Employee Benefits

Full-time District employees working 30 or more hours per week.

Benefit plans effective July 1, 2016–June 30, 2017.

Take Care TAKE CHARGE

Your Health • Your Choice • Your Money

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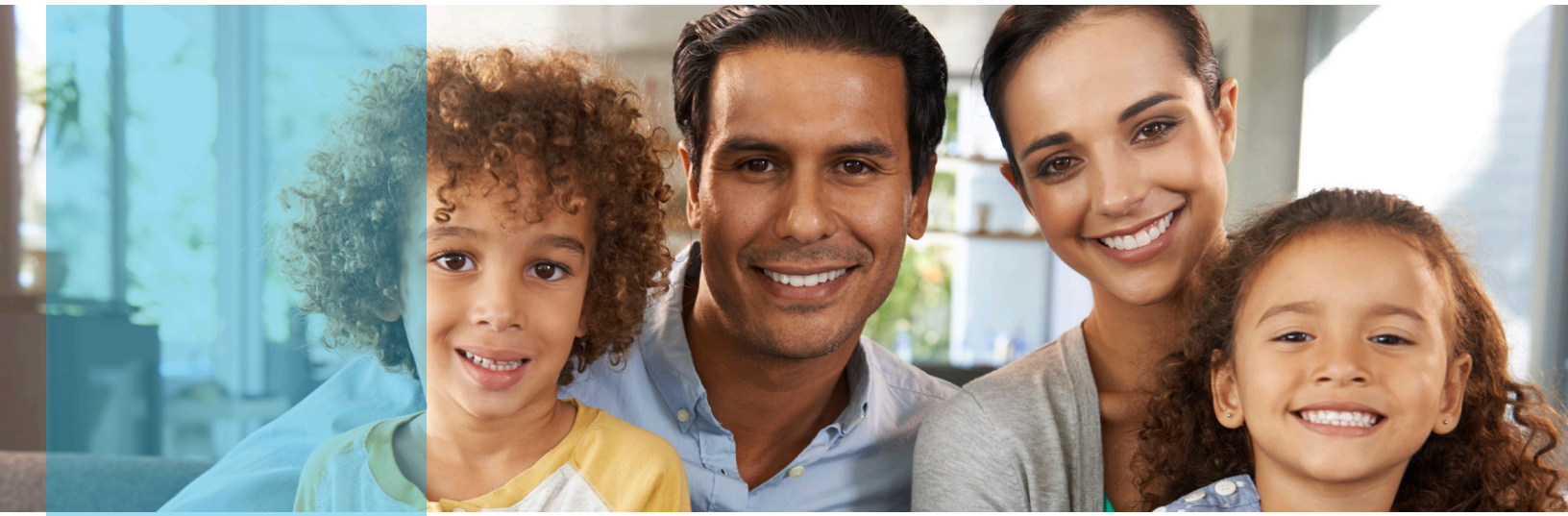


Benefits are an integral part of the overall compensation package provided by Jeffco Public Schools.

Within this Benefits Guide you will find important information on the benefits available to you for the July 1, 2016, through June 30, 2017, plan year.

Take a moment to review the benefits Jeffco Public Schools offers to determine which plans are best for you.

Please contact the Employee Benefits Department for more information regarding the material contained in this Benefits Guide.

Phone: 303-982-6527

Email: Benefits@jeffco.k12.co.us

Employee Benefits Overview

Benefits Eligibility for Full-Time Employees

District employees who are regularly scheduled to work at least 30 hours per week in one or more standard hour jobs are eligible for all of the benefits described in this guide.

Many of the plans offer coverage for eligible dependents, including:

- Your legal spouse, common-law spouse*, or civil union partner*.
- Your children under age 26, including stepchildren, legally-adopted children, children placed with you for adoption, and those for whom you have legal guardianship, regardless of student or marital status, residence, or level of financial support they receive from you.
- Your children of any age who are physically or mentally unable to care for themselves; proof that the disability began prior to age 26 is required.

*Additional documentation is required; contact the Employee Benefits Department for details. Note: You may be required to provide documentation to support dependent eligibility.

Important Note: Covering ineligible dependents adds unnecessary costs to the health plans. You may be responsible for reimbursing the plans for expenses incurred in error; furthermore, it may be cause for termination of employment.

The District benefits package consists of:

Medical insurance
Dental benefits
Vision benefits
Health savings account
Health care flexible spending account
Dependent day care flexible spending account
Basic life and AD&D insurance
Voluntary life insurance
Disability insurance
Retirement savings plans
Employee assistance program
Wellness program

Benefits Coverage Effective Date

Important: If you are returning from leave or transferring into a benefits-eligible position, you are eligible for benefits as early as the first day of the month following your effective return/start date.

Month of Hire or Rehire*	Effective Date for Medical, Dental, Vision, HSA, FSA, Life, and Disability Coverage	First Paycheck Deduction for Medical, Dental, Vision, and Voluntary Life Coverage	First Paycheck Deduction for HSA and FSA
January	March 1	End of February	End of March
February	April 1	End of March	End of April
March	May 1	End of April	End of May
April	June 1	End of May	End of June
May	July 1	End of June	End of July
June	August 1	End of July	End of August
July	September 1	End of August	End of September
August	October 1	End of September	End of October
September	November 1	End of October	End of November
October	December 1	End of November	End of December
November	January 1	End of December	End of January
December	February 1	End of January	End of February

*Employees rehired within 26 weeks, who were covered under a District medical plan at the time of termination, should contact the Employee Benefits Department for additional information regarding medical plan enrollment.

Employee Benefits Overview

Making Changes During Annual Benefits Enrollment

The annual benefits enrollment period, held in May each year, is the one time of year you can change your benefit elections, coverage levels, and tax treatment of your benefit deductions. The only exception is if you experience a qualified change in status (see page 5 for details). Changes made during the annual benefits enrollment period become effective July 1.

During annual enrollment, log into the ESS/Access Jeffco web portal to:

- Newly enroll in the benefit plans.
- Enroll in the flexible spending accounts—a new election is required every year for this benefit.
- Drop coverage.
- Add/drop dependents.
- Provide annual proof of other group medical coverage.
- Change the status of your deductions from before-tax to after-tax or vice versa.

Benefits Enrollment

You can enroll in benefits or change your benefit elections at the following times:

- During the annual enrollment period (May of each year).
- Within 60 days of your initial eligibility date (as a newly-hired employee).
- Within 60 days of your rehire* or return from leave date.
- Within 60 days of experiencing a qualifying life event.

