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MESA COUNTY

2025 BENEFITS GUIDE


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Table Of Contents

This Benefits Guide is an overview of the benefits provided by Mesa County Government. It is not a Summary Plan Description or Certificate of Insurance. If a question arises about the nature and extent of your benefits under the plans and policies, or if there is a conflict between the informal language of this Benefits Guide and the contracts, the Summary Plan Description and Certificates of Insurance will govern. Please note that the benefits in your Benefits Guide are subject to change at any time. The Benefits Guide does not represent a contractual obligation on the part of Mesa County Government.

Enrollment Guidelines

Welcome to the 2025 Benefits Guide for Mesa County Government. This Guide provides a quick overview of the benefits program and helps to remove confusion that sometimes surrounds Employee benefits. The benefits program was structured to provide comprehensive coverage for you and your family. Benefit programs provide a financial safety net in the event of unexpected and potentially catastrophic events.

Eligibility

You are eligible to enroll in the medical benefits program if you are a full-time employee working 30 or more hours per week; a part-time employee working 20 or more hours per week; a temporary, non-seasonal employee working at least 30 hours per week; an individual elected to the office of the 21st Judicial Attorney; or an individual who is a 21st Judicial Attorney elected official. Medical, Dental, Vision, FSA, Basic Life/AD&D and LTD benefits for newly hired employees will take effect the first day of the month following 30 days of qualified employment. Voluntary Life is effective the first of the month following 30 days of application if dated prior to that date. Otherwise, it's the first of the month following the date of signature (if signed within 30 days of eligibility).

Your legal spouse and your married or unmarried dependent children are eligible for medical coverage if less than 26 years of age. Your unmarried dependent children are eligible for dental and/or vision benefits if less than 26 years of age. Disabled unmarried children over age 26 may be eligible to continue benefits after approval of necessary applications.

For Dental, Vision, Life, Supplemental Life and Disability coverages; Actively at Work Provisions apply, including dependent non-confinement.

Open Enrollment

Open enrollment for health, dental and vision is once a year and benefit elections will take effect January 1st Participants may add or drop coverage or make changes to their coverage at this time. Late entrants (employees or dependents who apply for coverage more than 30 days after the date of individual eligibility) are also provided an opportunity to enroll for coverage during the plan's open enrollment. The elections you make stay in effect the entire plan year, unless a qualifying life event occurs.

Qualifying Life Events

Generally, you can only change your benefit elections during the annual Open Enrollment period. However, you may make changes during the plan year if you have a qualifying event.

Qualifying events include:

- Marriage
- Divorce
- Birth
- Adoption
- Death
- Loss of Coverage

When you have a qualifying event, you have 30 days after the event to complete and return a new enrollment/change form for health, dental, and/or vision coverage. You may be asked to provide proof of the change and/or proof of eligibility. (You have 60 days to complete and return a new enrollment/change form after coverage under Medicaid or CHIP terminates.)

Available Benefits

- Medical/Clinic
- Flexible Spending Account (FSA)
- Dental
- Vision
- 401(a) Defined Contribution
- 457(b) Deferred Compensation
- Basic Life/Accidental Death & Dismemberment
- Supplemental Life Insurance
- Basic Voluntary Dependent Life Insurance
- Long-Term Disability (LTD)
- Accident/Critical Illness/Hospital Indemnity/Legal/Identity Theft
- Sick Leave
- Vacation
- Employee Assistance Program (EAP)
- Social Security (FICA

Benefit Contacts

Primary Point Of Contact

UMR	**Medical Plan**	**(800) 826-9781** **www.umr.com**

Other Contacts

Prime Therapeutics Management	Prescription Benefit Manager	(800) 424-6817 www.primetherapeutics.com
Delta Dental	Dental Group #12141	(800) 610-0201 www.customer_service@ddpco.com
VSP	Vision	(800) 877-7195 www.vsp.com
Rocky Mountain Reserve	Flexible Spending Account	(888) 722-1223 www.rockymountainreserve.com
UNUM	Life/AD&D Insurance, Voluntary Life & Long-Term Disability	(800) 421-0344 www.unum.com
Teladoc	Video Doctor Consultation	(800) Teladoc (835-2362) www.Teladoc.com/mobile
Mesa County Government	Nina Atencio HR Director Shelley Vehik Benefits Manager	(970) 255-7145 nina.atencio@mesacounty.us (970) 244-1847 shelley.vehik@mesacounty.us
Novo Benefits	Sharon Bacon Manager, Client Experience Coordinator Team	(402) 802-9089 sbacon@novoconnection.com
Novo Benefits	Tre' Bradley Sales and Client Experience Executive	(970) 773-9145 tbradley@novoconnection.com

Glossary Of Terms

The following terms will help you better understand your benefits.

Co-pay: A Copay is the portion of the Covered Expense that is your responsibility, as shown in the Medical Schedule of Benefits. A Copay is applied for each occurrence of such covered medical service and is not applied toward satisfaction of the Deductible.

Deductible: A Deductible is the total amount of eligible expenses as shown in the Medical Schedule of Benefits, which must be Incurred by you during any Calendar Year before Covered Expenses are payable under the Plan.

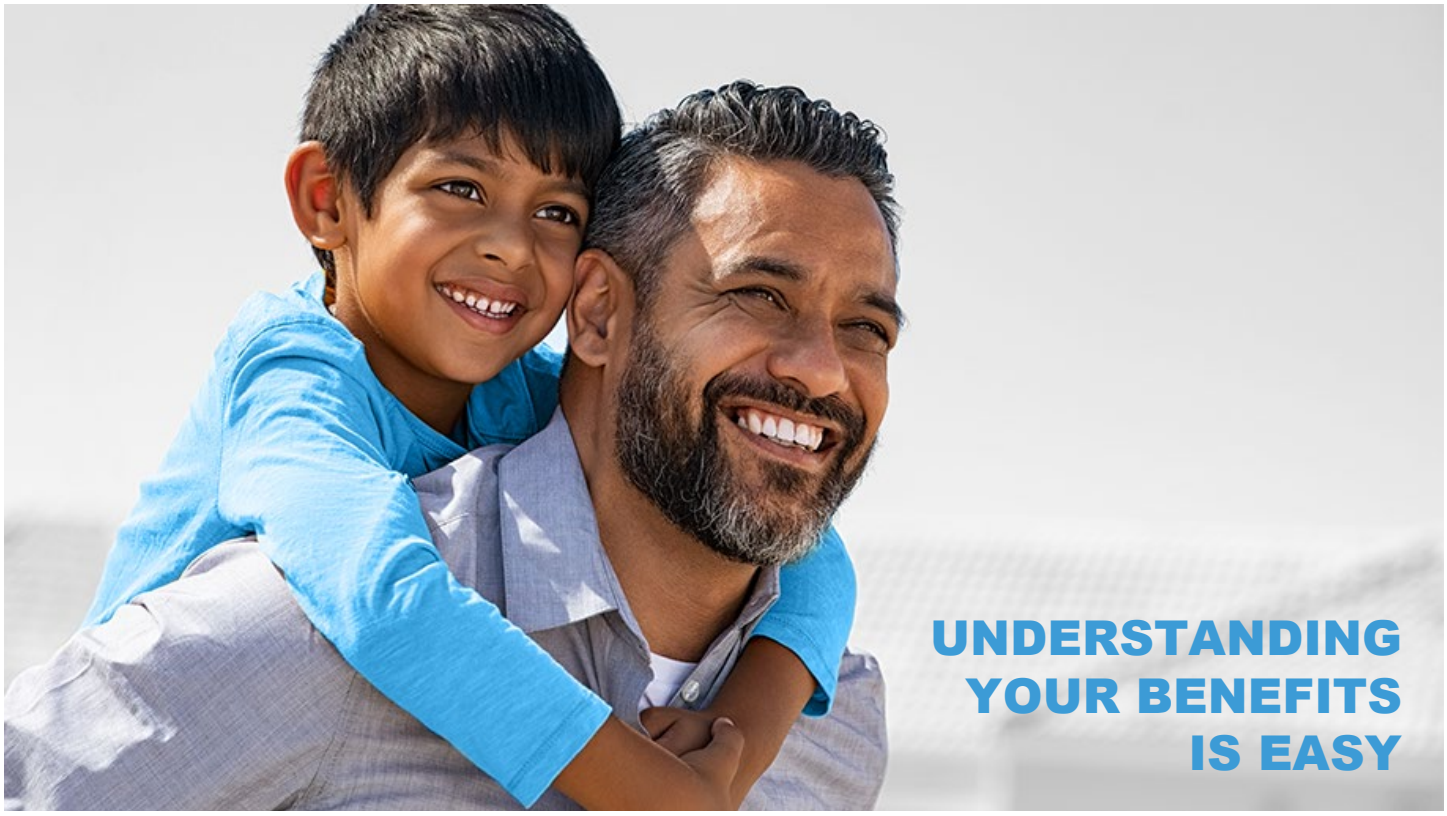
Coinsurance: Coinsurance is the percentage of eligible expenses the Plan and the Covered Person are required to pay.

Out-of-Pocket Maximum (OOPM): An Out-of-Pocket Maximum is the maximum amount you and/or all of your family members will pay for eligible expenses Incurred during a Calendar Year before the percentage payable under the Plan increases to 100%.

PPO (Preferred Provider Organization): This type of plan utilizes network and non-network benefits.

In-Network: The Plan offers a broad network of providers and provides the highest level of benefits when Covered Persons utilize “in-network” providers. These networks will be indicated on your Plan identification card.

Out-of-Network: Any non-contracted providers. The services from these providers are subject to balance billing, meaning members can be billed for the difference between the insurance carrier's fee schedule and the billed charges.



Premiums

Employee Contributions
Effective January 1, 2025

PPO Medical Plan	Premium Paid By Employee
	Monthly
Single	$42.00
Employee + Spouse	$371.00
Employee + Child(ren)	$244.00
Family	$404.00

Delta Plan - Humana	Premium Paid By Employee
	Monthly
Single	$27.00
Employee + Spouse	$62.00
Employee + Child(ren)	$55.00
Family	$92.00

VSP Vision Plan	Premium Paid By Employee
	Monthly
Single	$9.57
Employee + 1	$16.99
Family	$27.40

Medical Benefits

Mesa County Government offers medical benefits through UMR. This medical plan balances affordability with the freedom to go outside the network. You may choose a participating or a non-participating provider. Participating providers have agreed to provide services at a discounted fee. For out-of-network care, you are responsible for charges above the out-of-network allowance for services, in addition to the deductible and coinsurance. To find a participating provider, visit www.umr.com.

Benefit	PPO Plan	
	In-network	Out-of-network
Deductible	$1,250/single $2,500/family	$5,000/single $10,000/family
Out-of-Pocket Max (Includes deductible and copays)	$5,000/single $10,000/family	Unlimited Unlimited
Preventive Care	0% (Deductible Waived)	Not Covered
Office Visit (PCP)	$10 copay; all other services 20% coinsurance after deductible	$60 copay; all other services 50% coinsurance after deductible
Teladoc (Telemedicine) General Medicine Behavioral Health Dermatology	 $0 copay $0 copay $10 copay	 N/A N/A N/A
Specialist Office Visit	$45 copay; all other services 20% coinsurance after deductible	$60 copay; all other services 50% coinsurance after deductible
Chiropractic Services	$40 copay; all other services 20% coinsurance after deductible	Not Covered
Diagnostic Lab/X-ray	Laboratory: $15 copay X-Ray: $30 copay	50% After Deductible 50% After Deductible
Imaging (CT/PET scans: MRI's)	20% After Deductible	50% After Deductible
Inpatient Hospital	20% After Deductible	50% After Deductible
Outpatient Hospital	20% After Deductible	50% After Deductible
Maternity Prenatal Delivery and All Inpatient Services	 0% (Deductible Waived) 20% After Deductible	 50% After Deductible 50% After Deductible
Family deductible and out-of-pocket amounts are embedded. This means an individual would not pay more than the individual deductible/out-of-pocket amounts.		

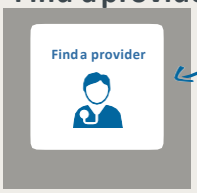
Medical Benefits (Continued)

Benefit	PPO Plan	
	In-network	Out-of-network
Mental Health/Substance Abuse Office	$10 copay	$60 copay; all other services 50% coinsurance after deductible
Mental Health/Substance Abuse Inpatient/Outpatient	20% After Deductible	50% After Deductible
Emergency Room	$150 Copay, All Other Services 20% After Deductible	
Emergency Transport/Ambulance	20% After Deductible	
Urgent Care	$30 copay; all other services 20% coinsurance after deductible	50% After Deductible
Prescriptions – through Prime Therapeutics Retail – 30-day supply Generic Preferred Non-Preferred Specialty	Separate Prescription Deductible $150 $20 copay or 20%, AD $45 copay or 30%, AD $60 copay or 40%, AD 25% up to $150, AD	 Not covered Not covered Not covered Not covered
Mail Order – 90-day supply Generic Preferred Non-Preferred Specialty	 $60 copay, or 20%, AD $135 copay or 30%, AD $180 copay or 40%, AD N/A	 Not covered Not covered Not covered Not covered
What you pay and what the plan pays The above Summary of Benefits shows how much you pay for care, and how much the plan pays. It's a brief listing of what is included in your benefits plan. For more detailed information, see your summary plan description.		
Pre-Certification Requirement:	Some services may require Pre-Certification. Please see Summary Plan Description document for more details.	
***The Steadman Clinics are Out-of-Network.**		

Find a provider

Finding a network provider on umr.com has never been easier

1 Go to **umr.com** and select **"Find a provider"**



2 Search for **UnitedHealthcare Choice Plus Network** using our alphabet navigation or type **UnitedHealthcare Choice Plus** into the search box

Find a provider on-the-go using our umr.com mobile site

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3 For medical providers, choose **View Providers.** For behavioral health providers (including counseling and substance abuse), select **Behavioral health directory**.

