2024
BENEFITS GUIDE

BENEFITS OVERVIEW

Town of Superior is proud to offer a comprehensive benefits package to eligible employees. The complete benefits package is briefly summarized in this booklet. You will receive plan booklets, which give you more detailed information about each of these programs.

You share the costs of some benefits (dependent medical, dental and vision), and the Town of Superior provides other benefits at no cost to you (employee medical, dental, vision, life, accidental death & dismemberment, STD, LTD, EAP.) In addition, there are voluntary benefits with reasonable group rates that you can purchase through payroll deductions.

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BENEFITS OFFERED

- Medical
- Dental
- Vision
- Life Insurance
- Accidental Death & Dismemberment (AD&D) Insurance
- Voluntary Life and AD&D
- Short Term Disability (STD)
- Long Term Disability (LTD)
- Health Savings Account (HSA)
- Flexible Spending Account (FSA)
- Employee Assistance Program (EAP)
- Other Benefits

ELIGIBILITY

You and your dependents are eligible for the Town of Superior benefits on the first of the month following your date of hire. Employees who work 30 hours or more per week are eligible for benefits.

Eligible dependents are your spouse, children under age 26, or disabled dependents of any age.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 23-24 for more details.

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

Enrollment

When can I enroll?

New employees have 31 days from your date of hire to enroll in the Town of Superior's health, dental, and vision insurance. Coverage will be effective the first of the month following your date of hire.

Existing employees may make their election for the following plan year during open enrollment, which begins mid-October and end mid-November. During open enrollment, you must enroll in and/or decline coverage for the following year. The effective date of chosen benefits is January 1st.

Can I change my benefits?

After open enrollment ends, the benefits you chose will be in place from January 1st through December 31st of the following year. You may not change any benefits during this time unless you have a qualifying life event.

Life events include:

- Marriage or civil union
- Divorce or legal separation
- Birth or adoption of a child
- Death of spouse, civil union partner, or dependent child
- Spouse, civil union partner, or dependent child losing or gaining coverage
- Change in employment status for you, your spouse, or civil union partner
- Change is residence (only if our current coverage is not available in the new location)

MEDICAL BENEFITS

Administered by Anthem through the County Health Pool

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost.

PPO Plan
A PPO plan provides both in and out of network coverage, however, you save the most money when you seek services from an in-network provider. A PPO plan covers preventive care at 100% resulting in no out-of-pocket costs to you. The most commonly used services, such as office visits, urgent care, and prescription drugs are not subject to the deductible and you are only subject to a copay. Higher costs services, such as imaging, inpatient hospitalization, and outpatient surgery require you to meet your annual deductible before receiving coverage.

HDHP Plan
The High Deductible Health Plan (HDHP) option is a qualified plan for a Health Savings Account (HSA). With an HSA, you are able to set aside pre-tax funds into an account to be used for qualified medical expenses. For more information on how your HSA works, please see the HSA section of this booklet located on page 13.

An HDHP provides both in-and out-of-network benefits, similar to a PPO plan, however, before services, other than preventive care, are covered, you must meet the deductible. The HDHP contains a non-embedded deductible. This means that if you cover yourself and any other family member, you must meet the family deductible of $5,000 before services are covered.

	PPO PLAN A		HDHP 2500 PLAN	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible	$0 single $0 family	$2,000 single $6,000 family	$2,500 single $5,000 family	$5,000 single $10,000 family
Annual Out-of-Pocket Maximum (includes deductible)	$3,500 single $9,000 family	$8,000 single $24,000 family	$5,000 single $6,850 family	$10,000 single $20,000 family
Coinsurance	20%	40%	20%	40%
DOCTOR'S OFFICE				
Primary Care Office Visit	$25 copay, then 20% for all other services	40% after deductible	20% after deductible	40% after deductible
Specialist Office Visit	$25 copay, then 20% for all other services	40% after deductible	20% after deductible	40% after deductible
Wellness Care (routine exams, x-rays/tests, immunizations, well baby care and mammograms)	100% covered	40% coinsurance not subject to deductible	100% covered	40% coinsurance not subject to deductible
Urgent Care	$25 copay	40% after deductible	20% after deductible	40% after deductible
Telemedicine	$25 copay	Not covered	20% after deductible, to a max of $49	Not covered
Convenience Care	$25 copay	Not covered	20% after deductible, to a max of $49	Not covered

