not designed to replace existing relationships with primary care physicians.

Some services available at the clinic include:

- Sore throat, cough, cold and flu
- Bladder, ear, eye, and sinus infections
- Upper respiratory infections
- Skin disorders such as acne, rashes, insect bites, bee stings
- Minor fractures and lacerations
- Gastrointestinal disorders such as vomiting, diarrhea, heartburn, abdominal pain
- Sprains
- Minor surgical procedures such as wart removal, ear irrigation, nail avulsion
- Minor burn care
- Mild asthma exacerbations
- Headaches

Banner offers 3 locations:

Banner Urgent Care, Fort Collins
110 E. Boardwalk Drive
970-821-1500

Banner Urgent Care, Loveland
2555 E. 13th Street, Suite 110
970-820-4264

Lifestyle Health Program

This program is available to benefited employees and dependents. Non-benefited employees may also participate and pay the applicable fee for participation. This program assists those at risk for chronic conditions such as hypertension, asthma, diabetes, arthritis, and bipolar disorders. Services are completely voluntary and confidential. Services include:

- health assessments
- individualized care plans that include nutrition, health, and exercise
- care coordination with primary care providers
- care coordination with Employee Assistance Services

The Lifestyle Health Program is located at:

3702 Automation Way
Fort Collins, CO 80525 Phone: 970-495-7091

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
- professional fitness assessments
- wellness classes
- flu shots
- discounts at local fitness centers

In addition, an employee wellness portal is coming soon. The portal is a great place to access wellness programs, recipes, and many more items. Wellness portal services will be provided by RAMP Health. Additional information on how to access their site will be provided to employees in the upcoming months.

Genesis Health Clubs

We have partnered with Genesis Health Clubs to allow employees to access lower cost gym memberships. Employees with regular scheduled work hours or a contract are eligible and benefited dependents are eligible to participate.

Membership Details:

- **Genesis Health Clubs:** PSD employees have unlimited hours and access to the following Genesis locations:
  - Miramont North (1800 Heath Parkway)
  - Fort Collins Club (1307 Prospect Rd)
  - Miramont South (901 Oakridge Dr)
  - As well as all other Genesis locations (currently 70 in 10 states)
- **Partial-Fee Membership:** The Genesis membership will require a partial fee paid by the employee (while PSD covers a majority of the monthly membership rate).The rates are as follows:
  - **PSD Employee Single Membership Rate:** $19/month
  - **PSD Employee + Spouse Membership Rate:** $29/month
  - **PSD Employee + Family Membership Rate:** $49/month

You may visit the Wellness website at https://www.psdschools.org/staff (Employee Resources -> Employee Health & Wellness) for additional information.

Flexible Spending Accounts (FSA)

NOTE: Each year that you would like to participate in the FSAs, you are required to re-enroll during the annual open enrollment period.

An FSA provides valuable benefits and tax savings since many of your normal expenses can be paid with pre-tax money! Money withheld from your paycheck for the FSA is not subject to Federal, State or Medicare taxes, or PERA contributions. That's where the savings comes in (a possible savings of 15-40% depending on your tax bracket)! 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, even if they aren't enrolled in your PSD medical, dental, or vision insurance
- ✓ Dependent Care (or Daycare) FSA – used to pay for eligible daycare expenses for your eligible dependents

You use each account separately, but they work similarly. Funds cannot be transferred between the health care FSA and dependent care FSA.

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

Roll Over – You may roll over unused health care FSA funds – up to $660 to use in the following year. Any balance over $660 is forfeited at the end of the plan year. You do have 90 days from the end of the plan year to submit qualified expenses incurred through July 31 for reimbursement.