UnitedHealthcare Choice Plus:

The UnitedHealthcare online provider directories include network hospitals, primary physicians and specialists. The following information is available:

- Provider name, address and phone number
- Hospital affiliation
- Board certification
- UnitedHealth Premium® Quality &Cost Efficiency designations that highlight physicians by quality of care and cost standards in their specialty
- Average costs for care in your area and how different providers compare to the local average
- Provider ID number
- Office language capabilities (English, Spanish, etc.)
- Map and directions to each office

UMR CARE

The next time CARE clinical calls, it could save your life.

UMR CARE has a staff of experienced registered nurses and other clinicians who help you get the most out of your health plan benefits. They work with you, your doctors and other medical advisors to get the services that best meet your needs.

Our expert clinical CARE staff can guide you before, during and after your medical care. They will listen to your concerns, answer questions and explain your options. You will also receive automatic reminders about recommended medical appointments, vaccinations and more to help you stay on top of your health.

Clinical advocacy relationships to empower (CARE)

Our nurses meet you where you are and empower you on your health care journey.

Here for you in times of crisis

If you or a family member experience a serious injury or long-term illness, we have UMR CARE nurses to help at no cost to you.

They will assist you with your medical care and treatment decisions by:

- Serving as your health care advocate
- Reviewing treatment needs and options under the direction of your doctor
- Supporting you and your family holistically, providing assistance for medical and behavioral health needs
- Guiding you and your family through the complex health care system, providing help every step of the way
- Helping you better understand your health benefits

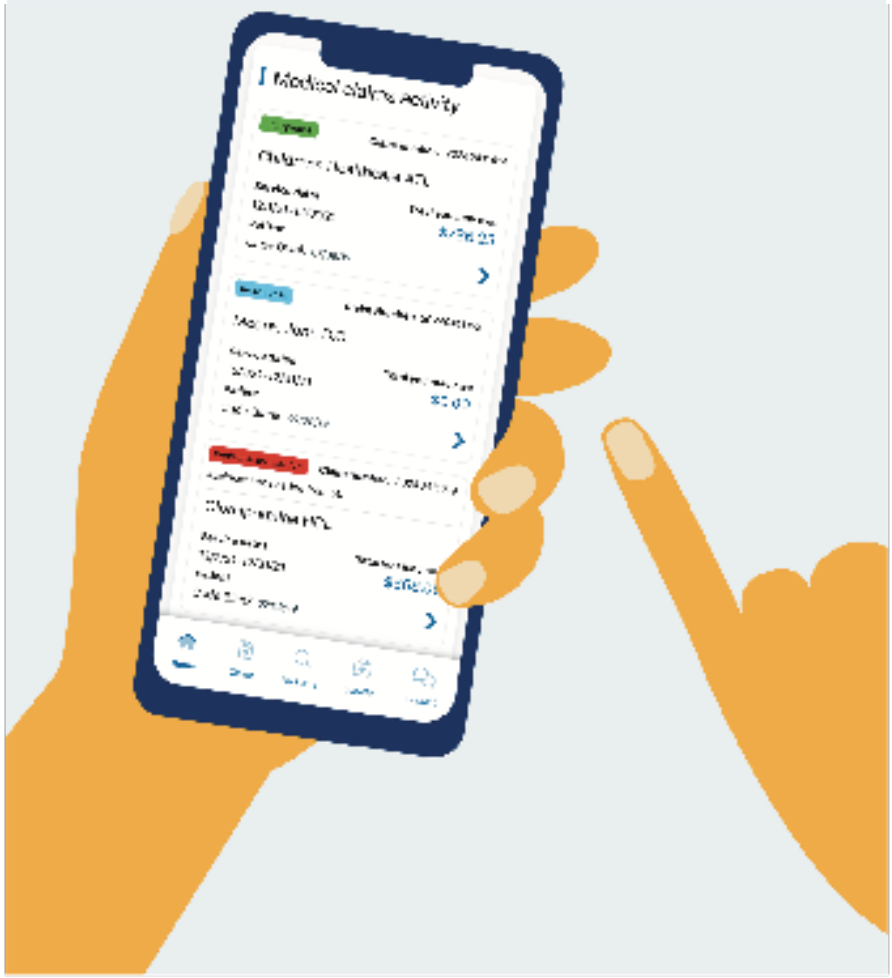
CARE
A UMR Solution

Welcome to a

smarter, simpler, faster

way to manage your health care benefits, right from the palm of your hand.

UMR on the go!



The UMR app has a smart fresh look, simple navigation, and faster access to your health care benefits information. View your plan details on demand—anytime, anywhere.

With a single tap, you can:

- Access your digital ID card
- See a personalized list of **Things to do** to stay on top of your health and keep your benefits up to date.
- Look up in-network health care providers
- Find out if there's a copay for your upcoming appointment
- View your recent medical and dental claims
- Chat, call or message UMR's member support team

Download the UMR app today!

Simply scan the QR code or visit your app store to get started.

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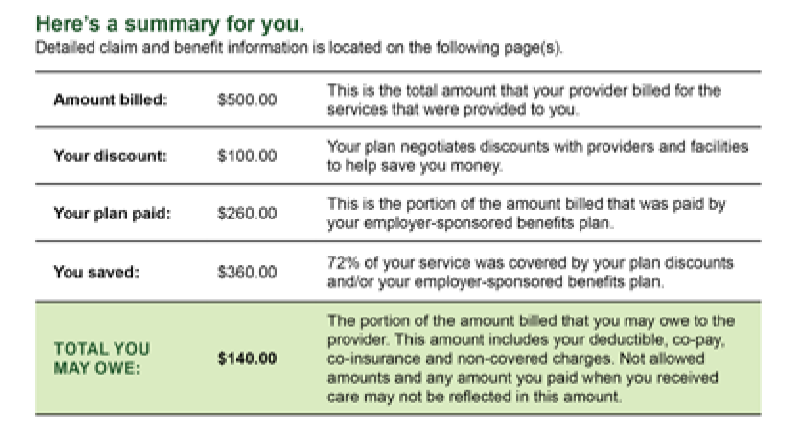
Understanding your EOB, as easy as 1-2-3

An explanation of benefits (EOB) is not a bill. It simply tells you everything you might want to know about how your recent medical service was covered by your benefits plan. You'll receive a bill from your provider for any amount you may owe.

1 Cost summary

The first page of your EOB is a summary of how much your provider billed, how much was covered by your plan and the total you may owe to your provider.



Here's a summary for you.
Detailed claim and benefit information is located on the following page(s).

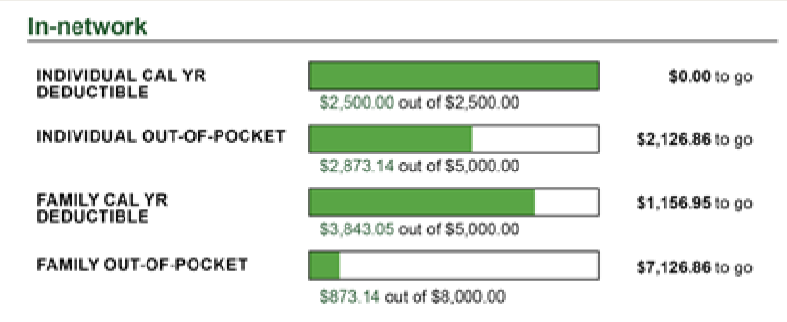
Amount billed:	$500.00	This is the total amount that your provider billed for the services that were provided to you.
Your discount:	$100.00	Your plan negotiates discounts with providers and facilities to help save you money.
Your plan paid:	$260.00	This is the portion of the amount billed that was paid by your employer-sponsored benefits plan.
You saved:	$360.00	72% of your service was covered by your plan discounts and/or your employer-sponsored benefits plan.
TOTAL YOU MAY OWE:	**$140.00**	The portion of the amount billed that you may owe to the provider. This amount includes your deductible, co-pay, co-insurance and non-covered charges. Not allowed amounts and any amount you paid when you received care may not be reflected in this amount.

2 Benefits update

On the next page, you'll find a breakdown of how much you and/or your family have applied toward your annual deductibles and out-of-pocket amounts.

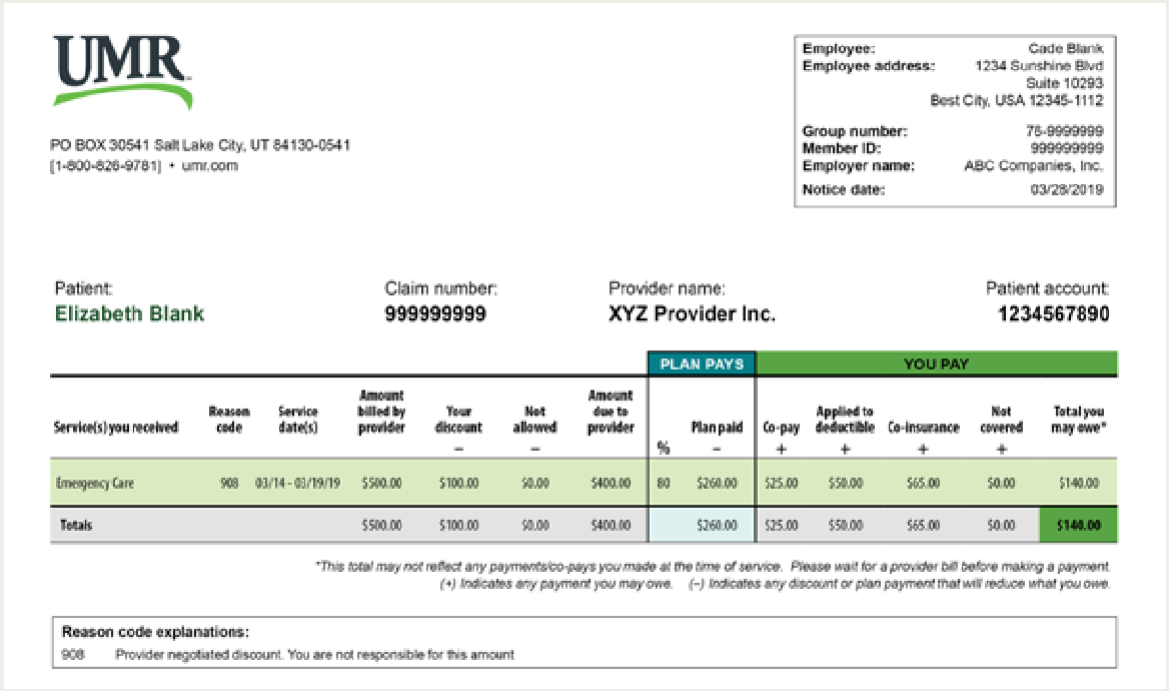
Deductible: *The amount you have to pay before your plan pays for specified services. Deductibles are usually an annual set amount.*

Out-of-pocket: *The most you could pay during a coverage period (usually one year) for your share of the costs of covered services. After you reach your "to go" amount, the plan will usually pay 100% of the allowed amount.*



In-network

INDIVIDUAL CAL YR DEDUCTIBLE	$2,500.00 out of $2,500.00	**$0.00** to go
INDIVIDUAL OUT-OF-POCKET	$2,873.14 out of $5,000.00	**$2,126.86** to go
FAMILY CAL YR DEDUCTIBLE	$3,843.05 out of $5,000.00	**$1,156.95** to go
FAMILY OUT-OF-POCKET	$873.14 out of $8,000.00	**$7,126.86** to go



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PO BOX 30541 Salt Lake City, UT 84130-0541
[1-800-826-9781] • umr.com

Employee:	Cade Blank
Employee address:	1234 Sunshine Blvd Suite 10293 Best City, USA 12345-1112
Group number:	75-9999999
Member ID:	999999999
Employer name:	ABC Companies, Inc.
Notice date:	03/28/2019

Patient: **Elizabeth Blank**
Claim number: **999999999**
Provider name: **XYZ Provider Inc.**
Patient account: **1234567890**

							PLAN PAYS		YOU PAY				
Service(s) you received	Reason code	Service date(s)	Amount billed by provider	Your discount −	Not allowed −	Amount due to provider	%	Plan paid −	Co-pay +	Applied to deductible +	Co-insurance +	Not covered +	Total you may owe*
Emergency Care	908	03/14 - 03/19/19	$500.00	$100.00	$0.00	$400.00	80	$260.00	$25.00	$50.00	$65.00	$0.00	$140.00
Totals			$500.00	$100.00	$0.00	$400.00		$260.00	$25.00	$50.00	$65.00	$0.00	$140.00

*This total may not reflect any payments/co-pays you made at the time of service. Please wait for a provider bill before making a payment. (+) Indicates any payment you may owe. (–) Indicates any discount or plan payment that will reduce what you owe.