*You may be eligible sooner if you have been rehired by the District within 26 weeks of termination and were covered by a District medical plan at the time of termination. Contact the Employee Benefits Department for details.

Online enrollment

Your benefits enrollment will be completed online, using the self-service system, ESS/Access Jeffco. You will be notified when you can access this system to complete your benefits enrollment.

Confirming your benefits choices

Benefit elections must process overnight before they will be reflected in the HR system. The day after you submit your benefit elections you are encouraged to order a confirmation statement. Please review the confirmation statement to ensure your choices were made correctly and the appropriate dependents have been included on your coverage. If you need to make corrections, you must do so while still in your enrollment period. Please contact the Employee Benefits Department at (303) 982-6527 if you need to have your enrollment reopened.

If you need personal enrollment assistance, please contact the Employee Benefits Department. The Service Desk is also available to assist with any navigation issues, and can be reached during business hours at 303-982-2200.

Making A Mid-Year Benefits Change

Due to IRS regulations, once you have made your elections for the plan year, you cannot change your benefits until the next annual benefits enrollment period. The only exception is if you have a qualified change in status.

An IRS-approved "change in status," may include:

- The addition of a dependent through birth, adoption, or marriage.
- The loss of a dependent through divorce or death, or if your child reaches the maximum age limit for coverage.
- A change in your or your dependent's employment status from full time to part time, or vice versa, or loss/gain of employment, resulting in the loss or addition of coverage.
- An unpaid leave of absence taken by you or your spouse.
- A change in your dependent's employer-provided coverage (i.e., annual enrollment).
- A change in your or your dependents' Medicaid, Medicare, and/or CHIP eligibility.
- Enrollment in the public Marketplace during the Marketplace annual enrollment period.
- A change in hours to less than full-time status, even though medical benefits are still available to the employee.

Remember, you may only make enrollment changes during the year if you have a qualified change in status. Election changes must be consistent with your status change. **To make a qualified change, you must submit a benefits change form with documentation of the change to the Employee Benefits Department within 60 days of the date of the status change.** No changes will be allowed beyond the 60-day limit. Most coverage changes are effective the first of the month following receipt of your written request and required documentation.

Termination of Coverage

Your benefits will end the last day of the month in which employment ends. Upon termination of coverage, you and your dependents may be eligible to continue your coverage through the provisions of COBRA. COBRA rates may be found on the Benefits website.

Benefit Plan Costs

Employer Contribution

Full-time District employees are eligible to receive a non-taxable employer contribution to be used to offset the cost of District medical insurance. Any remaining funds can be used to purchase dental or vision benefits or fund a health savings account (HSA) or health care flexible spending account (FSA).

Your Benefit Plan Costs

If you elect employee-only Kaiser HDHP or Kaiser DHMO coverage, you will have benefit dollars remaining, which can be used to purchase dental or vision benefits or fund an HSA (HDHP plans only) or FSA.

Monthly Medical Rates AFTER $515 District Contribution

Level of Coverage	Kaiser HDHP *HSA Eligible*	Kaiser DHMO	UHC HDHP Charter Network *HSA Eligible*
Employee Only	No cost to you	No cost to you	$183.70
Employee + Spouse	$379.27	$488.70	$882.41
Employee + Child(ren)	$334.55	$438.51	$812.54
Employee + Family	$692.25	$839.99	$1,371.50
Remaining Benefit Allocation*	$67.87	$13.15	N/A

* Available only to employees enrolled in employee-only coverage whose cost is less than the $515 employer contribution. May be used to purchase other benefits or fund an HSA or FSA.

Monthly Dental and Vision Rates

Level of Coverage	Delta Dental PPO Plan	Delta Dental Plus Plan	EyeMed Vision Plan
Employee Only	$27.30	$35.80	$6.50
Employee + Spouse	$54.60	$71.60	$13.00
Employee + Child(ren)	$54.60	$71.60	$13.00
Employee + Family	$81.90	$107.40	$19.50

Monthly Voluntary Employee Supplemental Life Insurance Rates

You may purchase 1x salary (to a maximum of $130,000), 2x salary (to a maximum of $260,000) or 3x salary (to a maximum of $390,000).

Age*	Employee Rate—Per $1,000 of coverage
<30	$0.05
30-34	$0.06
35-39	$0.07
40-44	$0.10
45-49	$0.15
50-54	$0.23
55-59	$0.40
60-64	$0.61
65-69**	$1.10*
70+**	$1.69*

*Your age is determined each June 1.
**Coverage amount is reduced by 35%.

Monthly Voluntary Spouse and Dependent Life Insurance Rates

Level of Coverage	Spouse Coverage
$10,000	$3.00
$20,000	$6.00
$25,000	$7.50

Level of Coverage	Child(ren) Coverage*
$2,500	$0.30
$5,000	$0.60
$10,000	$1.20

*Coverage is available for children age 14 days up to age 26.

Benefit Plan Costs

Before-Tax Versus After-Tax Deductions

You have the option of having the medical, dental, and vision plan costs deducted before or after taxes are calculated. On the benefit enrollment form on ESS, you will see that the benefit plans are listed twice—with "before-tax" and "after-tax" options. It is important that you make the right election, as your net pay will be affected by this selection. (If you are within four years for retirement, contact PERA for additional information on how this election may affect your highest average salary for retirement purposes.)

Note: After your initial enrollment, you will only be able to change this election during the annual benefits enrollment period, which takes place in May of each year, and will be effective on the June paycheck.

Before-tax benefit deductions

- Benefit costs are deducted before taxes are calculated; you are taxed on the remaining balance (you pay less taxes with this option).
- Your benefit deductions are not included as PERA-eligible earnings.
- PERA calculates retirement benefits based on the average of your three highest years' salary; if you are not close to retirement age, electing before-tax deductions may be your best option.

After-tax benefit deductions

- Taxes are calculated before benefit costs are deducted (you pay more taxes with this option).
- Your PERA-eligible earnings include your benefit deductions.
- 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.

Are you thinking about retiring in the next four years?

If so, it is important that you carefully consider whether to elect before-tax or after-tax deductions. Contact PERA for more information.

Benefit Plan Costs

Electing Coverage if You and Your Spouse are Both District Employees

If you and your spouse are both full-time District employees, a split-contract arrangement may be established (upon request). This arrangement allows the District to aggregate you, your spouse, and your children (if applicable), and report them as one family unit to the medical insurance carrier. This special arrangement provides an employer contribution to both you and your spouse, aggregates your premium, and accumulates your costs toward the deductible and out-of-pocket limits.