Plan Administrator:
The FSA plan is a benefit administered through Wex Health, Inc. The address for submitting FSA claims is:

Wex Health, Inc.
PO Box 2079
Omaha, NE 68103-2079
Phone: 866-451-3399
Email: cobraadmin@wexhealth.com

FSA Summary

HEALTH CARE FSA	DEPENDENT CARE (DAYCARE) FSA
Maximum Election Amount: $3,300 (per employee)	**Maximum Election Amount**: $5,000 (per household)
Who Does It Cover? You, your spouse, and any dependents, even if not enrolled in a PSD medical, dental, or vision plan.	**Who Does It Cover?** Your dependent children under age 13 and/or dependents who are mentally or physically incapable of caring for themselves

Common Eligible Expenses: • Prescriptions • Co-pays/Coinsurance • Dental services • Vision services • Chiropractic services The full amount of your election is available on the first day of the plan year (August 1) or your benefit eligibility date if not August 1.	**Common Eligible Expenses:** • Daycare expenses • Preschool expenses • Summer day camps • Elder care Funds are available as they are contributed each pay period.

Health Care FSA

Health care expenses can quickly add up. 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, vision, and pharmacy expenses. 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".

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.

How much can I contribute?

The maximum amount you may set aside is $3,300 per year ($275.00 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. The amount is limited per employee. Therefore, if both spouses work for PSD each could contribute $3,300.

Eligible Expenses

An eligible expense is defined as those expenses paid for care as described in Section 213(d) of the Internal Revenue Code. For more detailed information, please refer to 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 Simplified Benefits Administrators at 800-207-1018 prior to establishing your medical FSA. Plan carefully for all known expenses, since failure to receive eligible services during the plan year can 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(d). Any expense not listed that you believe may be eligible should be discussed with the administrator prior to enrollment.

Abortion (legal only)	Dental care including dentures	Orthodontia services
Acupuncture (excluding remedies/treatments prescribed)	Diagnostic fees and devices	Orthotics
Alcoholism treatment	Diabetic supplies	Osteopath fees (licensed)
Ambulance	Drug addiction treatment	Oxygen
Artificial limb	Drug and medical supplies	Physical therapy
Artificial teeth	Eye exams, eyeglasses, contacts	Physician fees
Automobile modifications (hand controls, lifts, etc.)	Fertility enhancement	Prescription medicines
Birth control (must be prescribed)	Guide dog	Routine physicals
Blood Pressure Monitor	Handicapped persons' schools	Smoking cessation-prescribed
Braille books	Hearing devices and batteries	Special education for the blind
Breast pumps & lactation expenses	Insulin	Surgical fees
Chiropractors	Laboratory fees	Transportation expenses
Co-payments & Co-insurance amounts	Laser eye surgery	Tubal ligation
Contact lenses & supplies	Learning disabilities-special school	Vaccines
Contraceptives (prescription only)	Obstetrical expenses	Vasectomy
Crutches	Operations	Wheelchair
Deductibles	Organ transplants	X-rays

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

Acid control medication (Prevacid, Prilosec, Zantac, etc.)	Nicotine patches or gum
Acne treatment	Pain relievers (Advil, Aspirin, Ibuprofen, Tylenol, etc.)
Allergy medication (Benadryl, Zyrtec, Claritin, etc.)	Pedialyte
Antacids (Tums, Rolaids, etc.)	Sinus medications/nasal spray
Antibiotic ointments	Sleep aid medication
Anti-itch medication	Stomach remedies (Pepto-Bismol, etc.)
Cold medicine (Alka-Seltzer, Nyquil, Sudafed, Theraflu, Vicks, etc.)	Sunburn relief (Solarcain)
Cough drops and throat lozenges	Wart removal medication
First aid creams and bandages (Bengay, Neosporin, etc.)	Suppositories and creams for hemorrhoids
Menstrual products	Wart removal medication

Ineligible Expenses

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

Alternative medicines	Health club memberships	Personal use items
Boarding school fees	Herbs*	Pre-payments or pre-

		treatments
Cosmetic surgeries & procedures	Herbal supplements*	Social activities (dance lessons, swimming lessons, etc.)
COBRA insurance premiums	Illegal services	Specialty foods*
Child care expenses	Insurance premiums	Storage fees (sperm, blood etc.)
Controlled substances	Lodging***	Sundries; toothpaste, face creams etc.
Exercise equipment	Long term care insurance/services	Teeth bleaching/whitening
Funeral expenses	Massage therapy*	Travel for general health
Genetic testing**	Maternity clothes	Varicose vein treatments*
Hair transplants	Medicare premiums	Veterinary fees
Hair growth medications (i.e. Rogaine)	Nutritional supplements*	Vitamins*
Hair removal treatments	Personal trainer	Weight loss programs/medications*

