DELTA COUNTY PUBLIC SCHOOLS

Benefit Plans

Medical PPO

Dental

DELTA COUNTY SCHOOL DISTRICT 50J Voluntary Vision

DELTA COUNTY SCHOOL DISTRICT 50J Group Life

Plan Arranged By
Willis Towers Watson
2000 S Colorado Blvd., Tower II, Suite 900
Denver, CO 80222

Phone: 303-773-1373
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WATS: 800-332-1168

Medical/Dental/Prescription Employee Premium:	
Employee Only	$94/Month
Employee & Spouse	$355/Month
Employee & Children	$297/Month
Family	$503/Month

Vision Premiums:	
Employee Only	$10/Month
Employee & Spouse	$14/Month
Employee & Children	$13/Month
Family	$24/Month

WHO IS WILLIS TOWERS WATSON?

Willis Towers Watson is the broker/administrator for Delta County School District 50J. It provides a Watts line for plan participants to obtain answers on claims and benefits questions at 800-332-1168. Willis Towers Watson has service representatives that make periodic visits to Delta County School District 50J to answer questions. Finally, Willis Towers Watson handles the premium invoice process between Delta County School District 50J and CNIC.

WHAT ARE THE ROLES OF CNIC / ROCKY MOUNTAIN HEALTH PLAN (RMHP) - ASO, CVS CAREMARK AND VISION SERVICE PLAN (VSP)?

CEBT has contracted with these managed health care companies to provide similar services:

CNIC / ROCKY MOUNTAIN HEALTH PLAN -ASO provides third party claim payment services and access to their provider network for CEBT members who have medical and/or dental coverage.

CVS Caremark provides the pharmacy payment and access to their provider network for CEBT members who have medical coverage.

Vision Service Plan provides the vision payment and access to their provider network for CEBT members who have vision coverage.

Much of your correspondence, such as Explanations of Benefits (EOB's) and requests for further information, will come from CNIC / RMHP-ASO. Additionally, you will receive ID cards from both CVS Caremark and CNIC / RMHP-ASO, but not from VSP.

ON-LINE CLAIM INFORMATION

Medical Claim information is available at http://secure.healthx.com/intc.asp. Log on with your username (FirstName.LastName) and password (initially, your social security number).
Prescription information is available at www.caremark.com.

CEBT
LIFE BENEFITS

SCHEDULE OF BENEFITS
LIFE INSURANCE, ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

Class	Amount of Life Insurance*	Full Amount of AD&D Insurance
All employees	$20,000	$20,000

*Your amount of insurance will be reduced as follows:

Age	65	40%
	70	65%
	75	75%
	80	80%

This is only intended to highlight some of the pertinent provisions of the Group Plan; such Plan will control in all instances.

DELTA COUNTY SCHOOL DISTRICT 50J
SUMMARY OF MEDICAL BENEFITS
July 1, 2016

Benefits will be payable during a calendar year as shown below, and may vary depending upon whether or not needed care is received from a hospital, physician, or other provider.

You are not required to arrange your treatment through a primary care physician. (Primary care physicians are family practice physicians, internists, and pediatricians.) You may arrange your care with a primary care physician or specialist of your choice.

MEDICAL PLANS	**PPO PLAN**
Deductible Per Calendar Year	$2,500 individual / $7,500 family (3 individual deductibles)
Co-insurance	Subject to deductible then, 80/20
Maximum Out of Pocket (Medical and Prescription drug combined out of pocket)	$6,600 individual / $13,200 family
Office Visits	Subject to deductible, then 80/20 of R&C
Non-Surgical X-Ray and Lab Expenses	100%, no deductible
Surgical X-Ray And Lab Expenses Injection Procedures Utilizing X-Rays During an X-Ray or Lab Procedure	Subject to deductible, then 80/20 of R&C
Hospital Expenses	
Inpatient Facilities	Subject to deductible, then 80/20 of R&C
Outpatient Facilities	Subject to deductible, then 80/20 of R&C
Emergency Room Facilities	Subject to deductible, then 80/20 of R&C
Urgent Care (Extended Hour/Walk-In Facilities)	Subject to deductible, then 80/20 of R&C
Ground or Air Transport	Subject to deductible, then 80/20 of R&C
Chiropractic Care	Subject to deductible, then 80/20 of R&C
Durable Medical Equipment (per item)	Subject to deductible, then 80/20 of R&C
Home Health Care	Subject to deductible, then 80/20 of R&C
Hospice Expenses	
Hospice Care	Subject to deductible, then 80/20 of R&C
Bereavement Counseling Maximum	Subject to deductible, then 80/20 of R&C

MEDICAL PLANS	PPO PLAN
Maternity Expenses	
Inpatient Hospital	Subject to deductible, then 80/20 of R&C
Inpatient Physician	Subject to deductible, then 80/20 of R&C
Birthing Center Facility	Subject to deductible, then 80/20 of R&C
Mental Health (Inpatient and outpatient)	Subject to deductible, then 80/20 of R&C
Substance Abuse (Inpatient and outpatient)	Subject to deductible, then 80/20 of R&C
Physical / Speech / Occupational Therapy	Subject to deductible, then 80/20 of R&C
Prescription Drugs (Generic and Brand)	$250 annual deductible separate from medical deductible After Deductible 80% Generic 70% Preferred Brand 60% Non-Preferred Brand To the combined medical and prescription drug maximum out of pocket amount. If a generic is available and a member or provider chooses a brand drug, the member will pay the difference in cost between the brand and generic plus applicable coinsurance.
Routine Well Adult and Child Care	100% - No Deductible
Women's Preventative Health Benefits	100% - No Deductible
MEDICAL ANNUAL MAXIMUM, per Individual: (includes all other maximums)	No Limit

The term "annual maximum" means the total amount of benefits which may be payable under the Plan for a calendar year (January 1 – December 31).

