2025 - 2026

Benefit Summary

Douglas Unified School District #27

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IMPORTANT: Douglas Unified School District #27 offers a fixed indemnity policy; this is NOT health insurance. If you are considering purchasing this policy, please read the notice on page 13 in its entirety.

If you 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 26-28 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.

Benefits Overview

Douglas Unified School District #27 is proud to offer a comprehensive benefits package to eligible, full-time employees who work 30 hours per week. The complete benefits package is briefly summarized in this booklet. You may request plan booklet, which give you more detailed information about each of these programs.

You share the costs of some benefits (medical), and Douglas Unified School District #27 provides other benefits at no cost to you (life, accidental death & dismemberment and EAP). In addition, there are voluntary benefits with reasonable group rates that you can purchase through payroll deductions.

Benefits Offered

- Medical
- Voluntary Dental
- Voluntary Vision
- Life Insurance
- Accidental Death & Dismemberment (AD&D) Insurance
- Voluntary Life
- Voluntary Short Term Disability
- Employee Assistance Program
- Voluntary Accident Insurance
- Voluntary Critical Illness Insurance
- Voluntary Hospitalization Insurance

Eligibility

You and your eligible dependents are eligible for Douglas Unified School District #27 benefits on the date of hire.

Eligible dependents are your spouse, domestic partner, children under age 26, disabled dependents of any age, or Douglas Unified School District #27 eligible dependents.

Elections made now will remain until the next open enrollment unless you or your family members experience a qualifying event. If you experience a qualifying event, you must contact HR within 30 days.

Making Changes to Your Benefits

Each year, you have the opportunity to make changes to your benefits during open enrollment. You may make mid-year changes to your benefits only if you have a qualifying life event. Examples of qualifying life events include:

- Marriage or divorce
- Birth or adoption of a child
- Change in a dependent's eligibility status
- Change in employment status for you or your dependents resulting in the loss/gain of coverage
- A significant change in the cost or coverage of your dependent's benefits
- Change in the cost of dependent care (for dependent care flexible spending accounts only)
- Death of a dependent

You have 30 days from the date of a qualifying life event to notify Human Resources to make any benefit adjustments.

Benefit Website

Medical Summary of Benefits and Coverage, Benefit Summaries, forms and carrier contact information may be found on the Douglas benefit website at https:/c2mb.ajg.com/dusd27.

Benefit Questions

If you have any questions regarding your benefits, please contact Human Resources.

Medical Benefits

Administered by Blue Cross Blue Shield of Arizona

Douglas Unified School District active employees have the choice of three medical plans from Blue Cross Blue Shield—the Class Silver PPO $500, Class Gold PPO $300, Copay Gold PPO $0. 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.

Review the following pages for the amount you will pay for the medical service listed. Also refer to the Benefit Website at **https://c2mb.ajg.com/dusd27** to view the Summary of Benefits and Coverage for medical plan information.

	PPO 500 (Classic Silver)		PPO 300 (Classic Gold)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Lifetime Benefit Maximum	Unlimited		Unlimited	
Annual Deductible	$500 single / $1,000 family	$1,400 single / $4,200 family	$300 single / $900 family	$1,200 single / $3,600 family
Annual Out-of-Pocket Maximum (includes deductible)	$4,500 single / $9,000 family	Unlimited	$4,000 single / $8,000 family	Unlimited
Coinsurance	20%	50%	15%	50%
Doctor's Office				
Primary Care Office Visit	$30 copay	50% after deductible & balance bill	$25 copay	50% after deductible & balance bill
Specialist Office Visit	$40 copay	50% after deductible & balance bill	$35 copay	50% after deductible & balance bill
Preventive Care (x-rays, immunizations)	Covered at 100%	50% after deductible & balance bill	Covered at 100%	50% after deductible & balance bill
Diagnostic Test (x-ray, blood work)	$30 copay / $40 copay or 20% after deductible	50% after deductible & balance bill may apply	$25 copay / $35 copay or 15% after deductible	50% after deductible & balance bill may apply
Imaging (CT/PET scans, MRIs)	$30 copay / $40 copay or 20% after deductible	50% after deductible & balance bill may apply	$25 copay / $35 copay or 15% after deductible	50% after deductible & balance bill may apply
Prescription Drugs				
Retail—Tier 1 Generic Drugs (30-day supply)	$10 copay	Not covered	$10 copay	Not covered
Retail—Tier 2 Preferred Brand Drugs (30-day supply)	20% ($25 copay to max $80 copay)	Not covered	20% ($25 copay to max $80 copay)	Not covered
Retail—Tier 3 Non-Preferred Brand Drugs (30-day supply)	40% ($40 copay to max $110 copay)	Not covered	40% ($40 copay to max $110 copay)	Not covered
Retail—Tier 4 Specialty Drugs (30-day supply)	20% ($100 copay to max $150 copay)	Not covered	20% ($100 copay to max $150 copay)	Not covered
Mail Order—Tier 1 Generic Drug (90-day supply)	$20 copay	Not covered	$20 copay	Not covered
Mail Order—Tier 2 Preferred Brand Drugs (90-day supply)	20% ($50 copay to max $160 copay)	Not covered	20% ($50 copay to max $160 copay)	Not covered
Mail Order—Tier 3 Non-Preferred Brand Drugs (90-day supply)	40% ($80 copay to max $220 copay)	Not covered	40% ($80 copay to max $220 copay)	Not covered