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

Estimating Your Health Care FSA Expenses
Use this table to estimate your medical/dental/vision costs to be incurred during the plan year (August 1 – July 31) and not reimbursed by insurance or any other benefit plan. Be sure to include expenses for you, your spouse, and all dependents.

Medical	
Insurance deductibles	$ _____
Copayments/coinsurance	$ _____
Routine exams	$ _____
Prescription drugs	$ _____
Over-the-counter medications	$ _____
Dental	
Insurance deductibles	$ _____
Copayments/coinsurance	$ _____
Exams, cleaning, x-rays, etc.	$ _____
Fillings, caps, crowns, bridges, etc.	$ _____
Orthodontia	$ _____
Vision	
Exams, contacts, glasses, LASIK, etc.	$ _____
Other eligible unreimbursed expenses	$ _____
Estimated Total Health Care FSA Expenses	**$ _____**

How Do You Get Reimbursed?
When you participate in the health flexible spending account, you will receive a debit 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.

If the provider, doctor's office, or merchant doesn't accept credit cards, you will need to pay the provider with cash or check and then submit the Flexible Spending Account Claim Form to Wex Health, Inc. for reimbursement. Be sure to include all details and necessary receipts on the form prior to submission. The form can be obtained on the PSD website at www.psdschools.org -> Staff -> Benefits -> PSD Benefits A – Z -> Forms.

Qualified Status Change for Health Care FSA
Your annual election cannot change during the plan year unless you experience an IRS qualified status change. 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 (or Daycare) 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 (daycare) 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 and your spouse work outside your home. ***This account is not for your dependents' health-related expenses.***

How much can I contribute?
The maximum is $5,000 per year per household ($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 combined contribution is $5,000 per year.

Eligible Expenses
An eligible expense is defined as those expenses paid for care as described in IRS Publication 503 – Child and Dependent Care Expenses. (www.irs.ustreas.gov). In general, eligible expenses include childcare (nursery, preschool or private sitter), before and after-school care, and day camps.

Ineligible Expenses
Ineligible expenses include all-day kindergarten tuition, overnight camps, expenses paid to a tax-dependent, expenses for food and clothing, and health care expenses for your dependents. 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.

Estimating Your Dependent Care FSA Expenses
Use this table to estimate your dependent care costs to be incurred during the plan year (August 1 – July 31).

Note: Enrollment requires a monthly deduction over 12 months. You CANNOT stop your deduction due to not needing daycare over the summer months. Therefore, if you do not work year-round, plan accordingly only for the months you need daycare. For example, you need daycare August – May (10 months) and will pay $400/month, your annual election will be $4,000. The $4,000 will be deducted monthly, August-July in the amount of $333.33.

Child Care Expenses	
Day care services	$ _____
In-home care	$ _____
Nursery and pre-school	$ _____
After-school care	$ _____
Summer day camps	$ _____
Elder Care Services	
Day care center	$ _____
In-home care	$ _____
Estimated Total Dependent Care FSA Expenses	**$ _____**

How Do You Get Reimbursed?
When you participate in the dependent care flexible spending account, you must submit for reimbursement directly to Wex Health, Inc. You must provide receipts as backup for the reimbursement request.

Qualified Status Change for Dependent Care FSA
Your annual election cannot change during the plan year unless you experience an IRS qualified status change. 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.**

Health Reimbursement Arrangement (HRA)

PSD will contribute $1,000 per plan year to an HRA for employees who participate in the Poudre Consumer Driven Health Plan (PCDHP) with employee only coverage and $2,000 per plan year for employees with employee/spouse, employee/child(ren), or employee/family coverage. The HRA is an employer funded account only. Employees cannot contribute to an HRA.