You or your spouse must contact the Employee Benefits Department to ensure proper enrollment for this coverage. In the event of a job or marital status change that would affect your eligibility for a split-contract arrangement, you must notify the Employee Benefits Department immediately or you will be responsible for repaying any amounts overpaid.

Here's how it works: One employee enrolls themselves, their spouse, and their children (if applicable) for medical coverage. They receive the District contribution to help offset the cost of medical coverage. The other spouse will receive their District contribution as a benefit allocation that is added to their earnings.

Waiving District Medical Insurance

If you have other group medical coverage, you may choose to waive District medical coverage and receive a monthly reduced benefit allocation of $80.00. In order to receive the reduced benefit allocation, you must enroll in the medical option, "waive medical, reduced allocation" in the medical section of the on-line enrollment form on ESS AND submit the "Proof of Other Group Medical Coverage" online form (also available on ESS). You must resubmit proof each year during the annual benefits enrollment period. You are not eligible for the reduced benefit allocation for waiving medical coverage if your other coverage is private or provided through the health insurance Marketplace (i. e., Connect for Health Colorado).

Health Care Reform Law Individual Mandate

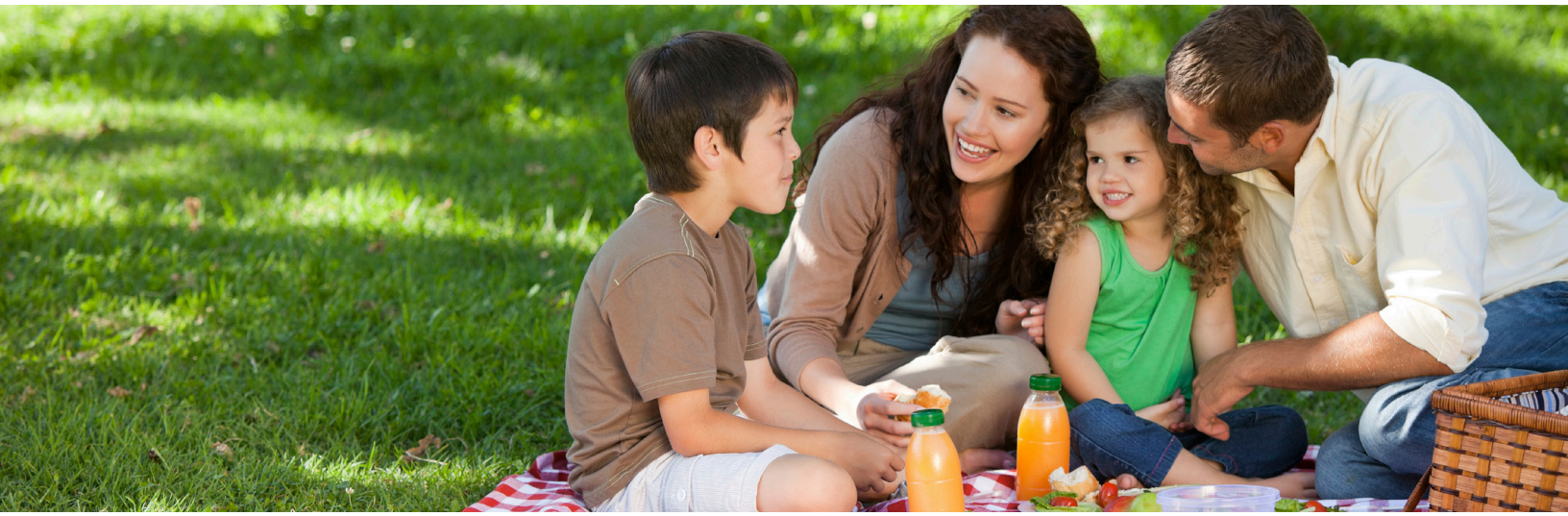
You and your family members are required to have health insurance. If you don't have coverage, you'll have to pay a penalty to the government. Some people may qualify for an exemption to this requirement.

If you are covered by any of the following, you will meet the individual mandate requirements: a District medical plan, your parent's or spouse's employer plan, an individual policy, a government plan such as Medicare, Medicaid, CHIP, TRICARE, or veterans coverage, student health coverage, state high-risk pool coverage, or coverage for non-U.S. citizens provided by another country.

Important

If you are a full-time District employee and are eligible for the District employer contribution, you and your dependents are not eligible to receive a subsidy from the government if you enroll in medical insurance through the public Marketplace.

Medical Insurance



Comparing Your Medical Insurance Plan Options

The District offers three medical plan options. Choosing the right medical plan is an important decision. Take the time to learn about your options to ensure you select the right plan for you and your family.

Kaiser HDHP

- Lowest cost per paycheck.
- Kaiser network only.
- Higher deductible (applies to all services).
- Members can fund an HSA or FSA.
- If you elect employee-only Kaiser HDHP or Kaiser DHMO coverage, you will have benefit dollars remaining, which can be used to purchase dental or vision insurance and/or fund an HSA or FSA.

Kaiser DHMO

- Mid-level cost per paycheck.
- Kaiser network only.
- Lower deductible (only applies to certain services).
- Members can fund an FSA.

UHC HDHP Charter Network

- Highest cost per paycheck
- UHC Charter network only.
- Higher deductible (applies to all services).
- Members can fund an HSA or FSA.
- If you enroll in the UHC plan (any coverage level) you will not have any benefit dollars remaining.

1. Do you prefer to pay more for medical insurance out of your paycheck, but less when you need care?
2. Or, do you prefer to pay less out of your paycheck, but more when you need care?
3. What planned medical services do you expect to need in the upcoming year?
4. Are you able to budget for your deductible by setting aside pre-tax dollars from your paycheck in an HSA?
5. Do you or any of your covered family members take any prescription medications on a regular basis?

FIVE THINGS TO CONSIDER

Did You Know?

If you enroll in the Kaiser HDHP or Kaiser DHMO and elect employee-only coverage, you will have benefit allocation dollars remaining, which can be used to fund a health savings account or health care flexible spending account.

Kaiser HDHP: $67.87 remaining per month = $814.44 per year!
Kaiser DHMO: $13.15 remaining per month = $157.80 per year!

Medical Insurance

The table below summarizes the key features of the medical plans. The coinsurance amounts listed reflect the percentage that the plans pay. Please refer to the official plan documents for additional information on coverage and exclusions.