Medical Benefits (Continued)

Administered by Blue Cross Blue Shield of Arizona

	PPO 500 (Classic Silver)		PPO 300 (Classic Gold)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Hospital Services				
Emergency Room	20% after deductible	20% after deductible	15% after deductible	15% after deductible
Inpatient	$250 copay access fee and 20%	$300 copay access fee and 50% after deductible & balance bill	$250 copay access fee and 15%	$300 copay access fee and 50% after deductible & balance bill
Outpatient Surgery	20% after deductible	50% after deductible & balance bill	15% after deductible	50% after deductible & balance bill
Ambulance Service*	$200 copay access fee and/or 20% after deductible	$200 copay access fee and/or 20% after deductible	$200 copay access fee and/or 15% after deductible*	$200 copay access fee and/or 15% after deductible*
Mental Health Services				
Inpatient Services	$250 copay access fee and 20%	$300 copay access fee and 50% after deductible & balance bill may apply	$250 copay access fee and 15%	$300 copay access fee and 50% after deductible & balance bill may apply
Outpatient Services	Office visit copay; or 20%. copay amount varies based on PCP/Specialist.	50% after deductible & balance bill may apply	Office visit copay; or 15%. copay amount varies based on PCP/Specialist	50% after deductible & balance bill may apply
Substance Abuse Services				
Inpatient Services	$250 copay access fee and 20%	$300 copay access fee and 50% after deductible & balance bill may apply	$250 copay access fee and 15%	$300 copay access fee and 50% after deductible & balance bill may apply
Outpatient Services	Office visit copay; or 20%. copay amount varies based on PCP/Specialist	50% after deductible & balance bill may apply	Office visit copay; or 15%. copay amount varies based on PCP/Specialist	50% after deductible & balance bill may apply
Other Services				
Maternity Services	Office visit copay; or 20%	50% after deductible & balance bill	Office visit copay; or 15%	50% after deductible & balance bill
All other maternity hospital/ physician services	$250 copay access fee and 20%	$300 copay access fee and 50% after deductible & balance bill	$250 copay access fee and 15%	$300 copay access fee and 50% after deductible & balance bill
Muscle Manipulation Services	$30 copay	50% after deductible & balance bill	$25 copay	50% after deductible & balance bill
Physical, Occupational and Speech Therapy Services 60-day calendar year	EAR: $250 copay access fee and 20%; PT/OT/ST/CT/PR: $30 copay	EAR: $300 copay access fee and 50% after deductible & balance bill; PT/OT/ST/CT/PR: 50% after deductible & balance bill	EAR: $250 copay access fee and 15%; PT/OT/ST/CT/PR: $30 copay	EAR: $300 copay access fee and 50% after deductible & balance bill; PT/OT/ST/CT/PR: 50% after deductible & balance bill
Skilled Nursing 60-day calendar year maximum	$250 copay access fee and 20%	$300 copay access fee and 50% after deductible & balance bill	$250 copay access fee and 15%	$300 copay access fee and 50% after deductible & balance bill

*Access fee applies to air transportation

EAR = Extended Active Rehabilitation Facility

Medical Benefits (Continued)