	PPO PLAN A		HDHP 2500 PLAN	
	In-Network	Out-of-Network	In-Network	Out-of-Network
PRESCRIPTION DRUGS				
PPO Plan A Only– Outpatient prescription drugs are subject to a $50 deductible per person. Once satisfied, then services are subject to the copayment.				
Retail—Generic Drug (30-day supply)	$10 copay or 10% coinsurance– whichever is higher	Not covered	20% after deductible	Not covered
Retail—Formulary Drug (30-day supply)	$25 copay or 20% coinsurance– whichever is higher		20% after deductible	
Retail—Nonformulary Drug (30-day supply)	$35 copay or 40% coinsurance– whichever is higher		20% after deductible	
Mail Order—Generic Drug (90-day supply)	$25/prescription		20% after deductible	
Mail Order—Formulary Drug (90-day supply)	$60/prescription		20% after deductible	
Mail Order—Nonformulary Drug (90-day supply)	$115/prescription		20% after deductible	
HOSPITAL SERVICES				
Emergency Room	$150/visit then 20% coinsurance		20% after deductible	
Inpatient	$350/ admission then 20% coinsurance	$1,500/ admission then 40% coinsurance	20% after deductible	40% after deductible
Outpatient Surgery	$250/ visit then 20% coinsurance	$1,500/ visit then 40% coinsurance	20% after deductible	40% after deductible
MENTAL HEALTH/ SUBSTANCE ABUSE SERVICES				
Inpatient Services	$350 admission then 20%	40% after deductible	20% after deductible	40% after deductible
Outpatient Services	$25 office visit or 20% for outpatient facility	40% after deductible	20% after deductible	40% after deductible
OTHER SERVICES				
X-ray and Labs	20% coinsurance	40% after deductible	20% coinsurance	40% after deductible
Imaging (CT, PET Scans, MRIs)	20% coinsurance	40% after deductible	20% coinsurance	40% after deductible
Maternity Services	$25 office visit copay	40% after deductible	20% after deductible	40% after deductible
All other maternity hospital/ physician services	$350 admission, then 20% coinsurance	40% after deductible	20% after deductible	40% after deductible
Rehabilitation/ Habilitation Services (max of 30 visits for speech, physical, occupational therapy)	$25 visit then 20% coinsurance	40% after deductible	20% after deductible	40% after deductible
Durable Medical Equipment	20% coinsurance	Not covered	20% after deductible	Not covered
Hospice	20% coinsurance	40% after deductible	20% after deductible	40% after deductible

HOW THE PLANS WORK

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses, but identifying the problems early can often be treated at minimal cost to you. Comprehensive healthcare also provides peach of mind. In case of illness or injury, you and your family are covered with excellent medical benefits through the Town of Superior's County Health Pool program offerings. You will have access to in-network benefits from health care providers and facilities. The Town of Superior offers you a choice of two plans through Anthem: a Preferred Provider Organization Plan (PPO) and a High Deductible Health Plan (HDHP).

PPO Plan:

- **Copay:** A copay is a set dollar amount that is paid when medical services are used. Plan copays may vary, but may look like the following: $25 for primary care visits and $15 for generic prescription drugs. These charges will be due upon the doctors visit and/or filling of a prescription.

- **Deductible:** Medical services which the deductible apply to require you to pay in full until your deductible is met. Your annual out-of-network deductible for an individual plan is $2,000 and for a family plan is $6,000. Copays do not count towards your deductible, however, services that are performed during a medical visits, such as lab work, is subject to your deductible.