	Kaiser HDHP *HSA Eligible*	**Kaiser DHMO**	**UHC HDHP Charter Network** *HSA Eligible*
Plan Year Deductible			
Individual/Family	$1,500/$3,000 *Family ded. applies if covering dependents*	$750/$2,250 *Each member has an individual ded.*	$2,600/$5,200 *Each member has an individual ded.*
Plan Year Out-of-Pocket Max			
Individual/Family *Includes deductible, coinsurance, & copays*	$3,000/$6,000 *Family OOP max applies if covering dependents*	$2,500/$5,500 *Each member has an individual OOP max*	$4,000/$8,000 *Each member has an individual OOP max*
Pay for Health Care with Pre-Tax Dollars	*You* **cannot** *fund both an HSA and an FSA*		*You* **cannot** *fund both an HSA and an FSA*
Eligible to fund an HSA	Yes	No	Yes
Eligible to fund a health care FSA	Yes	Yes	Yes
Physician Services			
Primary Care Physician	80% after ded.	$25 copay	85% after ded.
Specialist	80% after ded.	$45 copay	85% after ded.
Preventive Care	100%	100%	100%
Hospital Care			
Inpatient	80% after ded.	80% after ded.	85% after ded.
Outpatient	80% after ded.	80% after ded.	85% after ded.
Emergency Care	80% after ded.	80% after ded.	85% after ded.
Laboratory and X-Ray			
Diagnostic Lab at Office Visit	80% after ded.	Covered 100%	85% after ded.
Diagnostic Lab in Outpatient at Hospital	80% after ded.	80% after ded.	85% after ded.
Diagnostic and Therapeutic X-Ray	80% after ded.	80% after ded.	85% after ded.
MRI, CAT, PET	80% after ded.	80% after ded.	85% after ded.
Outpatient Therapies *20 visits/year/therapy*			
Physical, Speech, Occupational	80% after ded.	$25 copay	85% after ded.
Chiropractic	Not covered	Not covered	85% after ded.
Vision Care Exam	80% after ded.	$25 copay	85% after ded.
Retail Pharmacy (up to a 30-day supply)			
Tier 1	Ded., $15 copay	$15 copay	Ded., $10 copay
Tier 2	Ded., $30 copay	$30 copay	Ded., $30 copay
Tier 3	Ded., $50 copay	$50 copay	Ded., $50 copay
Mail-Order (up to a 90-day supply)	Ded., 2x retail copay	2x retail copay	Ded., 2.5x retail copay

*For the Kaiser HDHP, if you cover dependents (e.g., spouse or children), the individual deductible and out-of-pocket maximum do not apply. You must satisfy the full family deductible before the plan begins to pay towards services. These rules do not apply to the UnitedHealthcare HDHP.

KAISER PERMANENTE® HDHP and DHMO Members

Choose the right doctor for you.

With 22 Kaiser Permanente medical offices across the Denver–Boulder area, It's easy to find a doctor who is close to your home or workplace. Most Kaiser Permanente medical offices house primary care, laboratory, x-ray, and pharmacy services under one roof, which means you can visit your physician and manage many of your other needs in a single trip.

Call our appointment and advice line.

If you have an illness or injury and you're not sure what kind of care you need, our advice nurses can help. With access to your electronic health record, they can assess your situation and direct you to the appropriate facility, or even help you handle the problem at home until your next appointment. For advice, call **303-338-4545** 24 hours a day, seven days a week. For appointment services, call Monday through Friday from 7 a.m. to 6 p.m.

The care you need, when you need it.

PHYSICIAN OFFICE VISIT

WHAT IS IT FOR?

An expected care need—like a recommended preventive screening or a visit for a health issue.

EXAMPLES OF NONURGENT CARE NEEDS INCLUDE:

- Physical exams
- Pre-travel exams
- Ongoing anxiety issues
- Weight loss or gain
- Follow-up visits

WHAT DO YOU DO?

Make an appointment:

- Online through My Health Manager at kp.org (non-urgent appointments only).
- By phone at **303-338-4545.**

SAME-DAY AND AFTER-HOURS CARE

WHAT IS IT FOR?

An illness or injury that requires prompt medical attention, but is not an emergency medical condition.

EXAMPLES OF SAME-DAY AND AFTER-HOURS CARE NEEDS INCLUDE:

- Minor injuries
- Sore throats or coughs
- Earaches
- Backaches
- Urinary problems
- Pink eye

WHAT DO YOU DO?

Request a same-day appointment:

- Call **303-338-4545**

If you need after-hours care, we can confirm current hours and locations for you and direct you to the appropriate medical office.

EMERGENCY CARE

WHAT IS IT FOR?

A medical emergency is when you reasonably believe that your health is in serious danger—when every second counts.

EXAMPLES OF EMERGENCIES INCLUDE:

- Suspected heart attacks
- Poisonings
- Severe abdominal pains
- Severe cuts or burns
- Fractures
- Severe asthma attacks

WHAT DO YOU DO?

Take immediate action:

Call **911** or go to the nearest emergency room.

Personal Health Care Consultant

What you need, when you need it.

Kaiser Permanente provides a customer assistance service for District employees, which can help you with everything from answering questions about Kaiser Permanente health plans to explaining procedures and treatment options. Assistance is available for the following:

- Choosing the right plan for you and your family.
- Providing cost estimates of procedures.
- Assisting in scheduling hard-to-obtain doctors' appointments (as medically appropriate).
- Providing pharmacy costs and formulary options.
- Solving claims and billing issues.
- Reviewing payment options

Speak with a member of the Kaiser Permanente customer service team Monday through Friday during business hours. You can also set up an appointment time to speak with someone.

Call
303-338-3155 (before 07/01/16)
303-338-3990 (07/01/16 & after)

Email
Jeffco@kp.org (before 07/01/16)
Welcome@kp.org (07/01/16 & after)

Medical Insurance

UnitedHealthcare® HDHP Members

Your Primary Care Physician is Your Guide to Quality Care

The UnitedHealthcare HDHP Charter Network Plan helps you find your way to quality care by connecting you (and each of your covered dependents) to a primary care physician (PCP) that you can trust. Your PCP will provide and manage most of your care.

Select your primary care physician.

- Select your PCP from UHC's Charter network prior to logging into ESS to complete your on-line enrollment. You must enter the doctor's UHC physician ID number into the election form. If you do not select a PCP, UnitedHealthcare will assign one.
- Each family member may select a different PCP. However, the PCP must be located in the same local network in which the employee lives or works.
- The UnitedHealthcare HDHP provides in-network benefits only.
- Search for a Charter network PCP by: name, specialty, procedure, office hours, gender, education, location, and languages spoken.
- You can request to change your PCP after you enroll.