Reason code explanations:
908 Provider negotiated discount. You are not responsible for this amount

3 Service and payment details

This section includes information about who received the medical service, the name of the provider and what types of care they received. It gives you a breakdown of how the claim was processed, including:

- How much your provider billed
- Your network discount
- The amount paid by your employer-sponsored plan
- The amount you may owe, including co-pays, deductibles and out-of-pocket amounts

Go paperless on umr.com

Sign up for digital EOBs and you'll receive email reminders every time you have a new EOB. PLUS, we'll let you know if you need to take action on the EOB and give you more details about your claim.

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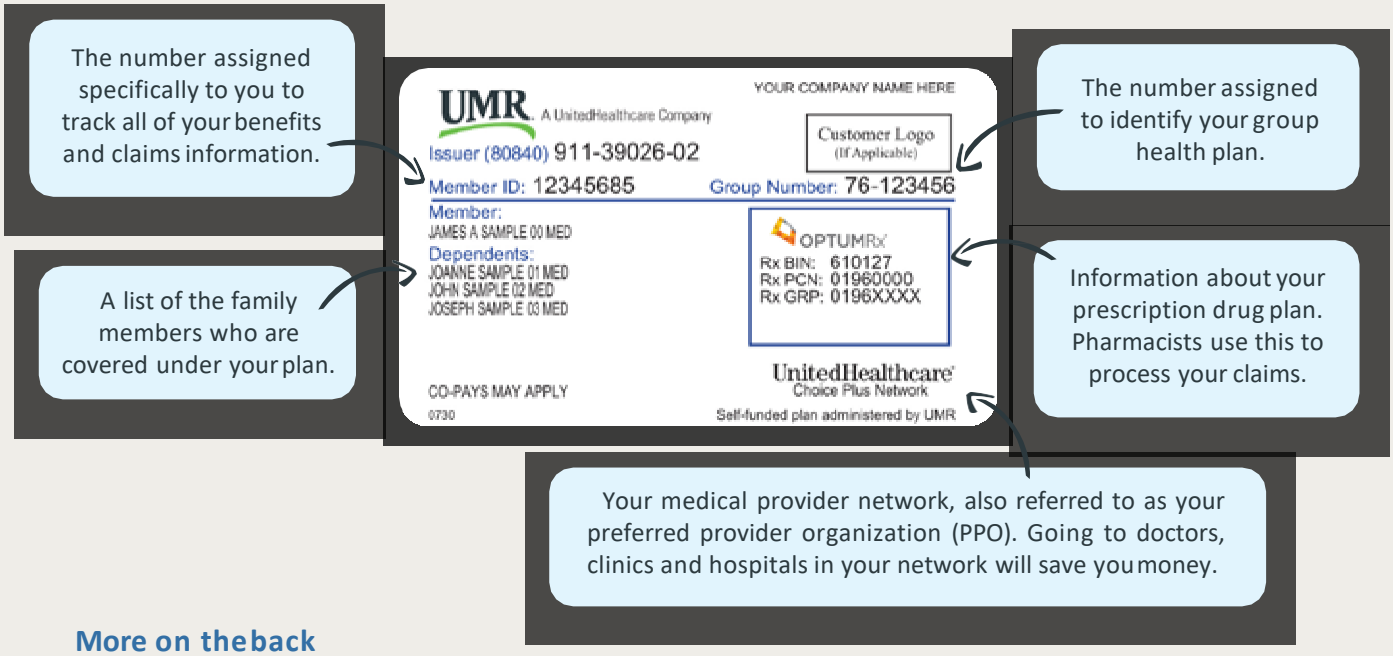
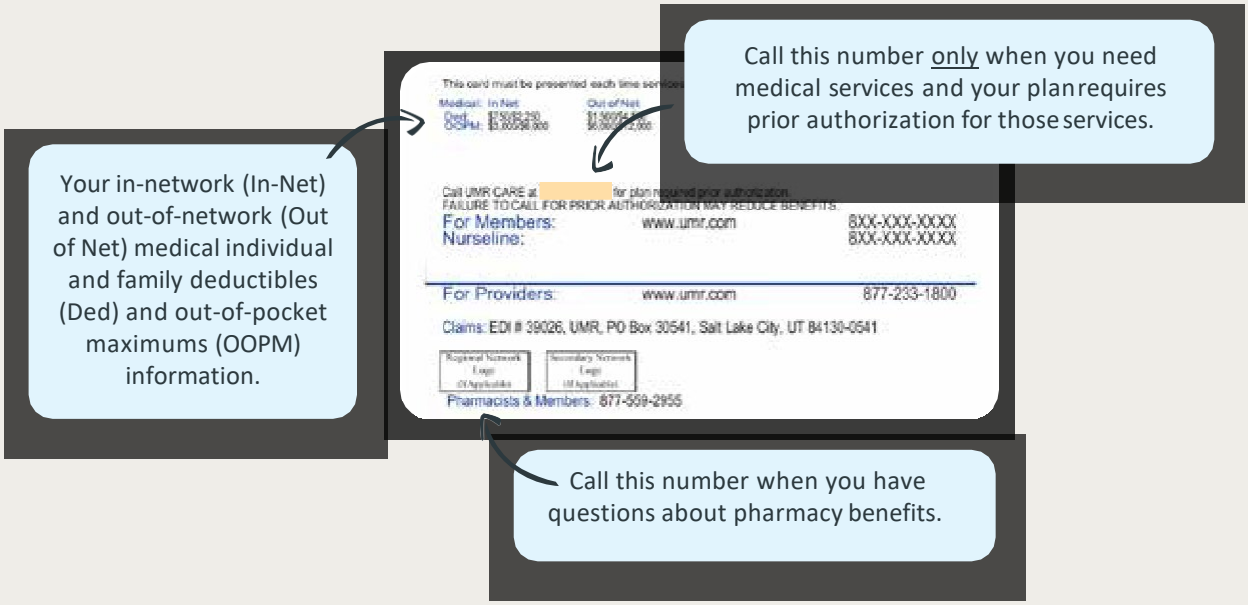
Understanding your new ID card

Have you ever wondered what all that stuff on your ID card really means? Here's a sample of what you might see. Each plan is different.



More on the back

Look for important contact information, including the customer service phone number to call for answers to claims or benefit questions. You can also go to **umr.com** to check your benefits, claims status, accumulators and eligibility.



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YOUR PLAN ADVISOR

Ready to connect – and guide you to the answers you seek

Health care in the modern world calls for a sensitive, personal approach to service – one that's built on real relationships and trust.

Which is why Plan Advisor delivers an experience that's beyond traditional models of member support. Our advisors partner with you so you feel more confident in the decisions you make about your health, and comforted by the steps you're taking to get there.

Because we all need a person we can rely on.
Let your Plan Advisor be yours.

Connecting you to the care you need

Whether your question is common or complex, we make it easier for you to get answers by ensuring you have the information you need.

Keeping it real

Your plan advisor is an actual person who's focused on serving you, equipped with knowledge and options to support and anticipate your unique needs and goals.

We're in it with you

If you need something that's out of our reach, we'll connect you to the resources your need – and we'll even stay on the call as long as you need.

Let's talk

Our plan advisors are available weekdays from 7 a.m. to 7 p.m. Mountain Time at 800-207-3172.

Dedicated to YOU

To connect with your Plan Advisor, call the number on the back of your member ID card.

Looking for a health care provider?

Compare quality and costs before you go

The next time you're in the market for a new doctor or are wondering how much you'll pay for a possible medical procedure, visit **umr.com** first. Your online services make it easy to look up UnitedHealthcare network providers and health care facilities and find cost estimates for different services – all in one place.

You'll get the information you need to make the right choices for you and your family and know what to expect before making an appointment

Stay in-network

With **umr.com**, you have anytime access to a searchable directory of UnitedHealthcare network providers in your area. Choosing a doctor or facility in the network ensures your benefits are paid at the highest level, so you can expect to pay less out of your own pocket. And when you go to a network provider for preventive services, there's typically no cost to you.

You can narrow your search to primary care providers or look up physicians by specialty. Then select a physician from your search results to learn more about where they went to school, where they practice and how to schedule an appointment.

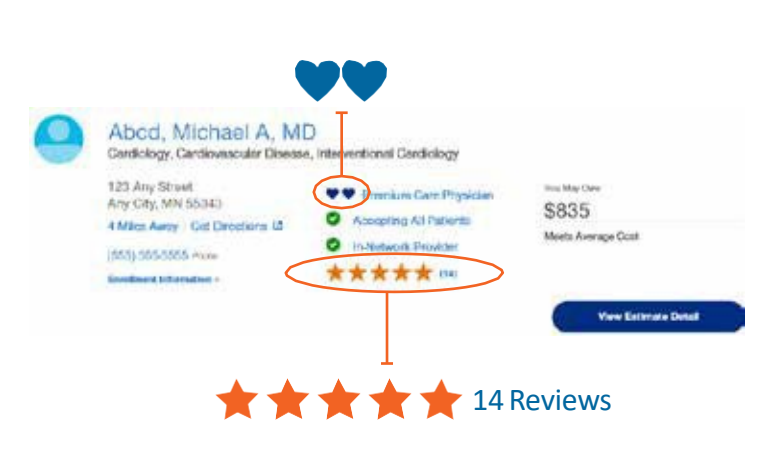
START SHOPPING TODAY

Log into **umr.com** and select Find a provider. Then choose View providers to search for medical providers. Or log in and look for the health cost estimator shopping cart icon to get started.

Check for quality

The two blue hearts next to a doctor's name tells you they are a Premium Care Provider who has been reviewed by UnitedHealthcare and meets quality standards for delivering cost-effective care.

You may also see star ratings for customer satisfaction based on reviews from previous patients.

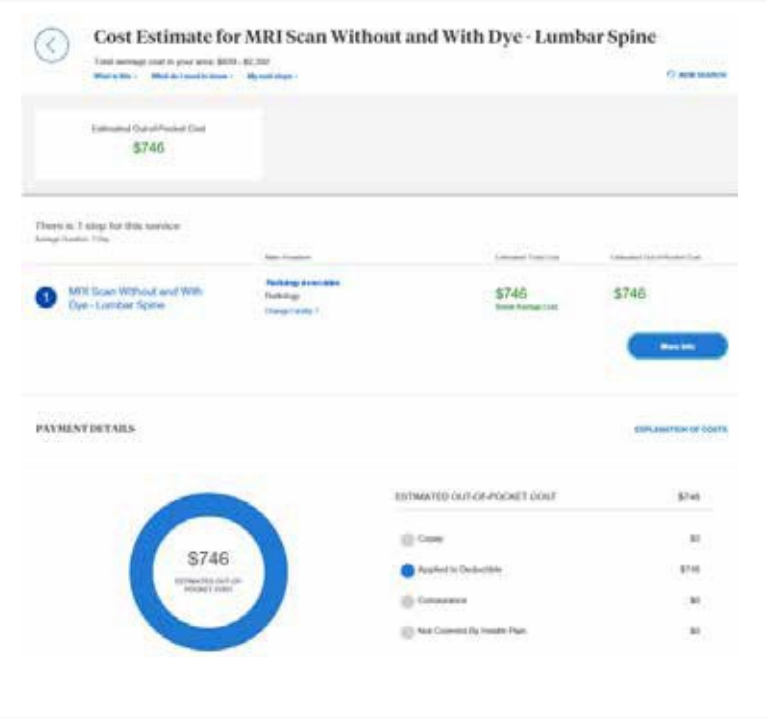


Understand the costs

Different providers may charge different amounts for the services they offer. Your search results will give you a range of the average costs for preventive care or medical procedures in your area. And the individual provider listings show whose costs are below, above, or meet the local average.

If a procedure typically includes multiple steps of treatment, you can review the total cost and your estimated out-of-pocket cost for each step. So you'll know what to expect, from start to finish.

Your estimated out-of-pocket costs are personalized to you, based on your own benefit plan's deductible, annual out-of-pocket max, co-pay, co-insurance and how much you've paid toward your deductible.



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WITH TELEHEALTH, HELP IS JUST A CLICK AWAY

What Is Telemedicine & Telehealth?