- **Coinsurance & Annual Out-of-Pocket Maximum:** Coinsurance is the cost sharing you will have with Anthem for this plan. Once the plan deductible is met, coinsurance is received for medical services until the annual out-of-pocket maximum is met. This plan's in-network coinsurance is 20% and the out-of-network coinsurance is 40%. This means that for in-network services Anthem will pay 80% of the charges and for out-of-network services Anthem will pay 60% of the charges. This plan's annual in-network out-of-pocket maximum is $3,500 for individual plans and $9,000 for family plans. The annual out-of-network out-of-pocket maximum is $8,000 for individual plans and $24,000 for family plans. All of the maximums include the deductible. Once the out-of-pocket maximum is met, the insurance company will pay 100% of the medical services covered under the plan for the rest of the plan year.

What are some advantages to a Preferred Provider Organization Plan?

- Best option for those who are willing to pay a higher premium each month in exchange for knowing how much they will own each time they visit the doctor

- Every visit to the doctor or pharmacy have a set copay. It will not change throughout the plan year—giving you predictability and peace of mind knowing you will not have to pay the full cost of a medical bill or prescription

- Preventive care is covered 100% when an in-network provider is used

HDHP Plan:

HDHP plans are created to keep premium costs low. Out-of-pocket payments are determined on your deductible and out-of-pocket maximum.

- **Deductible:** You will pay in full for services until the deductible is met. The in-network deductible is $2,500 for individual plans and $5,000 for family plans; out-of-network deductible are $5,000 for individual plans and $10,000 for family plans.
- **Coinsurance:** When the deductible is met, Anthem will share costs of services with you through coinsurance. The in-network coinsurance is 20% and the out-of-network is 40%. This means that for in-network services Anthem will pay 80% of the service charges and for out-of-network services Anthem will pay 60% of the service charges.
- **Annual Out-of-Pocket Maximum:** Coinsurance is paid until the annual out-of-pocket maximum is met. Once this happens, Anthem will pay 100% of medical services.

What are some advantages to a High Deductible Health Plan?

- Low monthly premiums
- You are eligible for an HSA, which can help pay for eligible medical expenses and lower taxable income—for more information on HSA please see page 13.
- This plan is preferred for people who do not anticipate frequent and/or significant medical expenses
- Preventive care is covered 100% for in-network providers

DENTAL BENEFITS

Administered by Anthem through the County Health Pool

Good oral care enhances overall physical health, appearance and mental well-being. Problems with the teeth and gums are common and easily treated health problems. Keep your teeth healthy and your smile bright with the Town of Superior dental benefit plan.

SERVICES	IN-NETWORK AND OUT-OF-NETWORK PPO
Annual Deductible	$50 per person; $150 family limit
Annual Benefit Maximum	$1,500
Preventive & Diagnostic Dental Services (cleanings, exams, x-rays)	100% covered; no deductible
Basic Dental Services (fillings, root canal therapy, oral surgery)	80% covered after deductible
Major Dental Services (crowns, inlays, onlays, dentures)	50% covered after deductible
Orthodontia Services (covered to age 19)	50% covered to $1,000 lifetime maximum

VISION BENEFITS

Administered by VSP through the County Health Pool

Regular eye examinations can not only determine your need for corrective eyewear, but also may detect general health problems in their earliest stages. Protection for the eyes should be a major concern to everyone.

SERVICE	IN-NETWORK (ANY VSP PROVIDER)	OUT-OF-NETWORK (ANY QUALIFIED NON-NETWORK PROVIDER OF YOUR CHOICE)
Eye Exam — once every 12 months	$15 copay; covered in full	Up to $45 reimbursement
LENSES — ONCE EVERY 12 MONTHS		
Single Vision Lenses	$15 copay; covered in full	Up to $30 reimbursement
Lined Bifocal Lenses	$15 copay; covered in full	Up to $50 reimbursement
Lined Trifocal Lenses	$15 copay; covered in full	Up to $65 reimbursement
Lenticular Lenses	$15 copay; covered in full	Up to $50 reimbursement
Frames — once every 24 months	Up to $150 allowance for a wide selection of frame brands; $80 allowance at Costco + 20% savings on amount over allowance, no copay	Up to $70 reimbursement
Contact Lenses — once every 12 months if you elect contacts instead of lenses/frames	Up to $150 allowance, no copay	Up to $110 reimbursement

No need for an ID card. To take advantage of your VSP vision benefit, simply contact a VSP provider and let them know you have VSP coverage—they handle the paperwork for you.