Need to change your PCP?
Call Member Services or log into myuhc.com.

An electronic referral is REQUIRED to see a specialist, chiropractor, or most other physicans other than your selected PCP.

- **You must receive a referral before seeing another network PCP or specialist. Services received without a PCP referral will not be paid by the plan and will not count toward your deductible or out-of-pocket maximum.**
- Check myuhc.com to see your referral, and save a screen shot of the confirmation for your reference. If no referral is listed on myuhc.com, call your PCP to notify them they need to submit the referral electronically (online).
- Prior authorization is required for certain services and procedures. Contact Member Services for details.
- A referral is not needed for emergency care even if received at a non-network hospital.

Referrals are NOT REQUIRED for services from network:

- OB/GYNs.
- Behavioral health and substance abuse disorder clinicians.
- Providers who provide routine refractive exams.
- Urgent and convenience care centers.

Contact UnitedHealthcare Member Services for details regarding:

- Medical care while travelling outside of the service area.
- Coverage for a student attending school outside of the service area.
- Questions regarding how a service or procedure will be covered.

When you need care, call your PCP first.

1 Make an appointment with your PCP.

2 Your PCP evaluates you.
Your PCP asks questions to try to understand what may be causing the illness. If necessary, your physician will order some tests.

3 Based on the evaluation, your PCP may:
Provide a treatment plan and/or prescribe medications.
OR
Refer you to a network specialist.

Health Savings Account

Kaiser HDHP and UHC HDHP Charter Network Members, budget for your health care expenses with a health savings account (HSA).

An HSA is a personal health care savings account that you can use to pay out-of-pocket health care expenses with before-tax dollars (exempt from federal and state taxes).

You must be enrolled in the Kaiser HDHP or UHC HDHP in order to fund an HSA. Additional eligibility requirements apply (see IRS Publication 969 for details: https://www.irs.gov/publications/p969/ar02.html).

IRS HSA Contribution Maximums

You may contribute up to:

	2016	2017
• **Employee-only coverage:**	**$3,350**	**$3,400**
• **All other coverage tiers:**	**$6,750**	**$6,750**

Individuals age 55+ by December 31 may make an additional $1,000 annual catch-up contribution to their HSA.

HSA contributions are PERA-includible. You and the District will make PERA contributions on your HSA contributions.

Calculate your tax savings!

Use the calculator at www.optumbank.com to find out how much you can save by funding an HSA.

Funding an HSA helps for all stages of life.

Use HSA Dollars Today

Use your HSA dollars today to pay for qualified medical expenses such as: deductibles, doctor's office visits, dental expenses, eye exams, prescription expenses, and LASIK eye surgery.

Save HSA Dollars for Tomorrow

Use your HSA to prepare for the unexpected. An HSA allows you to save and roll over money from year to year. The money in the account is always yours, even if you change health plans or jobs.

Invest HSA Dollars for Retirement

The money in your HSA (including interest and investment earnings) grows tax free. And after you reach age 65, your HSA dollars can be spent penalty free on any expense.

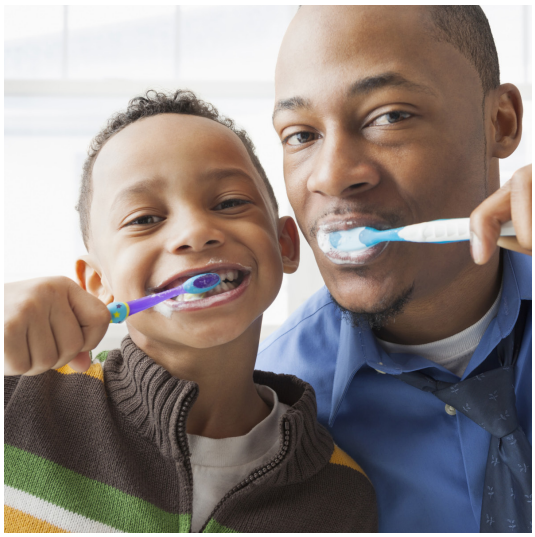
When you use your HSA it's like using a 20% off coupon for your health care expenses.*

5 REASONS TO FUND AN HSA

1. **Get a discount on health care expenses.**
   When you use HSA dollars for health care expenses you save money. That is because HSA contributions are not taxed. For example, when you receive a $400 bill from your provider and you pay with your HSA, you save about $100.
2. **Keep the money in your HSA, no matter what.**
   Money that you deposit into your HSA is yours to keep even if you move to a different medical plan or change jobs. Funding an HSA is a great way to save money for retirement. Plus, there are no vesting requirements or forfeiture provisions.
3. **Prepare for unexpected medical expenses.**
   You determine how much you contribute to your account and when to use the money to pay for eligible health care expenses. That way you have money for unexpected expenses. Pay for qualified medical expenses when they happen and use your HSA to reimburse yourself.
4. **Use your HSA for anyone in your family.**
   Funds in your HSA can be used for your expenses and those of your spouse and eligible dependents, even if they are not covered by the HDHP.
5. **Invest your HSA dollars.**
   You have the ability to invest your HSA savings in a variety of mutual fund offerings. The money that you earn through investing is tax-free. You can use that money for future medical expenses or save for retirement.

Dental Benefits

Dental Benefits



The District offers two dental plans through Delta Dental of Colorado—the Delta Dental PPO Plan and the Delta Dental Plus Plan. Locate a network provider at www.deltadentalco.com.

The PPO Plan provides in-network benefits only. All services must be provided by a Delta Dental PPO Network dentist.

The Plus Plan provides in- and out-of-network benefits, allowing you the freedom to choose any dentist. The amount you pay varies based on whether you choose a Delta Dental PPO provider, Delta Dental Premier provider, or out-of-network provider.

- You will pay less out of your pocket when you see a Delta Dental PPO dentist.
- Delta Dental PPO and Premier dentists file claims directly with Delta Dental and accept Delta Dental's reimbursement in full. When you see a Delta Dental dentist, you will only be responsible for your deductible and coinsurance, as well as any charges for non-covered services up to Delta Dental's approved amount.
- If you choose to see an out-of-network dentist, you will be billed the total amount the dentist charges (called balance-billing) and will incur additional out-of-pocket expenses.

The table below summarizes the key features of the dental plans. The coinsurance amounts listed reflect the amounts the plans pay.