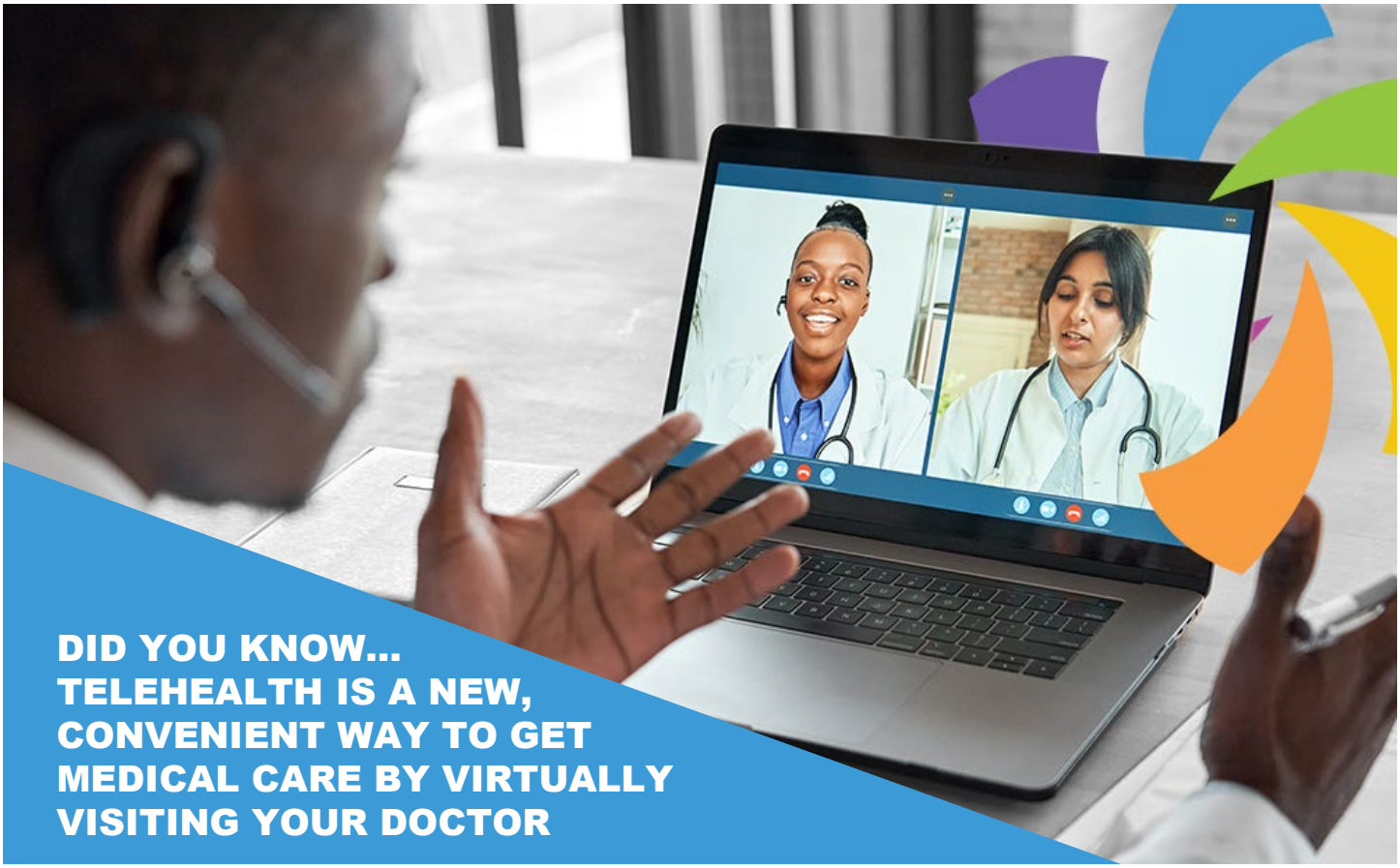
With the onset of Covid-19, telehealth has become an increasingly popular way for individuals to receive medical treatment and diagnosis without visiting a physical, clinical location such as a doctor's office or hospital.

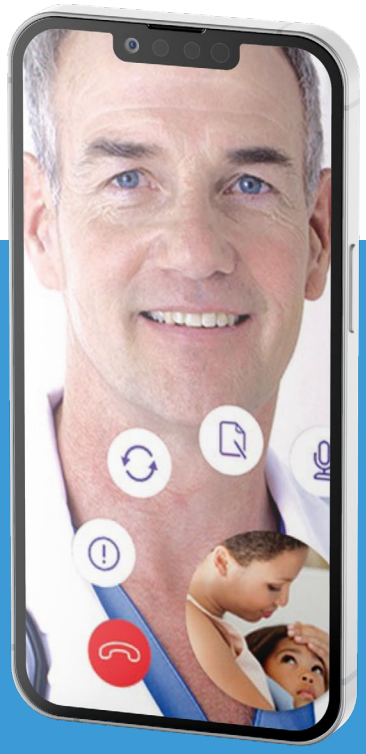
Telemedicine and telehealth are sometimes used interchangeably to describe both clinical and non-clinical interactions with health professionals through technology. While telemedicine focuses on remote clinical assistance, telehealth also includes educational and non-clinical remote interactions through the use of various technologies such as webcams, apps, and mobile devices.

Telemedicine and telehealth provide options for meeting virtually with a healthcare provider when you are not feeling well. Using technology and apps, it is now easier than ever to meet with a physician from your home, office, or while traveling. Additionally, physicians are available outside of normal business hours and on weekends.

Meeting with a doctor through an app like Teladoc is very similar to visiting your primary care physician in an office, except your interactions with the physician are through your mobile device. The doctor can give you a diagnosis based on your symptoms and even provide a prescription that can be picked up from your local pharmacy.

You can contact a doctor at any time using this benefit and there is no need to contact your care coordinator prior to using this service. We recommend you download the app to your phone now so that you can use this option when needed. More information is available on the next page.





TELADOC

Talk to a anytime

Meet With A Doctor Without Leaving Your Home Through Your Mobile Device!

Teladoc is one of the nation's most established providers of telehealth services. Our national network of U.S. board-certified doctors is standing by to provide quality healthcare for you and your family, 24/7.

From the information you provide, Teladoc can diagnose many illnesses and injuries, order prescriptions, and know immediately if you need to be referred to in-person emergency care.

Teladoc medical, behavioral health and dermatology visits are as follows:

Medical Visits:
- PPO Plan - $0 Copay

Behavorial Health Visits:
- PPO Plan - $0 Copay

Dermatology Visits:
- PPO Plan - $10 Copay

Benefits:
- Consults with U.S. Board-Certified doctors via phone or video conference 24/7
- Access to a doctor anytime, anywhere – from home, work, or on the road
- Diagnosis and treatment for many common, non-emergency medical conditions
- A way to avoid unnecessary visits to the ER and long waits for doctor appointments
- Prescriptions called-in when appropriate

Be Prepared For The Unexpected!

Download the App on Google Play for Android, or via the App Store for iPhone/iPad

Available on the App Store

ANDROID APP ON Google Play

Teladoc.com/mobile or visit your app store.

1-800-Teladoc

The right care when you need it most

TELADOC®

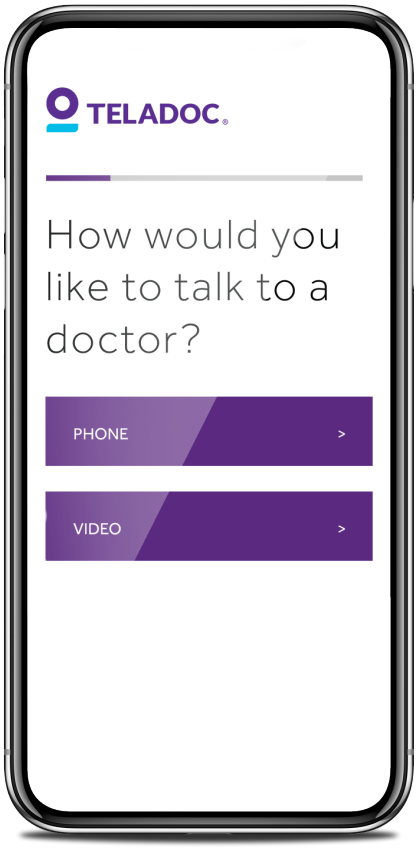
Teladoc gives you 24/7 access to doctors by phone, video or app for non-emergency conditions.

We treat allergies, flu and cold symptoms, pink eye, sinus infections, headaches, upset stomach and more.

Talk to a board-certified doctor anytime, anywhere*

Get a prescription or refill if needed

Skip the trip to the ER and save money



*Teladoc is not available internationally.

Feel better faster

Visit Teladoc.com

Call 1-800-TELADOC (835-2362) | Download the app

Refer to your employee booklet at umr.com for Teladoc benefits

Available on the App Store

ANDROID APP ON Google Play

TELADOC.

Overcome whatever comes your way

If something is on your mind —big or small—talking to an expert can help. Our licensed therapists are available seven days a week. Choose your therapist, pick a time that is convenient for you and then talk to the therapist from the privacy of home or anywhere you feel comfortable.

Teladoc therapists specialize in:

- Anxiety
- Depression
- Stress/PTSD
- Panic disorder
- Family and marriage issues
- And more

Feel like yourself again. Schedule a visit today.

Visit Teladoc.com

Call 1-800-TELADOC (835-2362) | Download the app

Refer to your employee booklet at umr.com for Teladoc benefits

Available on the App Store

ANDROID APP ON Google Play

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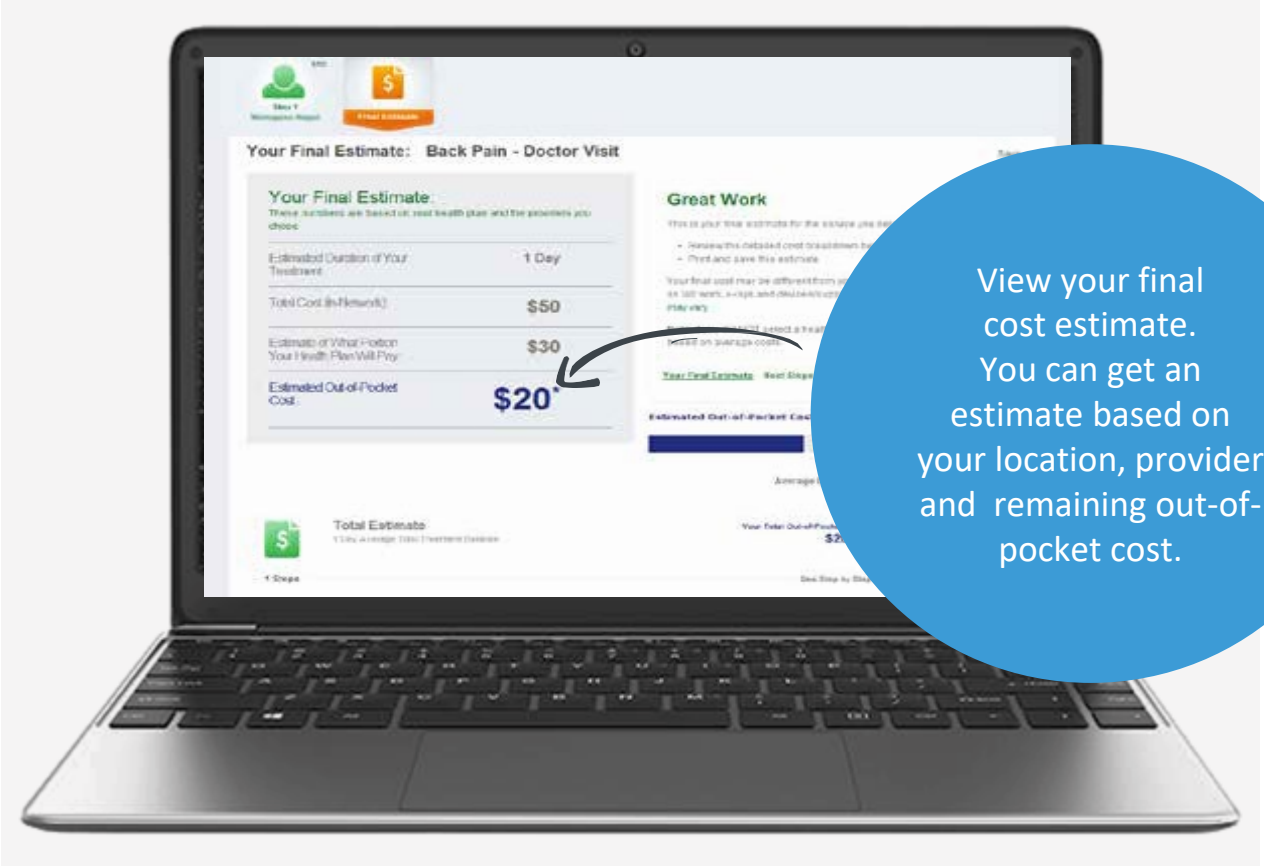
Group ID: 133325

myHealthcare Cost Estimator (myHCE)

myHCE allows you to research treatment options and learn about the recommended care and estimated costs employed with your selected treatment option. You can even access quality and efficiency measurements for participating providers.