Administered by Blue Cross Blue Shield of Arizona

	PPO 0 (Copay Gold)	
	In-Network	Out-of-Network
Lifetime Benefit Maximum	Unlimited	
Annual Deductible	$0 single / $0 family	$900 single / $2,700 family
Annual Out-of-Pocket Maximum (includes deductible)	$6,350 single / $12,700 family	Unlimited
Coinsurance	0%	50%
Doctor's Office		
Primary Care Office Visit	$30 copay	50% after deductible & balance bill
Specialist Office Visit	$40 copay	50% after deductible & balance bill
Preventive Care (x-rays, immunizations)	Covered at 100%	50% after deductible & balance bill
Diagnostic Test (x-ray, blood work)	$30 copay / $40 copay	50% after deductible & balance bill may apply
Imaging (CT/PET scans, MRIs)	$50 copay	50% after deductible & balance bill may apply
Prescription Drugs		
Retail—Tier 1 Generic Drugs (30-day supply)	$10 copay	Not covered
Retail—Tier 2 Preferred Brand Drugs (30-day supply)	20% ($25 copay to max $80 copay)	Not covered
Retail—Tier 3 Non-Preferred Brand Drugs (30-day supply)	40% ($40 copay to max $110 copay)	Not covered
Retail—Tier 4 Specialty Drugs (30-day supply)	20% ($100 copay to max $150 copay)	Not covered
Mail Order—Tier 1 Generic Drug (90-day supply)	$20 copay	Not covered
Mail Order—Tier 2 Preferred Brand Drugs (90-day supply)	20% ($50 copay to max $160 copay)	Not covered
Mail Order—Tier 3 Non-Preferred Brand Drugs (90-day supply)	40% ($80 copay to max $220 copay)	Not covered

Medical Benefits (Continued)

Administered by Blue Cross Blue Shield of Arizona

	PPO 0 (Copay Gold)	
	In-Network	Out-of-Network
Hospital Services		
Emergency Room	$150 copay (Copay waived If admitted)	$150 copay
Inpatient	$250 copay	$300 copay access fee and 50% after deductible & balance bill
Outpatient Surgery	$75 copay	50% after deductible & balance bill
Ambulance Service	Ground: $50 copay Air: $200 copay	Ground: $50 copay Air: $200 copay
Mental Health Services		
Inpatient Services	$250 copay	$300 copay access fee and 50% after deductible & balance bill may apply
Outpatient Services	Office visit copay or $75 copay. Office visit copay amount varies based on PCP/ Specialist	50% after deductible & balance bill may apply
Substance Abuse Services		
Inpatient Services	$250 copay	$300 copay access fee and 50% after deductible & balance bill may apply
Outpatient Services	Office visit copay or $75 copay. Office visit copay amount varies based on PCP/ Specialist	50% after deductible & balance bill may apply
Other Services		
Maternity Services	$30 copay / $40 copay	50% after deductible & balance bill
All other maternity hospital/ physician services	$250 copay	$300 copay access fee and 50% after deductible & balance bill
Muscle Manipulation Services	$30 copay	50% after deductible & balance bill
Physical, Occupational and Speech Therapy Services 60-day calendar year	EAR: $250 copay ; PT/OT/ST/CT/PR: $30 copay	EAR: $300 copay access fee and 50% after deductible & balance bill; PT/OT/ST/CT/PR: 50% after deductible & balance bill
Skilled Nursing 60-day calendar year maximum	$250 copay	$300 copay access fee and 50% after deductible & balance bill

*Access fee applies to air transportation

EAR = Extended Active Rehabilitation Facility

Generic Drugs

Generic drugs are FDA-approved, and shown to be just as safe and effective as their more expensive brand-name counterparts. Your plan requires mandatory generic drugs. If you choose a brand-name drug when a generic drug is available, you will pay the brand-name copay plus the cost difference between the generic equivalent and the brand-name drug.

Preferred Drugs

Blue Cross Blue Shield regularly reviews the latest prescription drugs on the market and maintains a list of preferred drugs that are clinically effective and not cost-restrictive. These drugs are available at a lower price than those not included on the list, which are called non-preferred drugs.

Specialty Drugs

Specialty drugs are typically used to treat chronic conditions like cancer or multiple sclerosis. These drugs tend to be more expensive and usually require special handling and monitoring. If you take a specialty medication, you could save money by using ASBAIT's mail-order pharmacy. You can register for mail-order pharmacy by logging on to **www.azblue.com**.