The funds will be used to cover expenses incurred under the Consumer Driven Health Plan and pharmacy benefits. They cannot be used for premiums.

Because the account is employer funded, HRA funds do not go with you when you leave employment. Funds are forfeited at the time of termination or when you no longer participate in the PCDHP.

EXAMPLE ON HOW THE HRA WORKS

Justin is a healthy 28-year-old single man enrolled in the PCDHP. PSD contributes $1,000 each year to his HRA. His plan's annual deductible is $7,700 for individual coverage.

Here is a look at the first two years of Justin's HRA plan, assuming the use of in-network providers.

Justin's annual deductible decreases by the total expense amount as well even when the expenses is covered by HRA funds.

Reminder: Preventive services are covered 100% by the plan. Therefore, Justin can also go to the doctor for his annual well exam and will not be charged.

Year 1	
HRA Balance	$1,000
Total Expenses: - Prescription drugs: $150	(-$150)
HRA Rollover to Year 2	$850
Since Justin did not spend all of his HRA dollars, he did not need to pay any additional amounts out-of-pocket this year.	

➔

Year 2	
HRA Balance	$1,850
Total Expenses: - Office visits: $100 - Prescription drugs: $200 - Preventive care services: $0 (covered by insurance)	(-$300)
HRA Rollover to Year 3	$1,550
Once again, since Justin did not spend all of his HRA dollars, he did not need to pay any additional amounts out-of-pocket this year.	

Short Term/Long Term Disability

PSD offers short- and long-term disability coverage for eligible employees. Employees scheduled to work 3 or more hours per week are eligible for short-term disability and employees scheduled to work 15 or more hours per week are eligible for long-term disability. 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.

Voya Financial 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 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 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 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

PSD employees have many optional retirement savings plans they can participate in to help accumulate money for retirement. Contributions to these plans are made through payroll deduction.

Options include:

- A traditional pre-tax contribution which allows employees to put part of their salary into 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.
- A Roth contribution which allows employees to put part of their salary into accounts on an after-tax basis which do not decrease your federal and state taxable income. Generally, with this type of account qualified distributions are tax-free.

PSD offers three programs for you to select from if you decide to set aside a portion of your compensation.

Tax Sheltered Annuities and Custodial Accounts – 403(b) The Internal Revenue Code Section 403(b) permits employees of educational institutions to purchase an annuity or custodial account. PSD has several approved providers who offer 403(b)s to PSD employees. Employees can choose a traditional pre-tax investment, Roth option, or a combination of both.

Most vendors offer mutual fund investment platforms which offer lower management fees and a diversified choice of funding options. In addition, employees have a self-directed option available which allows employees that would prefer not to utilize a licensed financial professional to participate in select funds on their own.

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. Employees can choose a traditional pre-tax investment, Roth option, or a combination of both.

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. 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. Employees can choose a traditional pre-tax investment, Roth option, or a combination of both.

Contact Information

401(k) Plan

The 401(k) plan is available through PERA and administered by Empower Retirement. 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:

• Corebridge Financial	Craig Fischer	720-288-2780
• Equitable Advisors	James Barkei	630-885-6686
	Leslie Gilsdorf	720-388-8331
• Security Benefit	Travis Whitaker	970-223-2377
	Randy Petrilli	970-215-6149

NEA DirectInvest Self-Directed Option with no advisor contact – only available through Security Benefit

Enrollment

Participants in any of the deferred compensation plans are required to elect to defer (contribute) to the plan by the 15th of 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 July 15.

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 Payroll Department, or online from the PSD website at www.psdschools.org -> Staff -> Quick Links -> S.A.F.E. -> Payroll Forms -> Voluntary Deduction Election.

To enroll in the NEA DirectInvest 403(b) option, you must contact NEA DirectInvest to setup your account and funding elections. You must then complete the NEA DirectInvest 403(b) Tax Sheltered Annuity Salary Reduction Agreement available by contacting PSD benefits at PSDBenefits@psdschools.org.