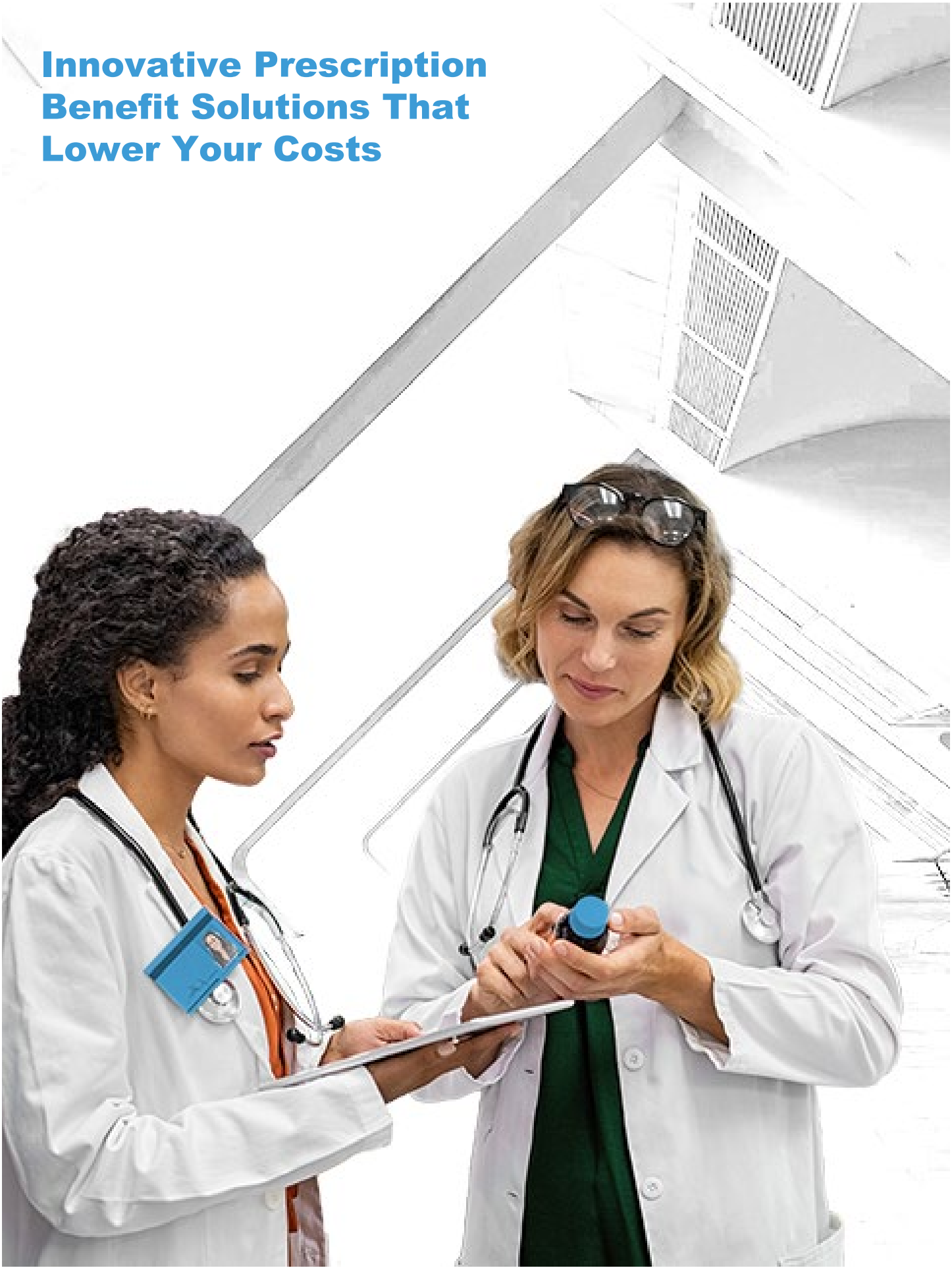
Medical Costs Can Vary A Lot From One Doctor To Another – So It Pays To Shop Around.

Your Care Coordinator can help you with the health cost estimator and can:

- Search for the type of service you need
- Compare the true costs of care using real data from real doctors
- Check which providers earned our UnitedHealth Premium rating for cost and quality
- See the total charge for your treatment, and know what to expect from beginning to end

Its easy to get started. Just look for the Health cost estimator tile on your personal home page

Innovative Prescription Benefit Solutions That Lower Your Costs



Prescription Drugs For Less

Novo Benefits has partnered with industry leaders in prescription benefit management, to help lower the cost of prescription drugs.

Prescription Care Coordinators work with your healthcare provider to deliver budget-friendly alternatives to high-cost medications with the same clinical outcomes as more costly drugs, ensuring the highest quality at the best cost.

What does this mean for you?
You will receive the same quality prescription with a lower out-of-pocket expense. There's no need to contact anyone. Your Prescription Care Coordinators will reach out to you if you are a good candidate for this program.

Significant Savings On Prescriptions

Novo Benefits has partnered with ElectRx to provide prescription drugs through a Personal Importation program.

The program offers significant discounts on certain high-cost medications without sacrificing quality.

Drugs are shipped from a pharmacy in Canada, United Kingdom, Australia or New Zealand directly to your home in the United States. The program dispenses only brand name drugs from the same manufacturers that are distributed to you in the United States.

Program Highlights

- Significant cost savings
- Shipped from pharmacies in Canada, United Kingdom, Australia, or New Zealand to your home.
- Same brand names available in USA
- $0 Co-pay for prescription drugs on ElectRx Formulary List

Save Money On Certain Brand Name Prescription Drugs Through The Electrx International Mail Order Program

Also known as Personal Importation or PI, you can order your brand name drugs from Canada, New Zealand, Australia, and United Kingdom using the same “brick and mortar” pharmacies that people in these countries use for their medications. Plan Members will have a $0 co-pay (FREE!) on all Brand drugs on the ElectRx Formulary.

1. Enroll in the program by calling (855) 353-2879. Enrollment is free and takes about 10 minutes.

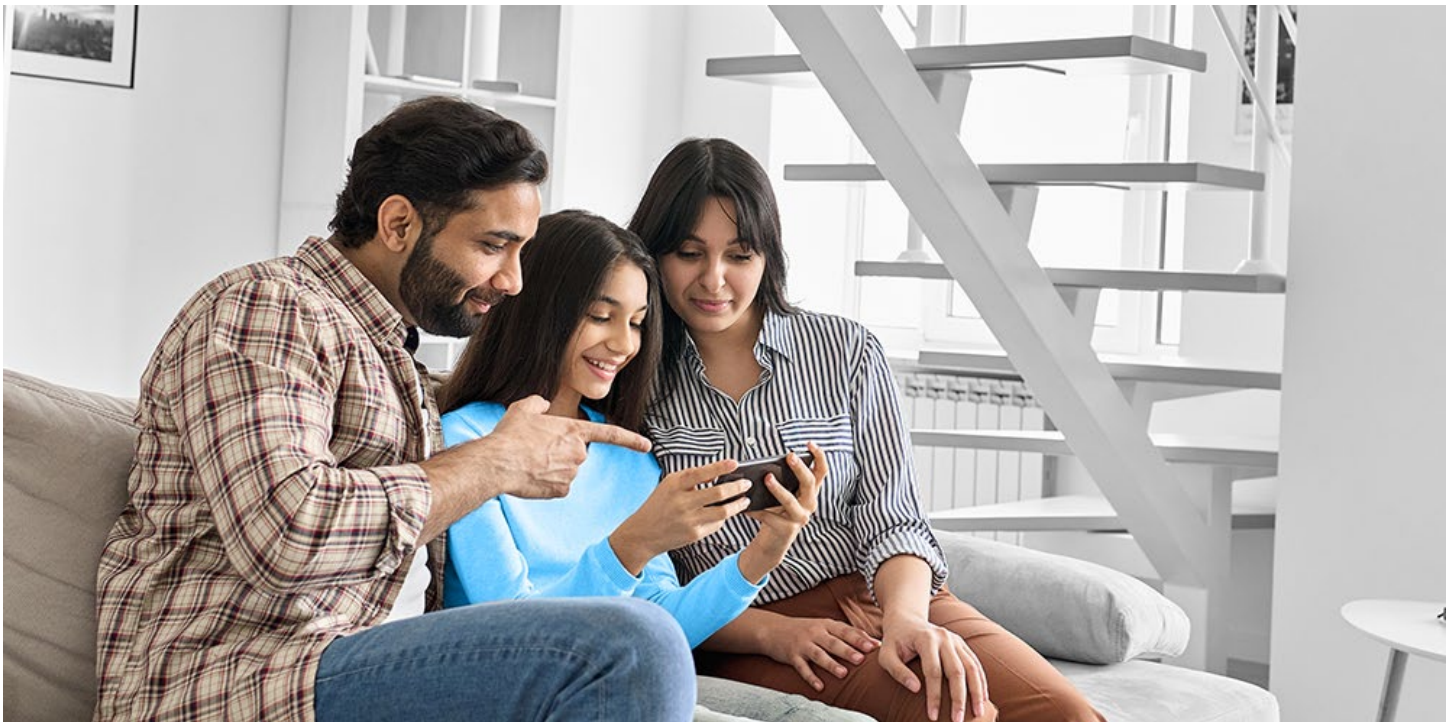
2. Elect Rx offers a variety of brand name prescriptions through the Personal Importation Program (PI). Call the number above to see if the medication you are currently taking qualifies for the program. You can order up to a 90-day supply of any brand name medication that is eligible for dispensing through this program.

3. Have your Physician prepare a prescription with 3 refills and FAX it to the ElectRx Toll Free Number at (833) 353-2879. Again, you have a $0 co-pay on your prescription and subsequent refills. You will receive an automated reminder notification of a pending renewal/refill. Shipping takes 5-15 business days from the date of completed requirements. Tip: Have a 30-day supply on hand to allow for plenty of delivery time.

ELECTRx
Pharmacy Benefit Strategists

Select Drugs And Products Program

At Prime Therapeutics Pharmacy, we are partnering across the industry to provide a connected healthcare experience that truly leads humanity to healthy, vibrant lives. We are dedicated to giving you the best service and resources to help you and your family make better healthcare decisions.



The **Select Drugs and Products ProgramSM** is administered by Paydhealth and is designed to improve access to specialty drugs. This program will assist you in reducing the cost of your medication by seeking sources of alternate funding for specialty drugs on the Select Drugs and Products List.

You must specifically enroll in the Select Drugs and Products Program in order to take advantage of these benefits. All specialty drugs listed on the Select Drugs and Products List require that you seek prior review and that your case be submitted to alternate funding before your benefit will apply. If you do not participate in the program, you will have a 100% reduction in your payable benefit for specialty medication.

If you are taking a specialty drug, you will be contacted by a Program Case Coordinator. Your Case Coordinator will provide you with further information regarding the Select Drugs and Products Program and walk you through the enrollment process and requirements.

If you have any questions regarding the Select Drugs and Products Program, please call the Specialty Contact Center at 877.869.7772 (8:00 a.m. – 8:00 p.m. EST).

Paydhealth

PRIME THERAPEUTICS®

Paydhealth

Select Drugs and Products™ Program

The Plan's Select Drugs and Products™ Program allows you to take an active role in helping the Plan reduce your costs, while allowing the Plan to continue to offer generous healthcare benefits to all Participants. The Plan is sponsoring this program at no cost to you. If you are prescribed a drug included on the Paydhealth Select Drugs and Products™ List, you must enroll in the Program to comply with benefit requirements.

Plan Members Taking Specialty Drugs – 1 – 2 – 3

1. Paydhealth will initiate outreach to you by text message or phone call.

2. Complete the digital enrollment application which will allow Paydhealth to match you to alternate funding programs.

   Note: you may be asked to provide household size and income information.

3. Your Paydhealth Case Coordinator will coordinate with you and your pharmacy to ensure you are able to get your medication in a timely manner.

A Case Coordinator is available (8:00 am to 8:00 pm CST) to guide you through the enrollment process and the program. Please respond to calls from your Case Coordinator in a timely manner.

This program keeps will not share your information with any 3rd party solicitors. If you would like to complete your application over the phone or speak with a Paydhealth Case Coordinator, please call (877) 869-7772. Common questions and answers about your Plan's Select Drugs and Products™ Program can be found on the next page.

There are two reasons why you are receiving this important message:

- Your Plan has added an important program that includes the Paydhealth Select Drugs and Products™ List*.
- Your Plan is continuing to offer generous specialty drug benefits while attempting to reduce costs to you and the Plan.

*The Paydhealth Select Drugs and Products™ List includes drugs typically prescribed by a specialist for multiple sclerosis, hepatitis C, Crohn's disease, hemophilia, cancer, psoriasis, rheumatoid arthritis, transplants, HIV/AIDS, and other complex conditions.

How It Works

What is the Select Drugs and Product™ Program?