EMPLOYEE CONTRIBUTIONS

BENEFIT PLAN	TOTAL PREMIUM PER MONTH	COST TO EMPLOYEE PER MONTH
Medical– PPO Plan A ($0 Deductible)		
Employee	$1,192.00	$0.00
Employee + One	$2,235.00	$223.50
Employee + Two or more	$2,744.00	$411.60

BENEFIT PLAN	TOTAL PREMIUM PER MONTH	COST TO EMPLOYEE PER MONTH	TOWN MONTHLY CONTRIBUTION TO HEALTH SAVINGS ACCOUNT
Medical– HDHP 2500 Plan ($2,500 Indiv./ $5,000 Family Deductible)			
Employee	$808.00	$0.00	$166.67
Employee + One	$1,513.00	$151.30	$333.34
Employee + Two or more	$1,861.00	$279.15	$333.34

Full-time employees have the option to receive $200 per month in lieu of benefits, if they are able to provide proof of medical coverage.

BENEFIT PLAN	TOTAL PREMIUM PER MONTH	COST TO EMPLOYEE PER MONTH
Dental Rates		
Employee	$34.15	$0.00
Employee + One	$68.15	$6.82
Employee + Two or more	$88.65	$13.30
Vision Rates		
Employee	$5.70	$0.00
Employee + One	$11.35	$1.14
Employee + Two or more	$14.75	$2.21

LIFE INSURANCE BENEFITS

LIFE AND DISABILITY INSURANCE

Insured by Mutual of Omaha and Anthem

Life Insurance

Life insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump sum payment if you die while employed by the Town of Superior. The company provides basic life insurance of 2x your annual salary up to $350,000 at no cost to you. The amount of life insurance received will reduce if you are age 65 or older. In addition, each employee has $10,000 of life insurance through the County Health Pool, insured through Anthem.

Accidental Death and Dismemberment (AD&D) Insurance

Accidental Death and Dismemberment (AD&D) insurance provides payment to you or your beneficiaries if you lose a limb or die in an accident. The Town of Superior provides AD&D coverage equal to the amount of life insurance in force on your life through Mutual of Omaha and Anthem. This coverage is in addition to your company-paid life insurance described above.

Short Term Disability

Short-Term Disability insurance can provide employees with the peace of mind that a protected paycheck brings, if you are unable to work because of an illness or injury that occurs off the job. Once enrolled in the plan, your short-term disability insurance pays you 66.67% of your salary up to $1,600 per week (after an elimination period of 7 days for sickness and 0 days for an injury) if you become disabled and are not able to work. This coverage is provided at no cost to you by the Town of Superior. The maximum benefit period is 13 weeks.

Long Term Disability

Long-Term Disability replaces a portion of your income if you are unable to work because of an injury or illness that occurs off the job and continues for a longer term duration. Long Term Disability insurance provides payment to you of 66.67% of your salary up to $7,500 per month (after the later of an elimination period of 90 calendar days or the date your short-term disability ends) if you become disabled and are not able to work. This coverage is provided at no cost to you by the Town of Superior.

VOLUNTARY LIFE AND AD&D INSURANCE

Insured by Mutual of Omaha

You may purchase life and AD&D insurance in addition to the company-provided coverage. You may also purchase life and AD&D insurance for your dependents if you purchase additional coverage for yourself. You are guaranteed coverage (up to $50,000 and up to $25,000 for your spouse) without answering medical questions if you enroll when you are first eligible.