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 or online at www.psdschools.org -> Staff > Quick Links -> S.A.F.E. -> Payroll Forms -> Voluntary Deductions Election.

To make changes to your NEA DirectInvest 403(b) contribution election, use the NEA DirectInvest 403(b) Tax Sheltered Annuity Salary Reduction Agreement available by contacting PSD benefits at PSDBenefits@psdschools.org. This agreement will only authorize a change to your payroll deduction. It is your responsibility to contact the provider directly for any funding changes.

Contribution Limits

The following charts show a brief summary of the limits and catch-up provisions for each plan for the 2025 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.

NOTE: The total amount you may contribute to the 401(k) and 403(b) plans, whether pre-tax or Roth (after-tax), is subject to the annual IRS limits noted in the chart below.

Annual Contribution Limit	2025
401(k)	$23,500
403(b)	$23,500
457(b)	$23,500

Age 50+ catch-up	$7,500

Combined Annual Limits	2025
401(k) and 403(b)	$23,500
401(k) and 457(b)	$47,000
403(b) and 457(b)	$47,000

Combined Annual Limits with Age 50+ Catch-Up	2025
401(k) and 403(b)	$31,000
401(k), 403(b) and 457(b)	$62,000

"Standard" Catch-Up Elections	401(k)	403(b)	457(b)
15 years of services with the same employer	Not available	Up to $15,000 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

AFLAC

AFLAC offers many insurance coverage options including accident, hospital indemnity, and critical illness. These coverages pay 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 719-487-8520 or via email at tama_glazebrookhinckley@us.aflac.com.

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. Additional coverage includes:

- Elder Law
- Home Equity Loan for Primary and Secondary Residence
- Insurance Disputes
- Minor Traffic from 1x/year to unlimited
- Refinancing for Secondary Residence

Features include: in-office services, telephone advice, and online resources. 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 - $18.25

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, access code: 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 Nationwide

Pets can take a bite out of your budget. 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 My Pet Protection with Wellness coverage, PDS employees receive an employee discount. Pet Parents with multiple pets receive additional discounts.

Choose the level of coverage that's right for you – 50% or 70% reimbursement.

Plus every 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.

For additional information:
- Visit PetsNationwide.com

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 an additional 2% administrative fee. COBRA continuation applies to your medical, dental, and vision insurance as well as your health care flexible spending account. Detailed information is available from Simplified Benefits Administrators at 800-207-1018.

CONTINUATION OF COVERAGE FOR 18 MONTHS	CONTINUATION OF COVERAGE FOR 29 MONTHS	CONTINUATION OF COVERAGE FOR 36 MONTHS
Employee's termination of employment	Termination of disabled employee (coverage beyond	Death of covered employee

Employee's reduction of hours	18 months is subject to verification of disability)	Divorce/legal separation/annulment Ineligibility of dependent child

Important Compliance Notices

Availability of Summary of Benefits and Coverage (SBC) Document(s)

In accordance with law, our plan provides you with an SBC as a way to help you understand and compare medical plan benefits. The SBC summarizes and compares important information including, what is covered, what you need to pay for various benefits, what is not covered, and where to get answers to questions. SBC documents are updated when there is a change to the benefits information. The most current SBC is available on the Benefits Services website at www.psdschools.org -> Staff -> Benefits -> PSD Benefits A-Z -> Summary of Benefit Coverage.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act (WHCRA)

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles, copayments, and coinsurance apply:

- PPO1 Plan
  - Individual in-network deductible: $750
  - In-network inpatient services and in-network outpatient services: Member pays 30% after deductible
- PPO2 Plan
  - Individual in-network deductible: $1,500
  - In-network inpatient services and in-network outpatient services: Member pays 30% after deductible
- Consumer Driven Health Plan
  - Individual in-network deductible: $7,700
  - In-network inpatient services and in-network outpatient services: Member pays 100% up to deductible

If you would like more information on WHCRA benefits, call your plan administrator at 800-207-1018.