The Select Drugs and Products™ Program provides advocacy services to assist you by identifying and facilitating your enrollment in programs that may reduce or eliminate your out-of-pocket costs for eligible specialty drugs, products, and services. A Case Coordinator will contact you to guide you through the program. The Plan continues to offer generous healthcare benefits but needs your help to continue to meet this goal.
Your active role in helping the Plan reduce its costs and yours is important. The Plan is sponsoring this program at no cost to you. However, you may be required to pay a portion of the cost to acquire your specialty drug, product or service depending on specific situations.

What is the Enrollment Requirement for the Select Drugs and Products™ Program?

The Plan requires you to enroll in the Select Drugs and Products™ Program by following the three-step process outlined above, which starts with a response to texts or calls from the Paydhealth Case Coordinator in a timely manner.

What happens after I enroll in the Select Drugs and Products™ Program?

After enrolling in the Select Drugs and Products™ Program, you will be asked to complete certain documentation related to the alternate funding programs identified by your Case Coordinator. This will include providing required documents and information to the alternate funding program from you and may require your prescriber's participation as well. Your timely responses will help you avoid any delays in processing your documentation.

Your Case Coordinator will help you obtain your eligible specialty drugs, products or services and reduce your out-of-pocket costs by coordinating alternative forms of funding. After your acceptance into an alternate funding program, your Case Coordinator will contact you before and after each refill to ensure there is no disruption in your treatment.

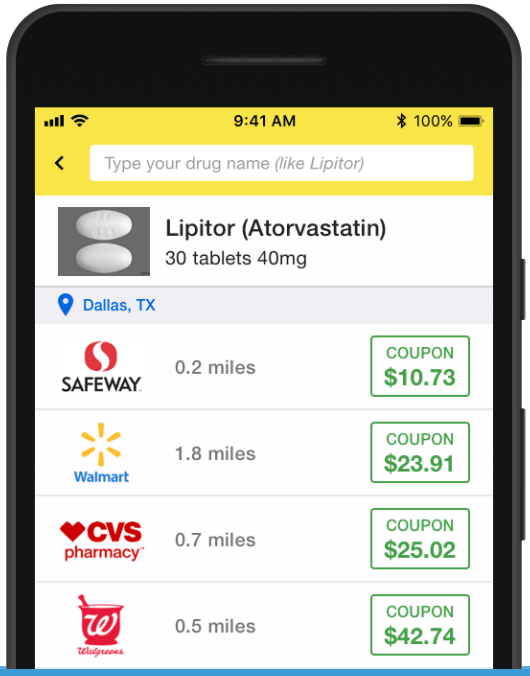
Call toll-free at 1-(877) 869-7772 to speak to a Case Coordinator, M-F, 8AM to 8PM CT.

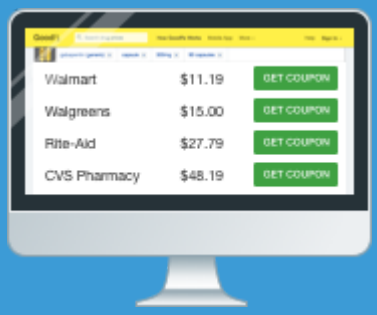
GoodRx – The Free Rx Savings Solution

Drug prices vary widely between pharmacies. GoodRx finds the lowest prices and discounts.

How?

1. Collect and compare prices for every FDA-approved prescription drug at more than 70,000 U.S. pharmacies
2. Find free coupons to use at the pharmacy
3. Show the lowest price at each pharmacy near you





Compare Prices
GoodRx collects prices and discounts from over 70,000 U.S. pharmacies

Print Free Coupons
Or send coupons to your phone by email or text message

Save Up To 80%
Show the coupon to your pharmacist for massive savings on your meds

GoodRx

Available on the App Store

ANDROID APP ON Google Play

DELTA DENTAL

Delta Dental PPO plus Premier
MESA COUNTY – Group # 12141

MAXIMUM BENEFIT Calendar Year Maximum	$2,000 per member, per calendar year
CALENDAR YEAR DEDUCTIBLE Applies to Basic and Major Services	Individual Deductible – $50.00 Combination of in and out-of-network Family Deductible – $100.00 Combination of in and out-of-network

PPO Dentist	PREMIER Dentist	NON-PAR Dentist	COVERED SERVICES	BENEFIT INFORMATION (subject to Delta Dental guidelines)
DIAGNOSTIC AND PREVENTIVE SERVICES				
100%	100%	100%	Oral Exams and Cleanings	Twice each in a calendar year. Two additional cleanings may be covered for those with a documented EBD condition.
			Sealants	Once per tooth in a 36-month period for unrestored permanent molars, through age 14
			Bitewing X-Rays	Once in a calendar year
			Full Mouth X-Rays	Once in a 60-month period
			Fluoride	Twice in a calendar year, through age 15
			Space Maintainers	One per quadrant, per lifetime to maintain space for eruption of permanent posterior teeth, through age 13
BASIC SERVICES				
80%	80%	80%	Fillings (Composite or Amalgam)	Once per tooth in a 12-month period
			Simple Extractions	
			Oral Surgery	
			Endodontics	
MAJOR SERVICES				
50%	50%	50%	Periodontics	
			Crowns	Once per tooth in a 60-month period. Not a benefit under age 12.
			Implants	Once per tooth in a 60-month period. Not a benefit under age 16.
			Dentures, Bridges	Once in a 60-month period, only when existing prosthesis cannot be made serviceable. Fixed bridges or removable partials are not a benefit under age 16.
ORTHODONTICS $2,000 lifetime maximum				
50%	50%	50%	For covered children to age 19	

You and your family members may visit any licensed dentist but will enjoy the greatest out-of-pocket savings if you see a Delta Dental PPO dentist. There are three levels of dentists to choose from.

PPO Dentist - Payment is based on the PPO dentist's allowable fee, or the actual fee charged, whichever is less.
Premier Dentist - Payment is based on the Premier Maximum Plan Allowance (MPA), or the fee actually charged, whichever is less.
Non-Participating Dentist - Payment is based on the non-participating Maximum Plan Allowance. Members are responsible for the difference between the non-participating MPA and the full fee charged by the dentist. You will receive the best benefit by choosing a PPO dentist.

Open Enrollment applies. Members may add or terminate coverage once per year.

Delta Dental PPO℠ plus Premier

With the Delta Dental PPO plus Premier plan, you and your family members may visit any licensed dentist, but **you will receive the greatest out-of-pocket savings if you see a Delta Dental PPO provider**. Participating providers file claims directly with Delta Dental and accept Delta Dental's reimbursement in full. You are responsible only for your deductible and coinsurance (as determined by your plan), as well as any charges for non-covered services. If you choose to see an out-of-network provider, you will incur additional out-of-pocket expenses, and you will be billed the total amount the provider charges (called balance-billing). When you see a Delta Dental PPO or Premier® provider, you are protected from balance-billing for covered services.

Advantages of the Delta Dental PPO plus Premier plan:

- SAVINGS: Delta Dental PPO providers offer our members the greatest savings.
- CHOICE: If you choose to visit a Premier provider, you will still save money because Premier providers also accept discounted fees (however, discounts are not as great as if you see a PPO provider).
- NETWORK: Delta Dental's dual network has nearly 102,000 PPO providers and 152,000 Premier providers nationwide.

To find a participating provider or to see if your current provider is in the PPO network, visit our website at deltadentalco.com and click on the **Find a Dentist** search tool. Or use our free mobile app for iPhone and Android. You may even be able to schedule an appointment online or on the app if your provider has Brighter Schedule.

You can also contact our customer relations department, Monday–Friday 8 a.m. to 6 p.m. Mountain Time, at 1 -800-610-0201 (toll-free) or customer_service@ddpco.com.

Looking for a dentist? Concerned about costs? PPO providers offer you the greatest savings.			
Service: Porcelain Crown (*Benefit illustration only*. Example assumes deductible has been met.)			
	Greatest Savings ◄		► Least Savings
	Protected from balance-billing		Not protected from balance-billing
Network	Delta Dental PPO Provider	Delta Dental Premier Provider	Out-of-Network Provider
Procedure Cost	$1,000	$1,000	$1,000
Maximum Provider Can Charge Patient	$710	$950	Unlimited
Maximum Provider Can Charge Insurance (MPA)*	$710	$950	$660
Benefit Percentage	50%	50%	50%
Delta Dental Pays	$355	$475	$330
You Pay	$355	$475	$670

*The maximum a provider can charge your insurance company for covered services is called the Maximum Plan Allowance (MPA). The MPA for an out-of-network provider is always lower than in-network MPA. Delta Dental pays a portion of the MPA only, which exposes you to balance-billing from an out-of-network provider.

deltadentalco.com

A Look at Your VSP Vision Coverage

With VSP and MESA COUNTY GOVERNMENT, your health comes first.

As a member, you'll get access to savings and personalized vision care from a VSP network doctor for you and your family.

Value and savings you love.

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras which provide offers from VSP and leading industry brands totaling over $3,000 in savings.

Provider choices you want.

With thousands of choices, getting the most out of your benefits is easy at a VSP Premier Edge™ location.

Shop online and connect your benefits.

Eyeconic® is the preferred VSP online retailer where you can shop in-network with your vision benefits. See your savings in real time when you shop over 70 brands of contacts, eyeglasses, and sunglasses.

Quality vision care you need.

You'll get great care from a VSP network doctor, including a WellVision Exam®. An annual eye exam not only helps you see well, but helps a doctor detect signs of eye conditions and health conditions, like diabetes and high blood pressure.

Using your benefit is easy!

Create an account on vsp.com to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with Exclusive Member Extras. At your appointment, just tell them you have VSP.

vsp vision care

More Ways to Save

Extra

$20

to spend on Featured Brands†

bebe · Calvin Klein · COLE HAAN · DRAGON · FLEXON · LONGCHAMP PARIS · and more

See all brands and offers at vsp.com/offers.

+

Up to

40%

Savings on lens enhancements‡

Create an account today.

Contact us: **800.877.7195** or **vsp.com**

Your VSP Vision Benefits Summary

MESA COUNTY GOVERNMENT and VSP provide you with an affordable vision plan.

PROVIDER NETWORK:
VSP Signature

EFFECTIVE DATE:
01/01/2024

vsp vision care

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
Your Coverage with a VSP Provider			
WELLVISION EXAM	• Focuses on your eyes and overall wellness	$10	Every 12 months
ESSENTIAL MEDICAL EYE CARE	• Retinal screening for members with diabetes • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP doctor for details.	$0 per screening $20 per exam	Available as needed
PRESCRIPTION GLASSES		**$10**	
FRAME†	• $170 featured frame brands allowance • $150 frame allowance • 20% savings on the amount over your allowance	Included in Prescription Glasses	Every 24 months
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Included in Prescription Glasses	Every 12 months
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 40% on other lens enhancements	$0 $80 - $90 $120 - $160	Every 12 months
CONTACTS (INSTEAD OF GLASSES)	• $150 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months
EXTRA SAVINGS	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to **vsp.com/offers** for details. • 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam.		
	Routine Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor		

YOUR COVERAGE GOES FURTHER IN-NETWORK

With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to vsp.com to find an in-network provider.

†Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change.
‡Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.
+Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on vsp.com.

Save Up to 60% on Brand-Name Hearing Aids

Like vision loss, hearing loss can have a huge impact on your quality of life. However, the cost of a pair of quality hearing aids usually costs more than $5,000,* and few people have hearing aid insurance coverage.

TruHearing makes hearing aids affordable by providing exclusive savings to all VSP® Vision Care members. You can save up to 60% on a pair of hearing aids with TruHearing. What's more, your dependents and even extended family members are eligible too.

In addition to great pricing, TruHearing provides you with:

- One year of follow-up visits for fittings, adjustments, and cleanings
- 60-day trial
- Three-year manufacturer warranty for repairs and one-time loss and damage replacement
- 80 free batteries per hearing aid for non-rechargeable models

Plus, with TruHearing you'll get:

- Access to a national network of more than 7,000 hearing healthcare providers
- Discounted pricing on a wide selection of the latest brand name hearing aids
- High-quality, low-cost batteries delivered to your door

Best of all, if you already have a hearing aid allowance from your health plan or employer, you can combine it with TruHearing prices to reduce your out-of-pocket expense even more!

vsp exclusive member extras

TruHearing®

truhearing.com/vsp

Here's how it works:

Contact TruHearing.
Call **877.396.7194**. You and your family members must mention VSP.

Schedule exam.
TruHearing will answer your questions and schedule a hearing exam with a local provider.

Attend appointment.
The provider will perform a hearing exam, make a recommendation, order the hearing aids through TruHearing, and fit them for you.

Learn more about this VSP Exclusive Member Extra at truhearing.com/vsp or call 877.396.7194 with questions.

*Based on a 2018 third-party survey of nationwide provider and manufacturer retail pricing.

VSP is providing information to its members but does not offer or provide any discount hearing program. The relationship between VSP and TruHearing is that of independent contractors. VSP makes no endorsement, representations, or warranties regarding any products or services offered by TruHearing, a third-party vendor. The vendor is solely responsible for the products or services offered by them. If you have any questions regarding the services offered here, you should contact the vendor directly.