Employee— $10,000 to $250,000 in increments of $10,000;not to exceed 5x your annual earnings rounded to the next higher multiple of $10,000

Spouse— $5,000 up to $50,000 in increments of $5,000; spouse amount may not exceed more than 50% of the employee's amount

Children— $2,000 up to $10,000 in increments of $1,000; child amount may not exceed more than 50% of the employee's amount

FLEXIBLE SPENDING ACCOUNTS (FSA)

Administered by Rocky Mountain Reserve

Flexible Spending Accounts (FSAs) allow employees to use pretax dollars for healthcare or child/dependent care expenses not covered by insurance plans. Employees contribute a portion of each paycheck to an FSA and save significantly on taxes. Money in an FSA can be used to pay for out-of-pocket medical, dental and vision expenses or dependent care expenses. Employees do not need to be enrolled in the Employer's Health Plan to have an FSA. Town of Superior offers two Health Flexible Spending Accounts (Healthcare or Limited Purpose) and a Dependent Care Flexible Spending Account.

Healthcare FSA

A Healthcare FSA is a pre-tax benefit account used to pay for eligible medical, dental, and vision care expenses that aren't covered by your insurance plan or elsewhere. It's a smart, simple way to save money while keeping you and your family healthy and protected. The IRS sets a limit on how much you can contribute to this account each year. **For 2024, the spending limit was $3,200.**

Limited Purpose FSA

A Limited Purpose FSA (LPFSA) is a flexible spending account that only reimburses you for eligible dental and vision expenses. A LPFSA is available to employees who are enrolled in a high deductible health plan (HDHP); you may enroll in both the LPFSA and the Health Savings Account (HSA). By establishing a LPFSA, you can save money on taxes by using your LPFSA dollars for your dental and vision expenses while preserving your HSA funds for other purposes, including simply saving those funds for the future. The IRS sets a limit on how much you can contribute to this account each year. **For 2024, the spending limit was $3,200.**

Dependent Care FSA

A Dependent care FSA is a pre-tax benefit account used to pay for dependent care services, such as preschool, summer day camp, before or after school programs, and child or elder daycare. Children are eligible for coverage up to age 13. A Dependent Care FSA is a smart, simple way to save money while taking care of your loved ones so that you can continue to work. The IRS sets a limit on how much you can contribute to this account each year. **For 2024, the spending limit was $5,000 if married and filing jointly or head of household or $2,500 if married and filing separately.**

Here's How an FSA Works

1. Decide the annual amount you want to contribute based on your expected health care and/or dependent childcare/elder care expenses.
2. Elections are deducted from each paycheck before income and Social Security taxes, and deposited into your FSA. Your entire annual election is available immediately after the beginning of the plan year for the Health Care FSA and LPFSA. For the Dependent Care FSA you can only receive the amount that is in your account when your claim is paid.
3. For eligible health care expenses you can pay with the Health Care FSA or LPFSA debit card for or submit a claim form for reimbursement. For dependent care you pay for eligible expenses when incurred, and then submit a reimbursement claim form or file the claim online.
4. You are reimbursed from your FSA. So, you actually pay your expenses with tax-free dollars.
5. At the end of the calendar year, any unused amount in your Healthcare FSA will be forfeited with the exception of a maximum $610 rollover to be used for the next calendar year. The $640 rollover does not apply to the Dependent Care FSA.
6. You can use the LPFSA only for dental and vision expenses.

HEALTH SAVINGS ACCOUNT (HSA)

Administered by UMB

A Health Savings Account (HSA) is an individually-owned, tax-advantaged account that you can use to pay for current or future IRS-qualified medical, dental and vision expenses. With an HSA, you'll have the potential to build more savings for healthcare expenses or additional retirement savings through self-directed investment options.