Terms to Know

- **Copay** - A set dollar amount you pay for a covered health care service, usually when you receive the service.
- **Deductible** - What you pay out of pocket for health care services before the plan begins to pay a portion.
- **Coinsurance** - Your share of the costs of covered health care services after you reach the deductible. You pay the percentage noted in the medical table on pages 3-7, and the medical plan pays the rest.
- **Out-of-pocket Maximum** - What you have to pay before the plan pays 100% of your covered costs.
- **Network** - The facilities and providers the medical plan has contracted with to provide health care services. In-network providers typically provide services at a lower negotiated rate.

Finding In-network Providers

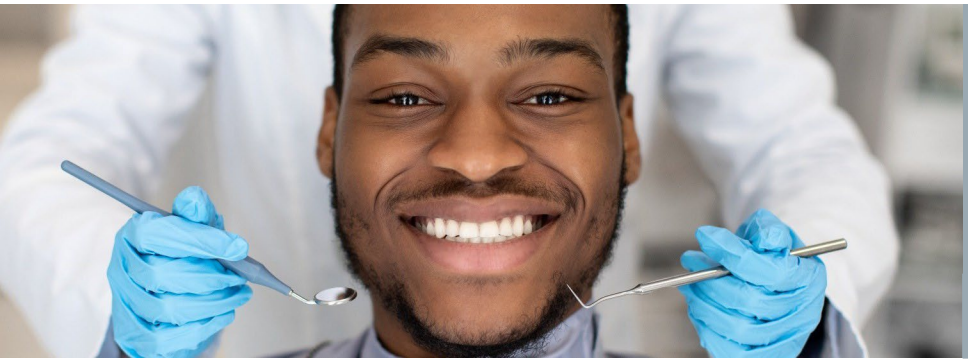
You save the most money when you choose in-network doctors, facilities and pharmacies. Log on to **www.azblue.com** **or** call **844.422.2729** to find providers in the Blue Cross Blue Shield network.

Voluntary Dental Benefits

Administered by Guardian

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 Douglas Unified School District #27 dental benefit plan.

Services	In-Network and Out-of-Network Value Plan (VZ - 10)
Annual Deductible	$50 per person; $150 family limit
Annual Benefit Maximum	$2,000
Preventive Dental Services (exams, cleanings, and fluoride, sealants, radiographs– x-rays)	100% covered, deductible waived
Basic Dental Services (space maintainers, emergency palliative treatment, minor restorative services– fillings, endodontic services– root canals, periodontic services, simple extractions, other basic services– misc. services)	80% after deductible
Major Dental Services (other oral surgery, crowns repairs– surgical extractions and other oral surgery, major restorative services– crowns, anesthesia services, relines and repairs - to bridges and dentures, prosthodontic services - bridges and dentures)	50% after deductible
Orthodontia Services (covered to age 19)	50% to $1,000 lifetime maximum



Finding In-network Dentists

You pay less for services when you use a dentist in the Guardian Insurance network. You can find an in-network dentist by visiting **www.guardianlife.com** or calling **888.600.1600**.

Maximum rollover
If claims made for a certain year don't reach a specified threshold, them the set maximum rollover amount can be rolled over. Please visit the employee website listed below for additional information

Voluntary Vision Benefits

Administered by MetLife

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.

Your MetLife Vision coverage utilizes the VSP Choice Doctor network

Service	In-Network (any VSP Choice provider)	Out-of-Network (any qualified non-network provider of your choice)
Eye Exam — once every 12 months	$10 copay	Up to $45
Lenses — once every 12 months		
Single Vision Lenses	$20 copay	Up to $30
Lined Bifocal Lenses	$20 copay	Up to $50
Lined Trifocal Lenses	$20 copay	Up to $65
Frames — once every 24 months	Frame: $20 copay, then $200 allowance plus 20% off remaining balance; Featured Frame: $220 allowance plus 20% off	Up to $70
Contact Lenses — once every 12 months if you elect contacts instead of lenses/frames		
Elective	$200 allowance	Up to $105
Medically Necessary	$20 copay then covered in full	Up to $210
Separate fitting allowance	$60 allowance	N/A

Not everyone's personal situation is the same; your family needs may be different from the needs of your coworkers.

In recognition of these differences, we offer voluntary benefits, which you can purchase at group rates.

Finding In-network Eye Doctors

You can find an in-network eye doctor in the MetLife network by visiting **www.metlife.com/mybenefits** or call member services at 855.638.3931.