TruHearing offers individuals the opportunity to purchase hearing aids at discounted prices, including individuals covered by self-funded health plans not subject to state insurance or health plan regulations. TruHearing is not insurance and not subject to state insurance regulations. TruHearing provides discounts to certain healthcare groups for hearing aid sales and services; TruHearing provides fitting, programming, and three adjustment visits at no cost; the member is obligated to pay for testing, and all post-fitting hearing care services, but will receive a discount from those healthcare providers who have contracted with TruHearing. Not available directly from VSP in the states of Washington and California.

Classification: Public

TruHearing Hearing Aid Discount Program

vsp exclusive member extras

VSP® Vision Care members can save up to 60% on the latest brand-name prescription and over-the-counter hearing aids. Dependents and even extended family members are eligible for exclusive savings too.

TruHearing®
truhearing.com/vsp

Hearing loss is growing in the workplace

Like vision loss, hearing loss can have a huge impact on productivity and overall quality of life. Unfortunately, 38 million Americans need hearing aids, 70% of the people with hearing loss don't treat it, and only 30% seek treatment.[1] And the high cost of hearing aids is a major factor keeping people from addressing their hearing loss.

Ninety-six percent of customers surveyed would recommend TruHearing to their friends and family.[2]

More than just great pricing

TruHearing also provides members with:

- One year of follow-up visits for fittings, adjustments, and cleanings
- A 60-day trial
- Three-year manufacturer warranty for repairs and one-time loss and damage replacement
- 80 free batteries per hearing aid on all non-rechargeable aids

Plus, members get:

- Access to a national network of more than 7,000 hearing healthcare providers
- Straightforward, nationally fixed pricing on a wide selection of the latest brand-name hearing aids
- High-quality, low-cost batteries delivered to your door

Best of all, if your organization already offers a hearing aid allowance, members can combine it with TruHearing prices to reduce their out-of-pocket expense even more!

Over-the-counter hearing aids are also available through phone or online orders.[3]

Here's how it works:

Contact TruHearing.
Members and their family call **877.396.7194** and mention VSP.

Schedule exam.
TruHearing will answer questions and schedule a hearing exam with a local provider.

Attend appointment.
The provider will perform a hearing exam, make a recommendation, order the hearing aids through TruHearing, and fit them for you.

Learn more about this VSP Exclusive Member Extra at truhearing.com/vsp or call 877.396.7194 with questions.

1. Kochkin S. MarkeTrak VIII: The key influencing factors in hearing aid purchase intent. Hearing Review. 2012; 19(3):12–25. "Quantifying the Obvious: The Impact of Hearing Instruments on Quality of Life." The Hearing Review. Kochkin and Rogin. Jan 2000. 2. Based on a 2018 satisfaction study of VSP members. 3. Over-the-counter hearing aids are different from prescription hearing aids.

VSP is providing information to its members, but does not offer or provide any discount hearing program. VSP makes no endorsement, representations or warranties regarding any products or services offered by TruHearing, a third-party vendor. TruHearing is not insurance and not subject to state insurance regulations. For additional information, please visit **vsp.com/offers/special-offers/hearing-aids/truhearing**. For questions, contact TruHearing directly. Not available directly from VSP in the states of Washington and California.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**.

Flexible Spending Account (FSA)

The General-Purpose Health Flexible Spending Account allows you to set aside up to $3,300 in pre-tax dollars to pay most out-of-pocket medical, dental or vision expenses not paid by insurance; including deductibles and copayments. Please refer to the next page for a list of eligible expenses or refer to the most recent version of IRS publication 502.

You decide how much to deposit into your account. Your election amount is evenly deducted pre-tax from your paycheck throughout the plan year. When you have an expense that qualifies, you pay the bill, submit a claim, and you are reimbursed with tax-free dollars from your account.

If you participate in the Health Flexible Spending Account, you may roll over up to $660 of unused amounts in the Health Flexible Spending Account remaining at the end of one Plan year to the immediately following Plan Year. These amounts can be used during the following Plan Year for expenses incurred in that Plan Year. Unused amounts are those remaining after expenses have been reimbursed during the runout period. Amounts in excess of $660 will be forfeited.

Dependent Care Account

The Dependent Care account allows you to set aside tax-free dollars to pay for qualified dependent care expenses, such as daycare, that you would normally pay with after-tax dollars. Qualified dependents include children under age 13 and/or dependents who are physically or mentally unable to care for themselves. If your spouse is unemployed or doing volunteer work, you cannot set up a dependent care account. You must meet the following criteria in order to set up this account:

- You and your spouse both work; OR
- You are the single head of household; OR
- Your spouse is disabled or a full-time student.

The IRS allows you to contribute the following amounts (each calendar year), depending on family status:

- If you are single, the lesser of your earned income or $5,000
- If you are married, you can contribute the lesser of
  - Your (or your spouse's) earned income
  - $5,000 if filing jointly or $2,500 if filing separately

Plan Year
January 1, 2025 through December 31, 2025

Once Enrolled, You May Not Change Your Election
You cannot change your annual election after the beginning of the plan year. However, there are certain limited situations when you can change your elections if you have qualified change in status.

Flexible Spending Account – Eligible Expenses
Your Health Care Reimbursement Flexible Spending Account lets you pay for medical care expenses not covered by your insurance plan with pre-tax dollars. The expenses must be primarily to alleviate a physical or mental defect or illness and be adequately substantiated by a medical practitioner. The products and services listed on the next page are examples of medical expenses eligible for payment under your FSA, to the extent that such services are not paid by your medical and/or dental insurance plan.

Reimbursements

To claim reimbursements, fill out a claim form and attach any supporting information. For health care this will include receipts of the amount you paid and the date(s) on which you or a dependent received services. For dependent care this may include any contracts, letters, or receipts. You may send this information to Rocky Mountain Reserve via email, fax, or standard mail.

Email: claims@rmrbenefits.com
Fax: 866-557-0109
Mailing Address:
PO Box 631458,
Littleton, CO 80163
Website:
rockymountainreserve.com

Flexible Spending Account Eligible Expenses

Eligible Expenses

These are only examples, and this list is not all-inclusive – it only provides some of the more common expenses. Additional information is available in IRS Publication 502.

Common Eligible Medical Expenses:

- Eyeglasses, eye exams, sunglasses
- (prescription)
- Over-the-counter drugs
- Menstrual care products
- Eye surgery
- Fertility enhancement
- HMO expenses
- Hearing aids, batteries, and exams
- Hospital services
- Immunizations, vaccines, flu shots
- Laboratory fees
- LASIK eye surgery
- Medicines (prescribed)
- Obstetric services
- Optometrist
- Orthodontia
- Prescription drugs
- Psychiatric care
- Psychologist
- Speech therapy
- Stop smoking programs
- Surgery/operations
- Therapy
- Vasectomy
- Wheelchair
- X-rays

Dual Purpose Expenses That Potentially Qualify:

The expense must be for a specific medical reason and be accompanied by a prescription.

- Vitamins
- Supplements
- Massage therapy
- Herbal supplements
- Natural medicines
- Aromatherapy
- Weight-loss program
- Health club dues

Health Care Reform & Over-the-Counter Items:

Over-the-Counter Medicine and Drugs do not require a prescription to be eligible for reimbursement under the plan.

- Allergy medications
- Antacids
- Anti-diarrhea medicine
- Bug-bite medication
- Cold medicine
- Cough drops and throat lozenges
- Diaper rash ointments
- Hemorrhoid medication
- Incontinence supplies
- Laxatives
- Muscle/joint pain products/rubs
- Nicotine medications, gum, patch-es
- Pain relievers
- Sinus medications, nasal sprays, nasal strips
- Sleep aids
- Wart removal medication
- Band-aids/bandages
- Cold/hot packs for injuries
- Condoms
- Contact lens solutions
- Diabetic supplies
- First aid kits
- Medical alert bracelets/necklaces
- Pregnancy test kits
- Thermometers

Ineligible Expenses:

- Cosmetic surgery
- Long term care
- Hair transplant/re-growth
- Maternity clothes
- Nutritional supplements
- Personal use items: such as toiletries, cotton swabs, toothbrush, toothpaste, facial care, shampoo
- Teeth whitening
- Drunk driving classes

Dependent Care Eligible Expenses:

- A dependent receiving care must be a child under the age of 13, or a tax dependent unable to provide for their own care, who resides with you. The care must be necessary for you or your spouse to be gainfully employed or to go to school. Care may be provided by anyone other than your spouse or your children under the age of 19. Expenses for schooling, kindergarten, over-night care, and nursing homes are not reimbursable. See IRS Publication 503.

- The maximum you can elect, in a calendar year, is equal to the smallest of the following:

- $5,000 – Married and filing federal taxes jointly or a single parent
- $2,500 – Married and filing separate federal tax return

- The amount contributed year-to-date, is available for reimbursement.

Life Insurance

Mesa County provides eligible employees (at no cost to the employee) Basic Life/AD&D coverage. All regular full-time employees scheduled to work at least 20 hours each week in active employment in the U.S. will be enrolled in the group Life/AD&D plan.

Life Insurance Amount	**$20,000**	
Reduction Schedule	Benefits are reduced to 65% at age 65; to 40% of the original amount at age 70, and to 25% of the original amount at age 75.	
Accidental Death & Dismemberment (AD&D) **Loss must occur while insured and within 365 days after the accident is sustained** **The total benefit paid for all losses due to the same accident will not be more than 100%**	<u>Loss:</u> Life One Limb Speech & Hearing Speech or Hearing Thumb & Index Finger of Same Hand Quadriplegia Paraplegia Hemiplegia Sight of One Eye	<u>Amount of Additional Benefit Paid:</u> 100% 50% 100% 50% 25% 100% 75% 50% 50%
Accelerated Benefit	If you are certified as terminally ill with a life expectancy of 12 months or less, you may elect to receive a portion of your life insurance benefit up to 75% in advance. Upon death, your beneficiary will receive the balance of your benefit.	
Additional Benefits	Safe Driver Benefit (seatbelt & airbag) Dependent Education Benefit Child Care Benefit Disappearance & Exposure Child Education Repatriation Portability	
Basic Employee-Paid Voluntary Dependent Life:	$5,000 Spouse (no age reduction) Child(ren) 14 days to 6 months - $1,000 / Age 19 or 26 if a full-time student - $2,500	

Employer Paid Life/AD&D Insurance Continued… Insured By Unum

Life Planning Financial & Legal Resources	**Personalized financial counseling provides expert, objective financial counseling to survivors and terminally ill employees at no cost. The financial consultants are master level consultants that will not offer to sell any product or service. They will help develop strategies needed to protect resources, preserve current lifestyles, and build future security.**
Waiver of Premium	If you become totally disabled for 6 months while insured, your life insurance will continue without payment to age 70 if the disability began prior to age 65. If total disability ends, you may exercise the conversion privilege.
Conversion	If your insurance terminates because you are no longer employed full-time, your insurance may be converted to an individual life insurance policy if you apply and include payment of the first premium within 31 days of termination. Conversion does not require proof of medical insurability.
Travel Assistance Benefits	To complement your Group Life Insurance coverage, you and your immediate family have access to Emergency Travel Assistance administered by Assist America. Emergency Travel Assistance offers you and your dependents worldwide medical, travel, concierge and legal and financial assistance services, 24 hours a day, 365 days a year. If you have a medical emergency while you are more than 100 miles away from home, you don't have to face it alone. With one phone call you can be connected to Assist America's staff of medically trained, multilingual professionals who can advise you in a medical emergency, 24x7. No matter where you are in the world, they will help you access or receive: Pre-qualified, English-speaking professionals working in hospitals, pharmacies, and dental offices; Medical consultation, evaluation and referral; Hospital admission, critical care monitoring, emergency medical evacuation, transportation to return home or to a rehabilitation facility, lost prescription assistance, legal and interpreter services, and more. Assist America pays for 100% of the services it arranges for and provides. Your spouse and dependent children up to age 19 are also covered.

Voluntary Life And AD&D Insurance

Coverage Amounts (Term Life and AD&D)	**Employee:** Up to 5 times earnings in increments of $10,000. Not to exceed $400,000. **Spouse:** Up to 100% of employee amount or $200,000, in increments of $5,000. **Children:** $10,000 of coverage if eligible. *Maximum death benefit for a child between the ages of live birth and 6 months is $1,000.*
Reduction Schedule	Benefits are reduced to 65% at age 70, and to 50% of the original amount at age 75
Guarantee Issue	$200,000 for yourself and any amount of coverage up to $30,000 for your spouse. Any Life insurance coverage over the Guarantee Issue amount(s) will be subject to evidence of insurability.
Accidental Death & Dismemberment (AD&D) *The total benefit paid for all losses due to the same accident will not be more than 100%*	Loss: — Amount of Benefit Paid: Life — 100% Both Hands — 100% Both Feet — 100% Sight of Both Eyes — 100% One Hand & Sight of One Eye — 100% One Foot & Sight of One Eye — 100% Speech & Hearing — 100% *Other losses may be covered.*
Additional AD&D Benefits	**Education Benefit:** If you or your insured spouse die within 365 days of an accident, an additional benefit is paid to your dependent child(ren). Your child(ren) must be a full-time student beyond grade 12. **Seat Belt/Air Bag Benefit:** If you or your insured dependent(s) die in a car accident and are wearing a properly fastened seat belt and/or are in a seat with an air bag, an amount will be paid in addition to the AD&D benefit.