Advantages of the High Deductible Health Plan (HDHP) with an HSA

The HDHP option is designed to encourage you to be more conscientious of your healthcare expenditures. It also offers a number of special features, for example:

- It has a lower monthly payroll contribution for dependent coverage
- You have access to a Health Savings Account (HSA) that allows you to put aside money, tax-free, to pay for eligible medical, dental and vision expenses. You choose when to use the money in your HSA account. It rolls over from year to year, allowing the balance to increase.

Setting Up an HSA Account

Your HSA is administered through UMB. You can open and contribute to an HSA if you:

1. Are covered by an HSA-qualified health plan (HDHP);
2. Are not covered by other health insurance (with some exceptions);
3. Are not enrolled in Medicare;
4. Are not eligible to be claimed as a dependent on another person's tax return;
5. Have not received health benefits from the Veterans Administration with the exception of services for a "service related disability" or an Indian Health Services facility within the last three months; and
6. Are not covered by your own or your spouse's Healthcare FSA.

Contributing to Your HSA

Health Savings Accounts have a triple tax advantage:

- Contribute tax-free
- Invest tax-free
- Make withdrawals for eligible medical expenses, or for any use after age 65 tax-free

Using Your HSA Funds

Money you use from your HSA to pay for qualified medical expenses is federally tax-free. If you use money for reasons other than qualified medical expenses before age 65, that money is taxable and subject to a 20% penalty. This isn't a complete list of rules and requirements for HSAs. More info can be found in the publication 969 of the IRS, at www.irs.gov.

HSA Contribution	2024 Calendar Year IRS Maximums	Town of Superior Contribution	Employees Maximum Contribution
Employee Only	$4,150	$166.67 per month for an annual total of $2,000	$2,150
Family	$8,300	$333.34 per month for an annual total of $4,000	$4,300
Catch-Up	Age 55+ may contribute an additional $1,000		

OTHER BENEFITS

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Administered by Anthem

Personal issues, planning for life events or simply managing daily life can affect employees' work, health, and family. The suite of services offered by an EAP provides support, resources, and information for personal and work-life issues. The Town of Superior offers an Employee Assistance Program to provide you and your family members with the assistance you need in your everyday life.

You receive up to 5 face-to-face counseling sessions per incident, per year. They are available 24/7 to assess your needs and find an appropriate solution for a range of concerns, including:

- Family Services, Nutrition, Stress Management, Financial Services, Legal Services, etc.

The program's user-friendly, confidential services are available by calling, toll-free at: 800-865-1044.

PATIENT ADVOCACY

Administered by Health Advocate

Health Advocate is a service provided by Town of Superior at no cost to you. With Health Advocate you have confidential, unlimited access to a Personal Health Advocate who can help you and your eligible family members resolve healthcare and insurance-related issues—all through a single toll-free number.

WELLNESS REIMBURSEMENT PLAN

Administered by the Town of Superior

The Town provides reimbursement of 50% of expenses up to $1,300 for the current plan year. For the purpose of this plan, Wellness is defined as a healthy balance of the mind-body and spirit that results in an overall feeling of well-being. Therefore, wellness expenses would include items related to: Nutrition, Exercise, Health Care, and Stress Management. The Wellness Reimbursement Plan is designed for all eligible employees and their immediate family members. The purpose of this plan is to assists employees' behavior in order to achieve better health, to optimize an already good state of health and to reduce health risks. The Town will not reimburse any expenses for material goods (i.e. exercise equipment) which could be resold to a third party.

RETIREMENT PLAN

Administered by COREBRIDGE

401(a)

The Town provides retirement benefits to full-time employees by contributing 15% of the employee salary to a 401(a) Money Purchasing Plan. This contribution is not deducted from the employee salary but instead is a benefit in addition to the employee salary. The account is administered through COREBRIDGE Retirement. The Town is exempt from Social Security and does not contribute to the program. Part-time employees contribute to Social Security and do not participate in the 401 (a) Money Purchasing Plan.