Life and AD&D Insurance

Administered by Minnesota Life Insurance Company

Douglas Unified School District #27 provides basic life and accidental death and dismemberment (AD&D) insurance through Minnesota Life Insurance Company at no cost to eligible employees. If you want additional coverage for yourself, your spouse, or your children, you can purchase voluntary coverage at our group rates.

	How it Works	Basic Life and AD&D (Company-paid benefit)	Voluntary Life (Employee-paid benefit)
Life	Your beneficiaries receive this benefit if you pass away	1x Annual Earnings to max $150,000	**You:** Increments of $10,000 up to $500,000 (Guarantee Issue Amount $250,000) **Your spouse:** Increments of $5,000 up to $250,000 (not to exceed 100% of EE's amount with Guarantee Issue Amount of $50,000) **Your child(ren):** Live birth to age 26: Options of $5,000, $10,000 or $15,000 (not to exceed 100% of EE's amount)
AD&D	You (or your beneficiaries) receive this benefit if you pass away or are seriously injured in an accident	1x Annual Earnings to max $150,000	N/A

If you request an amount above GI or requires an EOI, you must complete and submit the EOI form to the address on the form. Deductions will not be taken for your life insurance policy until you are approved by Minnesota Life. Your policy is not effective until your policy is approved and receipt of first premium.

Keep Your Beneficiaries Up to Date

You must log on to **ochs@ochsinc.com** to designate a beneficiary (the person who will receive the benefit) for your life and AD&D insurance. Make sure to keep this person's information updated so your benefit is paid according to your wishes.

Disability Insurance

Administered by Hartford Life Insurance Company

Douglas Unified School District #27 also provides disability insurance through Hartford Life Insurance Company. This benefit replaces a portion of your income if you become disabled and are unable to work.

	How it Works	Who Pays for the Benefit
Voluntary Short-term Disability	You receive 60% of your income up to $2,000 per week. Benefits begin after 7 calendar days of absence from work and continue for up to 13 weeks.	Employee

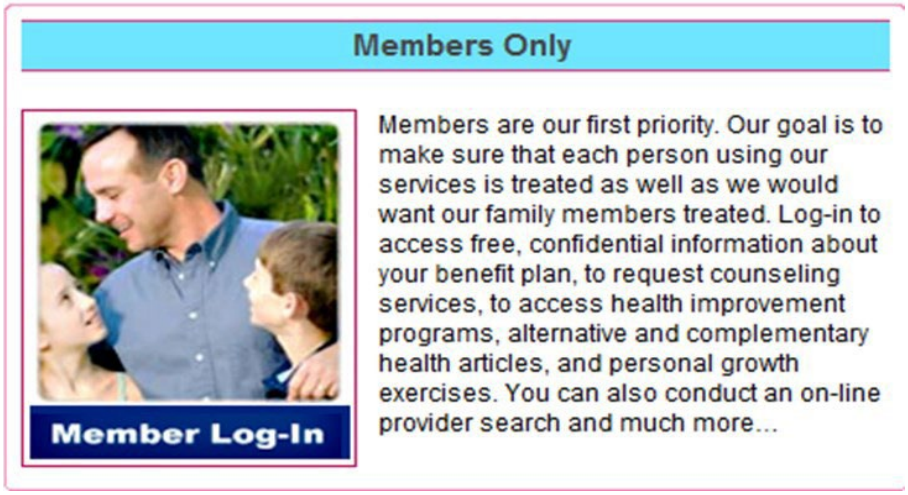
Employee Assistance Program

Administered by Jorgensen Brooks

Key Elements of the EAP

- **Confidentiality – 100% CONFIDENTIAL**
- **Voluntary Participation**
- **Nationwide 800 Number**
- **Crisis Hotline & Intervention**
- **Who is eligible to use this benefit: Employees and their household members, including adult children living in the household until age 26.**

- **SERVICES AVAILABLE**
  - Legal and Financial Counseling
  - LifeSolutions
  - WellnessConnect
  - Identity Theft
  - Crisis Hotline and Intervention
  - Weekly Webinars
  - Monthly Newsletters
  - ScriptSave Discount Card
  - TicketsatWork Discounts



Member Portal

Mobile Application is available
visits the website listed below for additional information

Internet Access – Member Web Portal

www.jorgensenbrook.com

User Name: DUSD

Up to Five (5) Free Face-to-Face Sessions

Per Household Member, Per Incident, Per Year with Licensed Clinician

Call: 8888.520.5400

to schedule appointment (hours 8:00am – 4:30pm PST)

Fixed Indemnity Notice

IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal Consumer Protections that apply to health insurance.