	Delta Dental PPO Plan	Delta Dental Plus Plan		
	PPO Network Provider	PPO Network Provider	Premier Network Provider	Out-of-Network Provider
Plan Year Deductible Individual/Family	$100/$300	$50/$150		
Plan Year Benefit Max	$1,250	$1,500		
Preventive Services* Sealants, oral exams, cleanings, x-rays, fluoride treatment	100%	100%	100%	80% after ded.**
Basic Services Fillings, simple extractions, oral surgery, periodontics, endodontics	80% after ded.	90% after ded.	80% after ded.	60% after ded.**
Major Services Dentures, bridges, crowns, onlays, night splints/occlusal splints, TMJ evaluation/ services, implants	50% after ded.	60% after ded.	50% after ded.	30% after ded.**
TMJ Lifetime Max	$1,000	$1,500		
Orthodontia Services Limited to dependent children under age 26; no coverage for adults	50%	50%	25%	0%
Orthodontia Lifetime Max	$1,250	$1,500		

*Preventive care exams, cleanings, and x-rays are not subject to the deductible and do not count toward the annual coverage maximum.
**Subject to balance billing.

The EyeMed vision plan covers an annual eye exam at 100%—no member copay required.

Vision Benefits

The District offers a vision plan through EyeMed. Plan members have the freedom to choose any eye care provider, but will maximize their benefits, and pay less out of their pocket, when an EyeMed network provider is used. Additionally, if a non-network provider is used, the plan member will be responsible for submitting a claim to EyeMed for reimbursement. Locate a network provider at www.eyemedvisioncare.com (choose the ACCESS network).

The table below summarizes the key features of the vision plan. In addition to the benefits listed below, EyeMed plan members receive the following discounts: 40% off additional eyewear purchases, 20% off non-prescription sunglasses, and 20% off remaining balance beyond plan coverage. EyeMed members also enjoy discounts on hearing services, which may be extended to family members not covered by the vision plan.

	EyeMed Vision Plan	
	In-Network	Out-of-Network
Eye Exam Every 12 months	$0 copay	Reimbursement up to $45
Lenses Every 12 months in lieu of contact lenses	Includes polycarbonate lenses for children and adults	
Single	$0 copay	Reimbursement up to $35
Bifocal (standard)	$0 copay	Reimbursement up to $50
Trifocal (standard)	$0 copay	Reimbursement up to $65
Standard Progressive	$65 copay	Reimbursement up to $70
Frames Every 12 months for children to age 19; every 24 months for adults	$130 allowance + 20% off balance	Reimbursement up to $90
Contact Lenses Every 12 months in lieu of lenses		
Elective	$130 allowance	Reimbursement up to $105
Medically Necessary	Covered in full	Reimbursement up to $210
Laser Correction	15% off retail price	N/A

Flexible Spending Accounts

The District offers two flexible spending account (FSA) options—the health care FSA and the dependent day care FSA—which allow you to pay for eligible health care and dependent day care expenses with before-tax dollars.

The FSAs are administered by ASI Flex. Log into your account at www.asiflex.com to: view your account balance(s), calculate tax savings, view eligible expenses, download forms, view transaction history, and more.

Health care FSA

The health care FSA (HCFSA) allows you to set aside money from your paycheck on a before-tax basis (before income taxes are withheld) to pay for eligible out-of-pocket expenses such as deductibles, copays, and other medical, dental, and vision expenses that are not paid by the insurance plans.

You may contribute up to $2,550 to the HCFSA for the plan year. The entire amount you elect is available to you on July 1 or your first day of coverage (if later).

Dependent day care FSA

The dependent day care FSA (DDCFSA) allows you to set aside money from your paycheck on a before-tax basis for certain day care expenses to allow you and your spouse to work or attend school full time. Eligible dependents are children under 13 years of age, or a child over 13, spouse, or elderly parent residing in your house who is physically or mentally unable to care for himself or herself. Examples of eligible expenses are day care facility fees, before- and after-school care, and in-home babysitting fees (income must be reported by your care provider).

If you use a care provider who is your own child or relative, you may only be reimbursed for eligible expenses if the care provider is at least 19 years of age. You must report the name, address, and Social Security number or Tax Identification number of your care provider on your federal tax return.

You may contribute up to $5,000 to the DDCFSA for the plan year if you are married and file a joint return or if you file a single or head of household return. If you are married and file separate returns, you can each elect $2,500 for the plan year. Certain rules apply.

Remember, do not include expenses for care during periods of time you are not working, such as the summer. **You can only be reimbursed up to the amount that has been deposited into your DDCFSA.**

How does an FSA work?

You decide how much to contribute to each FSA on a plan year basis up to the maximum allowable amounts. Your annual election will be divided by the number of pay periods and deducted evenly on a before-tax basis from each paycheck throughout the year.

When you have expenses to be reimbursed, submit your claim electronically online or submit a paper claim to ASI Flex. You may be required to submit documentation with the following:

- Date of service/item purchased.
- Description of service/item.
- Provider/merchant name.
- Person receiving services.
- Amount you are required to pay.
- Tax identification number for day care providers.

Things to consider before contributing to an FSA:

- **The IRS requires that you forfeit any money left in your account if you do not spend it by the end of the plan year grace period.**
- You cannot stop or change contributions to your FSA during the year unless you have a qualified change in status consistent with your contribution change.
- You cannot take income tax deductions for expenses you pay with your FSAs.
- Prior to enrolling, make sure that the expenses you wish to claim are eligible for reimbursement. Once you enroll for the year, you cannot change your elections unless you have a qualified change in status.
- **Visit www.asiflex.com for tools to help you estimate your expenses and potential savings.**

Grace Period Provision:
The grace period provision allows you to use any remaining funds for eligible services incurred from July 1 through September 15 following the end of the plan year. All claims must be submitted for reimbursement by October 31.

Basic Life & AD&D Insurance

Life and AD&D insurance are important elements of your income protection planning, especially for those who depend on you for financial security.

Basic Life and Accidental Death and Dismemberment Insurance

The District provides employees with basic life and accidental death and dismemberment (AD&D) insurance at no cost. Eligible employees are automatically enrolled. Your life and AD&D benefits are each equal to one times eligible annual base salary, with a minimum of $5,000 and a maximum of $130,000.

- In the event of your death, your beneficiary will receive your basic life benefit.
- In the event you die as a result of an accident, your beneficiary will receive both your basic life benefit and basic AD&D benefit, which is equal to your life benefit times two.
- If you are injured in an accident and suffer a covered loss, you may receive an AD&D benefit based on the type of injury sustained.