Deferred Compensation

As an employee of a public agency, you may also elect to enroll in one or both of the available Deferred Compensation plans. Employees may enroll in a 457 (b) which allows employees to defer a fixed amount of tax-free wages into a retirement annuity administered through COREBRIDGE Retirement. Employees may also enroll in a Roth 457 (b) which allows employees to defer a fixed amount of after-tax wages into a retirement annuity administered through COREBRIDGE Retirement. The normal contribution limit for elective deferrals to a 457 deferred compensation plan is $22,500 in 2023. 2024 limits have not been released yet. Employees age 50 or older may contribute up to an additional $6,500, for a total of $26,000. Employees taking advantage of the special pre-retirement catch-up may be eligible to contribute up to double the normal limit, for a total of $39,000.

OTHER BENEFITS

ECO PASS

The Town provides an EcoPass to all regular employees. EcoPass is an annual employer-sponsored pass providing employees unlimited rides on bus and rail, including the Flatiron Flyer. The Guaranteed Ride Home® is included with the EcoPass program and guarantees to employees a free taxi ride home from the office in the event of unplanned schedule changes, illness or other urgent situations. It provides peace of mind to those who choose an alternative mode of transportation to the office.

HOLIDAYS

HOLIDAYS	
New Year's Day	Monday January 1
Martin Luther King Jr. Day	Monday, January 15
President's Day	Monday, February 19
Memorial Day	Monday, May 27
Juneteenth	Wednesday, June 19
Independence Day	Thursday, July 4
Labor Day	Monday, September 2
Veteran's Day	Monday, November 11
Thanksgiving Day	Thursday, November 28
Day after Thanksgiving	Friday, November 29
Christmas Eve	Tuesday, December 24
Christmas Day	Wednesday, December 25

VACATION	
Initial Year of Service	Accumulate 0.83 days per month
Years of Service 1-3	10 days per year
Years of Service 4-7	15 days per year
Years of Service 8 and Thereafter	20 days per year

Up to twenty (20) days vacation may be carried forward from one year to the next unless a greater accumulation is authorized by the Town Manager and in the Town Manager's case, authorized by the Mayor.

Additionally, three floating holidays are allowed to be taken at a time chosen by the employee. The floating holidays must be used during the benefit calendar year or they are forfeited. They must be used as full days and must be taken in increments of 8 hours.

MEDICAL LEAVE

Medical leave shall be granted, on a reasonable basis, up to 12 days per year. Medical leave shall include sick days and office leave for medical, dental and vision appointments. Medical leave may also be used to attend to immediate family. In addition, employees are entitled to funeral leave, which is up to 3 days for immediate family members, and 1 day for extended family members. The Town Manager shall have the discretion to grant additional leave deemed appropriate.

Contact Information

If you have specific questions about a benefit plan, please contact the administrator listed below, or your local human resources department.

BENEFIT	ADMINISTRATOR	PHONE	WEBSITE/EMAIL
Medical	Anthem	800.698.0087	www.anthem.com
Dental	Anthem	800.627.0004	www.anthem.com
Vision	VSP	800.877.7195	www.vsp.com
Life and AD&D	Mutual of Omaha	800.775.8805	www.mutualofomaha.com
Short-Term Disability	Mutual of Omaha	800.877.5176	www.mutualofomaha.com
Long-Term Disability	Mutual of Omaha	800.877.5176	www.mutualofomaha.com
Voluntary Life	Mutual of Omaha	800.775.8805	www.mutualofomaha.com
Flexible Spending Account	Rocky Mountain Reserve	888.722.1223	www.rockymoutainreserve.com
Employee Assistance Program	Anthem	800.865.1044	www.anthem.com
Patient Advocacy	Health Advocate	866.695.8622	www.healthadvocate.com
Wellness Reimbursement	Town of Superior	303.499.3675 ext. 124	nadines@superiorcolorado.gov
Retirement	COREBRIDGE	800.448.2542	www.corebridgefinancial.com
Eco Pass	Town of Superior	303.499.3675 ext. 124	nadines@superiorcolorado.gov
Health Savings Account	UMB	866.293.9605	www.umb.com

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights
Town of Superior is committed to the privacy of your health information. The administrators of the Town of Superior Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Nadine Smith at 303.499.3675 ext. 124 or nadines@superiorcolorado.gov.