Looking for comprehensive health insurance?

- **Visit HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website **(naic.org)** under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

Worksite Benefits

Administered by Hartford

Douglas Unified School District provides employees an opportunity to purchase voluntary Accident, Hospital Indemnity and Critical Illness policies for themselves, spouse and children through payroll deduction. Details on all these benefits may be found on the benefit website.

Accident Insurance

Accident insurance pays you in the event you are injured as a result of a covered accident. Benefits include payments for the following due to an injury or accident: Hospital Admission, Emergency Treatment, Medical Appliances, Therapy, etc.

Hospital Indemnity

If you have a covered accident or illness that requires hospitalization, Hartford Group Hospital Indemnity Insurance may be right for you. Benefits include payments for Hospital Confinement, Hospital Admission, Hospital Intensive Care and Step-Down unit.

Critical Illness

If you are diagnosed with a covered critical illness, Hartford Group Critical Illness Insurance may be right for you. Sample Benefits include Cancer, Heart Attack (Myocardial Infarction), Stroke, Major Organ Failure, End Stage Kidney Disease and Coronary Artery Bypass Surgery

Employee Contributions for Benefits—21 pay

Benefit Plan	Per Pay Period
Medical/Rx PPO $500 (Classic Silver)	
Employee	$35.45
Employee + One	$357.98
Employee + Child(ren)	$283.55
Family	$560.01
Dual-Employee & Family	$241.02
Medical/Rx PPO 300 (Classic Gold)	
Employee	$61.17
Employee + One	$407.10
Employee + Child(ren)	$327.27
Family	$623.79
Dual-Employee & Family	$304.81
Medical/Rx PPO 0 (Copay Gold)	
Employee	$98.46
Employee + One	$478.35
Employee + Child(ren)	$390.69
Family	$716.30
Dual-Employee & Family	$397.31

Benefit Plan	Per Pay Period
Voluntary Dental Rates	
Employee	$0
Employee + One	$12.95
Employee + Child(ren)	$9.69
Family	$21.66
Dual-Employee & Family	$13.91
Voluntary Vision Rates	
Employee	$2.90
Employee + One	$5.82
Employee + Child(ren)	$6.21
Family	$9.93

Employee Contributions for Benefits—26 pay periods

Benefit Plan	Per Pay Period
Medical/Rx PPO $500 (Classic Silver)	
Employee	$28.63
Employee + One	$287.14
Employee + Child(ren)	$229.02
Family	$452.31
Dual-Employee & Family	$194.67
Medical/Rx PPO 300 (Classic Gold)	
Employee	$49.40
Employee + One	$328.81
Employee + Child(ren)	$264.34
Family	$503.83
Dual-Employee & Family	$249.19
Medical/Rx PPO 0 (Copay Gold)	
Employee	$79.53
Employee + One	$386.36
Employee + Child(ren)	$315.55
Family	$578.55
Dual-Employee & Family	$320.90

Benefit Plan	Per Pay Period
Voluntary Dental Rates	
Employee	$0
Employee + One	$10.46
Employee + Child(ren)	$7.82
Family	$17.49
Dual-Employee & Family	$11.24
Voluntary Vision Rates	
Employee	$2.34
Employee + One	$4.70
Employee + Child(ren)	$5.01
Family	$8.02

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	Blue Cross Blue Shield of Arizona	855.818.0237	www.azblue.com
Voluntary Dental	Guardian	888.600.1600	www.guardianlife.com
Voluntary Vision	MetLife	855.638.3931	www.MetLife.com/mybenefits
Life and AD&D	Minnesota Life Insurance Company	800.392.7295	www.ochsinc.com
Voluntary Life	Minnesota Life Insurance Company	800.392.7295	www.ochsinc.com
Voluntary Short Term Disability	Hartford	877.426.6483	www.thehartford.com
Employee Assistance Program	Jorgensen Brooks	800.321.2843	www.holmangroup.com
Benefits Specialist	Nidia Del Rio	520.364.2447	ndelrio@douglasschools.org

Legal Notices

Patient Protections Disclosure

The Douglas Unified School District #27 Health Plan generally allows 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, Blue Cross Blue Shield of Arizona 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 Blue Cross Blue Shield of Arizona at 855.818.0237 at www.azblue.com.