Voluntary Life And AD&D Insurance Continued… Insured By Unum

Each year you will be given the opportunity to change your Life and AD&D coverage, and may purchase additional life insurance up to the guarantee issue amounts without evidence of insurability as long as you are already enrolled in the plan (even at a minimum of $10,000). **If you waived coverage when you were first eligible and want to apply at a later date, all amounts are subject to evidence of insurability – there is no guarantee issue available.**	
Accelerated Benefit	If you become terminally ill and are not expected to live beyond a certain time period as stated in your certificate booklet, you may request up to 75% of your life insurance amount up to $250,000, without fees or present value adjustments. A doctor must certify your condition in order to qualify for this benefit. Upon your death, the remaining benefit will be paid to your designated beneficiary(ies).
Life Planning Financial & Legal Resources	Personalized financial counseling provides expert, objective financial counseling to survivors and terminally ill employees at no cost. The financial consultants are master level consultants that will not offer to sell any product or service. They will help develop strategies needed to protect resources, preserve current lifestyles, and build future security.
Waiver of Premium	If you become disabled (as defined by your plan) and are no longer able to work, your premium payments may be waived during the period of disability.
Portability/Conversion	If you retire, reduce your hours or leave your employer, you can take this coverage with you according to the terms outlined in the contract. However, if you have a medical condition which has a material effect on life expectancy, you will be ineligible to port your coverage. You may also have the option to convert your Term life coverage to an individual life insurance policy.
Suicide Exclusion	Life benefits will not be paid for deaths caused by suicide in the first twenty-four months after your effective date of coverage.

Long-term Disability Insurance

Monthly Benefit	60% of monthly earnings to a maximum benefit of $6,000, reduced by other income
Elimination Period	Benefits will begin after 180 days of disability
Benefit Duration	Your duration of benefits is based on your age when the disability occurs. Your LTD benefits are payable for the period during which you continue to meet the definition of disability up to the Social Security Normal Retirement Age. If your disability occurs on or after age 62, benefits would be paid for a reduced period of time.
Disability Definition	You are disabled when Unum determines that: • you are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury; and • you have a 20% or more loss in weekly earnings due to the same sickness or injury. • After benefits have been paid for 24 months, you are disabled when Unum determines that due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience. You must be under the regular care of a physician in order to be considered disabled.
Gainful Occupation	Gainful occupation means an occupation that is or can be expected to provide you with an income within 12 months of your return to work that exceeds: • 80% of your indexed monthly earnings, if you are working • 60% of your indexed monthly earnings, if you are not working
Pre-Existing Conditions	If you received treatment 3 months prior to your effective date under this plan and are disabled from that condition within the first 12 months, that disability will be excluded.
Rehabilitation and Return to Work Assistance	Unum has a vocational Rehabilitation and Return to Work Assistance program available to assist you in returning to work. We will make the final determination of your eligibility for participation in the program and will provide you with a written Rehabilitation and Return to Work Assistance plan developed specifically for you. This program may include, but is not limited to the following benefits: • coordination with your Employer to assist your return to work; • adaptive equipment or job accommodations to allow you to work; • vocational evaluation to determine how your disability may impact your employment options; • job placement services; • resume preparation; • job seeking skills training; or • education and retraining expenses for a new occupation. If you are participating in a Rehabilitation and Return to Work Assistance program, we will also pay an additional disability benefit of 10% of your gross disability payment to a maximum of $1,000 per month. In addition, we will make monthly payments to you for 3 months following the date your disability ends, if we determine you are no longer disabled while: • you are participating in a Rehabilitation and Return to Work Assistance program; and • you are not able to find employment.
Survivor Benefit	If you die after receiving benefits for 180 or more consecutive days, your eligible survivors will receive a lump sum benefit equal to three months of your gross disability payment.

This notice relates to the fixed indemnity coverage offered through Aflac

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.

Additional Voluntary Benefits

Aflac Group Accident Insurance

Introducing added protection for life's unexpected moments. If you're like most people, you don't budget for life's unexpected moments. But at some point, you may make an unexpected trip to your local emergency room. And that could add a set of unexpected bills into the mix. That's the benefit of the Aflac group Accident Advantage Plus plan.

In the event of a covered accident, the plan pays cash benefits fast to help with the costs associated with out-of-pocket expenses and bills—expenses major medical may not take care of, including:

- Ambulance rides.
- Wheelchairs, crutches, and other medical appliances.
- Emergency room visits.
- Surgery and anesthesia.
- Bandages, stitches, and casts.

Aflac Group Critical Illness Insurance

You can win the battle against a critical illness, but can you handle the added costs? A group critical illness plan helps prepare you for the added costs of battling a specific critical illness. The good news is that many people with a critical illness survive these life-threatening battles. Unfortunately, as the recovery process begins, people become aware of the medical bills that have piled up. Your recovery doesn't have to be spoiled by medical bills. With this plan, our goal is to help you and your family cope with and recover from the financial stress of surviving a critical illness.

Aflac Hospital Indemnity Insurance

The average cost of a hospital stay is $10,000-and the average length of a stay is 4.8 days. Hospital indemnity insurance can help reduce costs by paying you or a covered dependent a benefit to help cover your deductible, coinsurance and other out-of-pocket costs due to a covered sickness or injury related hospitalization.

Legal Shield Legal Plan

Imagine having access to top-rated legal professionals, without worrying about high hourly costs.

- Protect your family
- Save money and time
- Enjoy peace of mind… for pennies a day!

Preventive Law – Unlimited phone calls, letters and phone calls on your behalf, legal contract and document review, will preparation and annual updates, access to legal forms.
Trial Defense – Defense of civil actions, pre-trial and trial assistance, coverage increases each year for the first 5 years.
Family services, motor vehicle, IRS audit services, 25% member discount for services not covered on this plan.

This benefit summary was provided by Mesa County and Novo Benefits and is not responsible for any discrepancies.

Additional Voluntary Benefits (Continued)

LifeLock Identity Theft Protection Plan	Secure your privacy with complete detective and restorative identity protection around the clock. We watch over your personal and financial information on public and private databases, social media and the Internet. We also share proactive measures and educational tools so you can take steps to protect yourself. Our fraud specialists are a phone call away—24 hours a day, seven days a week—to help you every step of the way.

This benefit summary was provided by Mesa County and Novo Benefits and is not responsible for any discrepancies.

Retirement Benefits

Retirement Plan (Defined Contribution)

- Mesa County has a 401(a) retirement plan through Colorado County Officials and Employees Retirement Association (CCOERA). As a condition of employment at initial hire, an employee is required to contribute 3% of their gross base monthly salary which Mesa County matches at 100%.
- The employee becomes 100% vested after completion of the third year of service. Should an employee leave employment prior to completion of the third year of service, the match made by Mesa County is forfeited.

Retirement Plan (Deferred Compensation)

- The 457 plan is available at any time to employees as an additional option for retirement savings. Pre-tax contributions and after tax contributions (Roth IRA) are available as investment options.

This benefit summary is provided by Mesa County. Novo Benefits is not responsible for any discrepancies between this document and the contracts that govern each of your benefits .

IMPORTANT NOTICES

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage, or if the employer stops contributing towards your or your dependents' other coverage. However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). To be eligible for these Special Enrollment rights you must have completed a waiver when you were first eligible stating that you were declining because of other group health insurance coverage.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. In the case of marriage, eligible individuals must submit their enrollment forms prior to the Effective Dates of coverage in order for salary reductions to have preferred tax treatment from the date coverage begins.

Women's Health & Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, benefits under this Plan are provided for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). If you are receiving benefits in connection with a mastectomy, benefits are also provided for the following Covered Charges, as you determine appropriate with your attending Physician: 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; and Prostheses and treatment of physical complications of the mastectomy, including lymphedema. The amount you must pay for such Covered Charge (including Copayments and any Deductible) are the same as are required for any other Covered Charge. Limitations on benefits are the same as for any other Covered Charge.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices (the "Notice") describes the legal obligations of Mesa County Government and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, from which it is possible to individually identify you and that relates to:

(1) your past, present, or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present, or future payment for the provision of health care to you.

If you have any questions about this Notice or about our privacy practices, please contact Human Resources at 970-255-7145.

Effective Date

This Notice is effective September 23, 2013.

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices by internal company email.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if prior prescriptions contraindicate a pending prescription.

For Payment. We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations. We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. However, we will not use your genetic information for underwriting purposes.

Treatment Alternatives or Health-Related Benefits and Services. We may use and disclose your protected health information to send you information about treatment alternatives or other health-related benefits and services that might be of interest to you.

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use, and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to process your claims for Plan benefits or to provide support services, such as utilization management, pharmacy benefit management, or subrogation, but only after the Business Associate enters into a Business Associate contract with us.

As Required by Law. We will disclose your protected health information when required to do so by federal, state, or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors. For the purpose of administering the plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations
In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information without your specific authorization. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation. If you are an organ donor, we may release your protected health information after your death to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military. If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your protected health information for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your protected health information for public health activities. These activities generally include the following:
- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone involved in a legal dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.

Law Enforcement. We may disclose your protected health information if asked to do so by a law-enforcement official-
- in response to a court order, subpoena, warrant, summons, or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct; and
- about criminal conduct.

Coroners, Medical Examiners, and Funeral Directors. We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors, as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or are in the custody of a law-enforcement official, we may disclose your protected health information to the correctional institution or law-enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research. We may disclose your protected health information to researchers when:
(1) the individual identifiers have been removed; or
(2) when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures
The following is a description of disclosures of your protected health information we are required to make.
Government Audits. We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You. When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Other Disclosures
Personal Representatives. We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:
(1) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; or
(2) treating such person as your personal representative could endanger you; and
(3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members. With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations. Other uses or disclosures of your protected health information not described above will only be made with your written authorization. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your protected health information for marketing; and we will not sell your protected health information, unless you give us a written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Your Rights You have the following rights with respect to your protected health information:
Right to Inspect and Copy. You have the right to inspect and copy certain protected health information that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy.

To inspect and copy your protected health information, you must submit your request in writing to Human Resources. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to Human Resources.

Right to Amend. If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.
To request an amendment, your request must be made in writing and submitted to Nana Atencio at 544 Rood Avenue, Grand Junction, CO 81502. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.
- If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to Human Resources. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.
Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

We will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid in full by you or another person.

To request restrictions, you must make your request to Human Resources at 970-255-7145. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply-for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request to Human Resources at 970-255-7145. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to Be Notified of a Breach. You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.
To obtain a paper copy of this notice, contact Human Resources at 970-255-7145.

Complaints. If you believe that your privacy rights under this Notice have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact Human Resources at 970-255-7145 or 544 Rood Avenue, Grand Junction, CO 81502. All complaints must be submitted in writing. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

You may also file a written complaint directly with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Room 509F, Hubert H. Humphrey Building, Washington, D.C. 20201, or the appropriate Regional Office of the Office for Civil Rights. You may also call them at 1-877-696-6775; or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

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]

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.

[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.

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 Human Resources at (970) 255-7145.

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 Mesa County Government		4. Employer Identification Number (EIN) 84-6000783
5. Employer address 544 Rood Avenue		6. Employer phone number (970) 255-7145
7. City Grand Junction	8. State CO	9. ZIP code 81501
10. Who can we contact about employee health coverage at this job? Nina Atencio		
11. Phone number (if different from above)	12. Email address nina.atencio@mesacounty.us	

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

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

  ☐ All employees. Eligible employees are:

  ☐ **XX** Some employees. Eligible employees are:

  Full-time employee working 30 or more hours per week; part-time employee working 20 or more hours per week; temporary, non-seasonal employee working at least 30 hours per week; an individual elected to the office of the 21st Judicial District Attorney; or an individual who is a 21st Judicial Attorney elected official.

- With respect to dependents:

  ☐ **XX** We do offer coverage. Eligible dependents are:

  Legal Spouse; Common-Law spouse; partner to a civil union as recognized by law; dependent child under age 26; unmarried dependent child over the age of 26 if disabled and dependent upon parent subscriber.

  ☐ We do not offer coverage.

☐ **XX** 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.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. 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 July 31, 2024, 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)

MEDICARE PART D NOTICE

Important Notice from Mesa County Government 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 Mesa County Government 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. If neither you nor any of your dependents are eligible for or have Medicare, this notice does not apply to your or the dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede 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. Prime Therapeutics Management has determined that the prescription drug coverage offered by the Mesa County Government Employee Benefit Plan is on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current coverage, you and your dependents will be able to get this coverage back at the next annual open enrollment period.

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 Mesa County Government 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 Mesa County Government changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: October 15, 2024
Mesa County Government
Nana Atencio
544 Rood Avenue, Grand Junction, CO 81502
970-255-7145