HIPAA Special Enrollment Rights

Town of Superior Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Town of Superior Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. 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 new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Nadine Smith at 303.499.3675 ext. 124 or nadines@superiorcolorado.gov.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

Patient Protections Disclosure

The Town of Superior Health Plan generally may require the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Anthem designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Anthem at 800.698.0087 or www.anthem.com.

For children, you may designate a pediatrician as the primary care provider.
You do not need prior authorization from Anthem or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Anthem at 800.698.0087 or www.anthem.com.

Women's Health & Cancer Rights Act

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

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

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

Plan 1: PPO PLAN A (Individual: 20% coinsurance and $0 deductible; Family: 20% coinsurance and $0 deductible)
Plan 2: HDHP 2500 PLAN (Individual: 20% coinsurance and $2,500 deductible; Family: 20% coinsurance and $5,000 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 303.499.3675 ext. 124 or nadines@superiorcolorado.gov..

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). .

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. 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	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
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://dhs.iowa.gov/ime/members/medicaid-a-to-z/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://kidshealth.ky.gov/Pages/index.aspx 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/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp 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
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://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**
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) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
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	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
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 July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/agencies/ebsa

1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

www.cms.hhs.gov

1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

Notice of Creditable Coverage

Important Notice from Town of Superior

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 Town of Superior 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. **Town of Superior has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

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

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

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Town of Superior coverage may not be affected.

If you do decide to join a Medicare drug plan and drop your current Town of Superior coverage, be aware that you and your dependents may not be able to get this coverage back.

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 Town of Superior and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Town of Superior 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:	**January 01, 2024**
Name of Entity/Sender:	**Town of Superior**
Contact—Position/Office:	**Nadine Smith**
Office Address:	**124 E Coal Creek Dr Superior, Colorado 80027-9626 United States**
Phone Number:	**303.499.3675 ext. 124**

Model General Notice of COBRA Continuation Coverage Rights

(For use by single-employer group health plans)

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

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

The parent-employee dies;

The parent-employee's hours of employment are reduced;

The parent-employee's employment ends for any reason other than his or her gross misconduct;

The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);

The parents become divorced or legally separated; or

The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

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

The end of employment or reduction of hours of employment;

Death of the employee;

[add if Plan provides retiree health coverage: Commencement of a proceeding in bankruptcy with respect to the employer;]; or

The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days [*or enter longer period permitted under the terms of the Plan*] after the qualifying event occurs. You must provide this notice to: Nadine Smith at 303.499.3675 ext. 124 or nadines@superiorcolorado.gov.

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

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

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

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

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

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

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Nadine Smith at 303.499.3675 ext. 124 or nadines@superiorcolorado.gov.

MARKETPLACE NOTICE

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Nadine Smith at 303.499.3675 ext. 124 or nadines@superiorcolorado.gov.

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Town of Superior		4. Employer Identification Number (EIN)
5. Employer address 124 E Coal Creek Dr		6. Employer phone number 303.499.3675 ext. 124
7. City Superior	8. State CO	9. ZIP code 80027
10. Who can we contact about employee health coverage at this job? Nadine Smith		
11. Phone number (if different from above)		12. Email address nadines@superiorcolorado.gov

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

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

☒ All employees. Eligible employees are:

Employees who work 30 or more hours per week

☐ Some employees. Eligible employees are:

• With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Your spouse, children under the age of 26, and disabled dependents of any age

☐ We do not offer coverage.

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

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

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

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

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

☐ **Yes** (Continue)

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

☐ **No**

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

☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

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

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

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly <<Select frequency of employee contribution.>>

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

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

☐ Employer won’t offer health coverage

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

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

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

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

This benefit summary prepared by

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