For children, you may designate a pediatrician as the primary care provider.
You do not need prior authorization from Blue Cross Blue Shield of Arizona 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 Blue Cross Blue Shield of Arizona at 855.818.0237 at www.azblue.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 500 (Classic Silver) (Individual: 20% coinsurance and $500 deductible; Family: 20% coinsurance and $1,000 deductible) Plan 2: PPO 300 (Classic Gold) (Individual: 15% coinsurance and $300 deductible; Family: 15% coinsurance and $900 deductible) Plan 3: PPO 0 (Copay Gold) (Individual: 0% coinsurance and $0 deductible; Family: 0% coinsurance and $0 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 520.364.2447 or ndelrio@douglasschools.org.

Legal Notices

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).

The Genetic Information Nondiscrimination Act Of 2008 (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to any requests for medical information, if applicable. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

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

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

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

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

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

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

ALABAMA – Medicaid	**ALASKA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	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. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html 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	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

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

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

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)

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights

Douglas Unified School District #27 is committed to the privacy of your health information. The administrators of the Douglas Unified School District #27 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 Nidia Del Rio - Benefits Specialist at 520.364.2447 or ndelrio@douglasschools.org.

HIPAA Special Enrollment Rights

Douglas Unified School District #27 Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Douglas Unified School District #27 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 Nidia Del Rio - Benefits Specialist at 520.364.2447 or ndelrio@douglasschools.org.

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.

Notice of Creditable Coverage

Important Notice from Douglas Unified School District #27
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 Douglas Unified School District #27 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. **Douglas Unified School District #27 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?

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individual's can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15th through December 7th. Beneficiary's leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in a Medicare prescription drug plan and drop your group health plan prescription drug 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 Douglas Unified School District #27 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 Douglas Unified School District #27 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 maintainedcreditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	**July 01, 2025**
Name of Entity/Sender:	**Douglas Unified School District #27**
Contact—Position/Office:	**Nidia Del Rio - Benefits Specialist**
Office Address:	**1132 E 12th St** **Douglas, Arizona 85607-2337** **United States**
Phone Number:	**520.364.2447**

COBRA General Notice

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 must 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."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Douglas Unified School District #27, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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;
- 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 after the qualifying event occurs. You must provide this notice to: Nidia Del Rio.

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[1] 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.

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start

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

Douglas Unified School District #27
Nidia Del Rio - Benefits Specialist
1132 E 12th St
Douglas, Arizona 85607-2337
United States
520.364.2447

Marketplace Notice

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income. [1] [2]

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment- based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Nidia Del Rio.

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 Douglas Unified School District #27		4. Employer Identification Number (EIN) 86-0718412
5. Employer address 1132 E 12th St		6. Employer phone number 520.364.2447
7. City Douglas	8. State Arizona	9. ZIP code 85607-2337
10. Who can we contact about employee health coverage at this job? Nidia Del Rio		
11. Phone number (if different from above)	12. Email address ndelrio@douglasschools.org	

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

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

  X All employees. Eligible employees are:

  ☐ Some employees. Eligible employees are:

- With respect to dependents:

  X We do offer coverage. Eligible dependents are:

  ☐ 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.

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** (STOP and return this form to employee)

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

X 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

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)

WELLNESS PROGRAM DISCLOSURES

NOTICE REGARDING WELLNESS PROGRAM

The **Douglas Unified School District #27** wellness program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program by obtaining a preventative care screening for those enrolled in the Hartford Voluntary Accident and Hospital Indemnity policy You may also be asked to complete a biometric screening, which will include a blood test for total cholesterol, HDL cholesterol, TC/HDL ratio, LDL cholesterol, Glucose, Triglycerides as well as measurement of blood pressure, height and weight, body mass index and waist measurement. You are not required to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of a preventative care reimbursement. Although you are not required to participate in the preventative care screening, only employees who do so will receive$75 for the Accident and $50 for Hospital Indemnity upon submission of a claim to Hartford.

The information from your preventative care screening will be used to provide you with information to help you understand your current health and potential risks. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Douglas Unified School District 27 may use aggregate information it collects to design a program based on identified health risks in the workplace, Douglas wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the

same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) a doctor as directed by you

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

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

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Nidia Del Rio at ndelrio@douglasschools.org 520-364-2447 X7020.

Notes

This benefit summary prepared by

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Insurance | Risk Management | Consulting

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.