Imputed income

Any basic life insurance amount paid by an employer that provides a benefit greater than $50,000 is considered imputed income by the IRS. Imputed income is the value the IRS assumes you would pay to purchase a similar policy in the private market—based on your age and the amount of coverage. The IRS considers this value to be income, and thus if your District-provided basic life coverage is greater than $50,000, the imputed income associated with the plan will be added to your pay for tax purposes, and the additional taxes you owe as a result will be withheld from your paycheck.

Voluntary Life Insurance

Voluntary Supplemental Life Insurance

You have the option to purchase voluntary supplemental life insurance for yourself, your spouse/civil union partner, and your child(ren) through after-tax payroll deductions.

Detailed rate information is available on page 6. For employee life insurance, the monthly premium cost is based on the coverage level and age as of June 1 (on an annual basis). Monthly spouse and dependent child(ren) rates are a flat amount based on the coverage amount elected.

IMPORTANT: During the annual benefits enrollment period you may buy up one level of life insurance without completing evidence of insurability, including going from no coverage to one times your eligible annual base salary. As a newly-eligible employee, you may elect voluntary life insurance in any amount listed below.

Employee supplemental life insurance

Employees may purchase supplemental life insurance for themselves in the following amounts:

- One times your eligible annual base salary—up to $130,000
- Two times your eligible annual base salary—up to $260,000
- Three times eligible annual base salary—up to $390,000

Spouse life insurance

As long as you participate in District's basic life insurance plan, you may purchase spouse life insurance for your eligible spouse/civil union partner in the following amounts: $10,000, $20,000, or $25,000.

Dependent child life insurance

As long as you participate in the District's basic life insurance plan, you may purchase life insurance for your eligible dependent child(ren) in the following amounts: $2,500, $5,000, or $10,000.

Disability Insurance

Short-Term Disability Insurance

The District provides short-term disability (STD) insurance at no cost to employees. Eligible employees are automatically enrolled in the STD plan.

- **Benefit:** 60% of salary up to $1,500/week*
- **Elimination period:** 14 consecutive days
- **Benefit duration:** 180 days

Long-Term Disability Insurance

The District provides long-term disability (LTD) insurance at no cost to employees. Eligible employees are automatically enrolled in the LTD plan.

- **Benefit:** 60% of salary up to $6,500/month*
- **Elimination period:** 180 consecutive days
- **Benefit duration:** Social Security Normal Retirement Age

*Benefit amount is offset by any benefits for which you are eligible through PERA or social security disability benefits or other deductible income as defined by the insurance vendor contract.

PERA Disability Benefits

Employees with at least five years of PERA participation may be eligible for PERA-provided disability benefits after a 60-day absence from work due to a qualifying illness or injury. You will be required to apply for this benefit; your District short-term disability and long-term disability benefits will be offset by any amount paid or due from PERA.

Retirement Savings Plans

Visit the Benefits > Retirement Savings web page for more details.

PERA Defined Benefit Plan—Required For All District Employees

All District employees participate in the Public Employees' Retirement Association (PERA) defined benefit plan. As an employee, you are required to contribute 8% of your PERA-eligible salary to the plan. The District is required to contribute 19.15% of your eligible salary in 2016; that amount will increase to 19.65% effective January 1, 2017.

Your PERA retirement benefit is based on your age and service credit at retirement and highest average salary. Learn more about the PERA defined benefit plan at www.copera.org.

Voluntary Savings Plans

Will your PERA benefit be enough for you to live comfortably in retirement? Depending on your lifestyle, you may need additional income so that you can live the retirement life of your dreams. To help you reach your savings goals, the District offers all employees the option to enroll in the following voluntary retirement plans: Jeffco TSA/403(b) plan, PERA 401(k), and PERA 457(b).

Best Savings Practices to Consider

- **The impact of an early start.** Your decision to start today could give you quite a bit more income at retirement than starting five years from now.
- **Contribute what you can afford.** Start at a number that feels comfortable to you. You can always change it later. The important thing is to start investing right away and to keep increasing your contribution as your salary increases.
- **Invest more, pay less in taxes.** All three plans offer you the option to contribute on a before-tax or after-tax Roth basis.

  Before-tax contributions come out of your pay before income taxes are taken out. If you choose to take advantage of the after-tax Roth option, you'll pay taxes on your contributions, but your future distributions (money you withdraw, and any return on those investments) are tax-free.

Employee Assistance Program

Employee Assistance Program

The employee assistance program (EAP) is available to all District employees at no cost. The EAP offers guidance for personal issues and work issues, and provides information about other concerns that affect your life.

Services include:

- Confidential, voluntary, in-person assessment and brief solution-focused therapy for employees and family members experiencing personal problems of any kind. Typical concerns involve relationship problems, anxiety and depression, substance abuse, grief and loss, legal and financial problems, parent/child problems, domestic violence, and work/family balance.
- Short-term counseling for employees regarding work-related problems including harassment, work performance, burnout, and coworker conflicts.
- Referral to appropriate services. EAP staff use up-to-date information on school District, community, and health plan resources to make confidential referrals for clients with special needs.

More information about the employee assistance program is available at http://jeffcoweb.jeffco.k12.co.us/eap.

Wellness Connections

Wellness Connections

The District's Wellness Connections program reinforces our commitment to your health and well being. This program is central to the District's belief that healthy employees translate to a more positive and productive workplace. In addition, as employees improve their health and/or manage their health-related conditions more effectively, we believe we can begin to slow the pace of our health care cost increases.

To get started, visit **Employee Connections > Employee Resources > Wellness Connections** and enroll in Alliance. Then, look for more information on how to participate in District and site-based programs.

Coinsurance
The percentage a plan member must pay of the allowed amount for covered health services once he or she has met the plan year deductible.

Copay
The flat dollar amount a Kaiser DHMO member pays for certain services, including office visits and prescription drugs. Kaiser HDHP and UnitedHealthcare HDHP members pay a copay for prescription drugs after they meet their plan year deductible.

Deductible (Kaiser high-deductible health plan)
For individual coverage, the individual deductible is the amount a member must pay each plan year before the plan starts paying toward covered services. For family coverage, the individual deductible does not apply. The family deductible must be met, by one individual or by a combination of family members, before the plan begins to pay.