Family and Medical Leave Act (FMLA)

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

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

Military Family Leave Entitlements
Eligible employees with a spouse, child, 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 12 months, 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, Wage and Hour Division, 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.

HIPAA Privacy Notice

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

Your Rights
You have the right to:

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

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

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

Our Uses and Disclosures
We may use and share your information as we:

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

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

Get a copy of health and claims records

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

Ask us to correct health and claims records

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

Request confidential communications

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

Ask us to limit what we use or share

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

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

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

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on the last page.

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

Your Choices

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

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

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

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

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

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

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

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

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

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

Pay for your health services

We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

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

Help with public health and safety issues

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

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

Do research

We can use or share your information for health research.

Comply with the law

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

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

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

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

We can use or share health information about you:

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

Respond to lawsuits and legal actions

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

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.

- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

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

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

Other Important Information Regarding This Notice
- This notice is effective August 1, 2025
- It's important to note that these rules apply to the Poudre School District Health Plan ("The Plan"), not Poudre School District (PSD) as an employer/plan sponsor - that's the way the HIPAA rules work.
- The Plan may disclose protected health information (PHI) to a Business Associate of The Plan, if a Business Associate Agreement is in place. 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: Simplified Benefits Administrators, OptumRx, Delta Dental, and Wex Health, Inc.
- Employees of the plan sponsor (PSD), who administer and manage The Plan, and third-party administrators such as Simplified Benefits Administrators, OptumRx, Delta Dental or Wex Health, Inc., 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.
- For some types of PHI, there may be additional restrictions on our uses and disclosures described within. 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 regarding mental health services);
    - 27-10-120.5 (Mental health information)
- Any requests pertaining to items under "Your Rights" must be made in writing to:
    PSD Privacy Officer
    Attn: Benefits Services OR emailed to PSDbenefits@psdschools.org
    2407 Laporte Avenue
    Fort Collins CO 80521
- For questions regarding this notice, please call 970-490-3435.

Medicare Part D Notice – Creditable Coverage

Important Notice from Poudre School District About
Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Poudre School District Health Plan (including the PPO1, PPO2, and Consumer Driven Health 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 PPO1, PPO2, and Consumer Driven Health 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 the Poudre School District Health Plan 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, 2025
Name of Entity/Sender:	Poudre School District
Contact--Position/Office:	Melissa Johnson, Assistant Director of Benefits Benefits Services
Address:	2407 Laporte Avenue Fort Collins Colorado 80521
Phone Number:	970-490-3435

Children's Health Insurance Program (CHIP)

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of March 17, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**

Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website:https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

(pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since March 17, 2025, or for more information on special enrollment rights, contact either:

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

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

USERRA

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act. Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted, and you will continue to pay the same amount as if you were not absent. If the absence is for more than 31 days and not more than 24 months, you may continue to maintain your coverage under the Plan by paying up to 102% of the full amount of premiums. You and your dependents may also have the opportunity to elect COBRA coverage. If you elect not to continue your health plan coverage during your military service, you have the right to be reinstated in the Plan upon your return to work, generally without any waiting periods or pre-existing condition exclusions, except for service-connected illnesses or injuries, as applicable.

Wellness Program Notice

Poudre School District offers a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete an annual biometric screening, which will include a blood test for a full cholesterol panel (total cholesterol, high density lipoprotein, calculated low density lipoprotein, triglycerides). This will also include body measurements, such as height, weight, and waist circumference. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive a $25 per month medical premium discount. If the employee completes the annual biometric screening, the HRA, and earns additional activity points, they will be entered into a raffle. The amount of points you accumulate (including the points from the requirements above) will determine your additional incentive eligibility. Although you are not required to complete the HRA or participate in the annual biometric screening, only employees who do so will be eligible for an incentive at the end of the wellness year.

If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. You may contact the RAMP Health staff and they will work with you (and if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

The information from your HRA and the results from your annual biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as Wellness Challenges. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Poudre School District may use

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

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

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

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

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact RAMP Health.