Maximum Family Deductible: The Plan will consider each person's deductible to be satisfied for a calendar year once you and your dependent(s) incur covered expenses for a calendar year which satisfy all or part of each person's separate deductible; and together equal the maximum family deductible.

The term "deductible" means a specified dollar amount of covered expenses which must be incurred during a calendar year, or as specified, before any other covered expenses can be considered for payment.

The term "coinsurance" means the amount payable by the Plan for a covered expense. The covered person is required to pay the amount not paid by the Plan.

OUT-OF-POCKET MAXIMUM per Calendar Year, **including** the applicable calendar year deductible:

The following expenses will not be considered toward the out-of-pocket limits, nor will they be paid at 100% once the out-of-pocket limits have been reached:

1. Expenses for inpatient, partial, or outpatient treatment of mental health disorders, alcoholism or drug abuse.

2. Expenses payable at 100%.

3. Non-covered expenses.

The term "out-of-pocket maximum" means the total amount in deductibles and coinsurance a covered person must pay during a calendar year. All eligible accumulated deductibles and coinsurance amounts payable by the covered person are combined to satisfy the respective out-of-pocket maximums under all levels of benefits.

When the covered person reaches his or her out-of-pocket maximum, the Plan will pay 100% of any additional covered expenses eligible for that individual during the remainder of that calendar year or to the maximums of the Plan, whichever occurs first.

Disclaimer - This comparison of coverages is intended only as a general description for the principle features of the benefit plans. Please refer to the evidence of coverage for details.

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DELTA COUNTY SCHOOL DISTRICT 50J
SUMMARY OF DENTAL BENEFITS

You may use any licensed professional dental personnel of your choice.

Deductible, per Lifetime

Type I, II and III Services, per person	$ 75
Type IV Services, per person	$ 50

The term "deductible' means a specified dollar amount of covered expenses which must be incurred during the lifetime of the covered person while covered under the Plan, before any other covered expenses can be considered for payment.

Coinsurance Payable

Type III	- Preventative and Diagnostic Services	Ded., then 80% of R&C
Type II	- Basic Restorative Services	Ded., then 80% of R&C
Type III	- Major Restorative Services	Ded., then 50% of R&C
Type IV	- Orthodontic Services*	Ded., then 50% of R&C

*Orthodontic treatment must begin (bands in place) before the dependent child reaches age nineteen (19).

The term "coinsurance" means the amount payable by the Plan for a covered expense. The covered person is required to pay the amount not paid by the Plan.

Maximum Paid

Type I, II and III Services	$ 1,200 per person, per calendar year
Type IV Services	$ 1,500 per person, per lifetime

Disclaimer - This comparison of coverages is intended only as a general description for the principle features of the benefit plans. Please refer to the evidence of coverage for details.

07/01/16

CEBT
PLAN B VISION SERVICE PLAN (VSP)
(EFFECTIVE JULY 1, 2016)

	12/12/24 UP TO	
MEMBER DOCTOR BENEFITS		
Exam Co-pay	$ 15.00	Once every 12 months
Material Co-pay	$ 15.00	Once every 12 months
Corrective Contact Lenses Allowance	$ 130.00	Once every 12 months
Frame Allowance (retail)	$ 130.00	Once every 24 months

When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again for 12 months.

NON-MEMBER DOCTOR BENEFITS	
Exam	$ 35.00
Single Lens	$ 25.00
Bifocal Lens	$ 40.00
Trifocal Lens	$ 55.00
Elective Contact Lenses	$ 120.00
Frame	$ 45.00

ASSUMPTIONS

1. An employee or dependent may only enroll or drop coverage during the next open enrollment period.

2. An employer must have at least 25% of the eligible employees enrolled in the plan in order to have the coverage offered.

ENROLLMENT RESTRICTIONS – If any employee or dependent drops coverage, he or she must wait at least 2 open enrollment periods to enroll or re-enroll.

This summary of benefits is a matter of information only. In all cases the plan document will determine the benefits. 07/01/2016

To find a VSP Doctor, go to www.vsp.com and put your zip code in the Find VSP Doctor search.

DELTA COUNTY SCHOOL DISTRICT 50J GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

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 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 Plan when they would otherwise lose their group health coverage. For additional 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.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as 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 must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- 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 any of the following qualifying events happens:

- 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 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. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, 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), the employer must notify the Plan Administrator of the qualifying event.
You Must Give Notice of Some Qualifying Events

For the 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 after the qualifying event occurs. You must provide this notice to: your employer.

How is COBRA 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. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.
Disability

If you or a dependent are disabled at the time of a qualifying event, an 18 month COBRA period may be extended by 11 months. The 18 month period may also be extended if you or a dependent become disabled during the first 60 days of COBRA. You must be disabled under the terms of Title II or Title XVI of the Social Security Act. The maximum period may extend to 29 months from the original event. You must provide notice to the plan administrator within 60 days after such determination of disability is made. This notice must also be prior to the end of the 18 month COBRA
period. If notice is not given within these times, you will not be eligible for the extended period. If it is determined that you are no longer disabled, you must notify the plan administrator within 30 days of that final determination. The right to this extended period applies to each individual.

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

If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan

as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

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 ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of 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

Willis Towers Watson
1-800-332-1168 or 303-773-1373
2000 South Colorado Boulevard
Tower II, Suite 900
Denver, CO 80222