Deductible (Kaiser DHMO plan, UnitedHealthcare high-deductible health plan, and dental plan)
For individual coverage, the individual deductible is the amount an individual member must pay each plan year before the plan starts paying toward covered services. For family coverage, the family deductible is the maximum deductible amount the employee and their covered dependents must pay each plan year, individually or as a family, before the plan begins to pay. Each family member also has an individual deductible. If the individual deductible is met before the family deductible, he or she will begin paying copays and coinsurance before the rest of the family.

Dependent Day Care Flexible Spending Account (DCFSA)
An employer-sponsored flexible benefits plan that permits an employee to use before-tax dollars that are automatically deducted from their paycheck to pay the cost of care for children or elderly dependents.

Explanation of Benefits (EOB)
A statement from the insurance vendor that is sent to a plan member explaining how and why benefit payments were or were not made. A typical EOB includes the following: service date, provider name, description of service(s) performed, doctor's fee/amount allowed by the insurer, and the amount the patient/member is responsible for.

Health Care Flexible Spending Account (HCFSA)
An employer-sponsored flexible benefits plan that permits an employee to use before-tax dollars that are automatically deducted from their paycheck to pay for eligible health care expenses, including copays, coinsurance, dental care, eyeglasses, and LASIK eye surgery, for themselves and any tax-code dependents.

Health Savings Account (HSA)
A tax-advantaged savings account that can be used to pay for qualified health care costs, which is only offered to employees enrolled in a high-deductible health plan (HDHP). HSA funds can be used to pay for qualified medical expenses during the plan year or in future years (unused funds rollover from one year to the next).

Network Provider
A group of doctors, hospitals, and/or other health care providers that contract with an insurance vendor to provide quality health care services at a discounted rate.

Out-of-Pocket Maximum (OPM)
Under the medical plans, the OPM is the most a member will pay for covered services during the plan year.

Preventive Care
Medical, dental, and vision care aimed at keeping a member healthy and detecting and treating any health problems early. In-network preventive care is covered at 100%, is not subject to the deductible, and typically includes routine physical exams, immunizations, and teeth cleanings.

Important Notices

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later 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 towards your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e., legal separation, divorce, cessation of dependent status, death of an employee, termination of employment.
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within **60 days** after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within **60 days** of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within **60 days** after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within **60 days** after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

Employee Benefits Department
Phone: 303-982-6527
Fax: 303-982-6670
Email: Benefits@jeffco.k12.co.us

Continuation Coverage Under COBRA

COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family, who are covered under the District's plan, when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the District's plan and under federal law, refer to the District's "General Notice of Continuation Coverage Rights Under COBRA", available through the Benefits website. You may also contact the Employee Benefits Department to request a copy of this notice.

HIPAA Privacy and Security Notice

The Health Insurance Portability and Accountability Act of 1996 deals, in part, with ensuring that protected health information which identifies you is kept private. You have the right to inspect and obtain a copy of certain protected health information maintained by the Jeffco Public Schools Welfare Benefit Plans (the "Plan"). Also, if you believe the protected health information the Plan has about you is incorrect or incomplete, you have the right to request that the information be amended. The Plan maintains a Notice of Privacy Practices that provides information to individuals whose protected health information will be used or maintained by the Plan. This Notice of Privacy Practices is available to you. If you would like a copy of the Notice of Privacy Practices, contact the Employee Benefits Department or visit the Benefit website.

Notice of Right to Designate Primary Care Provider and of No Obligation for Pre-Authorization for Ob/Gyn Care

The Jeffco Public Schools medical plans require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. Until you make this designation, one will be designated for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Employee Benefits Department or the medical carrier.

For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care 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 Employee Benefits Department or the medical carrier.

Employee Benefits Department
Phone: 303-982-6527
Fax: 303-982-6670
Email: Benefits@jeffco.k12.co.us

Notice About Your Prescription Drug Coverage and Medicare

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. This notice is distributed to all employees age 64 and older by October 15. You may also obtain the notice on the Benefits website or by contacting the Employee Benefits Department.

- This notice states that the Jeffco Kaiser Permanente high-deductible health plan prescription drug coverage is considered creditable.
- This notice states that the Jeffco Kaiser Permanente deductible HMO plan prescription drug coverage is considered creditable.
- This notice states that the Jeffco Public Schools UnitedHealthcare high-deductible health plan prescription drug coverage is considered creditable.

To obtain more information, contact the:

Employee Benefits Department
Phone: 303-982-6527
Fax: 303-982-6670
Email: Benefits@jeffco.k12.co.us

Women's Health and Cancer Rights Notice

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections 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 lymphedemas.

The Jeffco Public Schools Employee Health Care Plans provide medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan

If you would like more information on WHCRA benefits, please refer to your official plan documents or contact your Plan Administrator at:

Employee Benefits Department
Phone: 303-982-6527
Fax: 303-982-6670
Email: Benefits@jeffco.k12.co.us

Important Contact Information

If you have any questions regarding your benefits or the material contained in this guide, please contact the Employee Benefits Department.

Jeffco Public Schools Employee Benefits Department

Address: 1829 Denver West Drive #27, Golden, CO 80401

Phone: 303-982-6527

Fax: 303-982-6670

Email: Benefits@jeffco.k12.co.us

	Contact Number	Website
Medical Plans Kaiser Permanente Kaiser Permanente Health Care Consultant	303-338-4545 303-338-3155 (before 07/01/16) 303-338-3990 (07/01/16 & after)	http://my.kp.org/co/jeffcops/ my.kp.org/co/jeffcops
UnitedHealthcare	800-377-5154	www.myuhc.com
Dental—Delta Dental of Colorado	800-610-0201	www.deltadentalco.com
Vision—EyeMed	866-723-0513	www.eyemedvisioncare.com
Health Savings Account—Optum Bank	866-234-8913	www.optumbank.com
Flexible Spending Accounts—ASIFlex	800-659-3035	http://jeffco.asiflex.com
Short- and Long-Term Disability—The Standard	800-378-2395	www.standard.com
Jeffco TSA/403(b) Plan—Empower Retirement	800-701-8255	http://jeffcoschoolsgwest.com/
PERA Retirement Savings Plans—Colorado PERA	800-759-7372	www.copera.org
Employee Assistance Program	303-982-0377	Employee Connections › Employee Resources › EAP
Wellness Connections		Employee Connections › Benefits › Wellness Connections

This guide contains highlights of the benefits options available to you through Jeffco Public Schools. They are not complete descriptions of the benefits. The District may terminate, withdraw, or modify any benefit described in this guide, in whole or in part, at any time. The descriptions of the benefits are not guarantees of current or future employment or benefits. If there is any conflict between this guide and the official plan document(s), the official documents will govern.