San Isabel Electric

BENEFITS GUIDE

JANUARY 1, 2023 - DECEMBER 31, 2023

RETIREES

SAN ISABEL ELECTRIC

Welcome

Thank you for taking the time to learn more about the employee benefits available to you in 2023. San Isabel Electric knows the value of employee benefits and more importantly, maintaining your health and income should you become ill or injured. This benefit booklet offers an overview of the key features of the plans. If you have questions, please contact Human Resources. We thank you for contributing to our success!

Open Enrollment Key Points

It's Open Enrollment time, and that means this is your one opportunity to make your benefit choices for the calendar year, 2023. Outside of a qualifying life event, like marriage or the birth of a child, your benefit selections will remain in place through December 31, 2023. Also, it is important to know that life events only allow you to add or terminate coverage for you or your dependents. They never allow you to change medical insurance plans, if your employer offers a choice. If you do have a life change, please talk with your HR department to clear up any questions you have and execute the change within 30 days of the date of your qualifying event.

Dates

Open Enrollment will be held from November 14th through December 2nd. Look for further communication.

Who is Eligible?

Full-time employees (as defined by your employer) are eligible to join the group plans. Check with your HR representative to further clarify their full-time status rules.

Eligible dependents include:

- Your legally married spouse, domestic partner or common law partner
- Dependent children up to age 26 (adopted children and/or stepchildren)

Questions?

Please contact your HR representative for any questions related to open enrollment and benefits.

Alex Clough - Benefits Broker - Benefits questions, Enrollment questions, escalated claim questions - 719-545-4840 - aclough@benefitsbroker.com

OPEN ACCESS PLUS (OAP)

YourCignahealthplanthatletsyouchoosewhich doctors to see and when

- You have the option of choosing a primary care provider (PCP) to guide your care (it is recommended but not required)
- You can see a specialist without a referral
- Using doctors and health care facilities in the Cigna OAP network may keep your costs lower
- You can choose doctors or facilities not part of the Cigna OAP network, but your costs may be higher
- You have access to Cigna's national network of labs, x-ray and radiology centers – plus 75% potential savings though in-network labs
- Nationwide in-network coverage for emergency care
- Once you meet an annual limit on your payments – out-of-pocket maximum – your plan pays 100% of covered costs

Cigna®

Cigna Medical
Open Access Plus

Benefits	In-Network
Office Visit - General Practice	$20 copay
Specialist Visit	$20 copay
Virtual Medicine	$0 copay
Preventive Care	Plan pays 100%
Individual Deductible	$300 per Individual
Family Deductible	$600 per Family
Co-Insurance Percentage *(applied after deductible)*	Plan pays 90%
Individual Out-of-Pocket Max	$1,300 per Individual
Family Out-of-Pocket Max *(after which plan pays 100%)*	$2,600 per Family
Inpatient Hospital	Plan pays 90% after deductible
Outpatient Hospital	Plan pays 90% after deductible
Emergency Room	$50 copay then plan pays 90%
Urgent Care	$25 copay then plan pays 100%
Associated Lab Work	Plan pays 100%
MRI, CT, PET Scans	Plan pays 90% after deductible
Prescription Drug Copays Retail Mail Order	 $15 copay / $30 copay / $50 copay $38 copay / $75 copay / $125 copay

The table above is for illustrative purposes only. See your Cigna summary plan descriptions for a complete explanation of benefits and limitations.

Search for an in-network physician: https://hcpdirectory.cigna.com/web/public/consumer/directory/search?consumerCode=HDC001

Cigna Medical
HSA Open Access Plus

Benefits	In-Network
Office Visit - General Practice	Plan pays 90% after deductible
Specialist Visit	Plan pays 90% after deductible
Virtual Medicine	Average cost per visit $40-$60
Preventive Care	Plan pays 100%
Individual Deductible	$1,500 per Individual
Family Deductible - **Non Embedded*	$3,000 per Family
Co-Insurance Percentage *(applied after deductible)*	Plan pays 90% in-network
Individual Out-of-Pocket Max	$2,900 per Individual
Family Out-of-Pocket Max - **Non Embedded* *(after which plan pays 100%)*	$5,800 per Family
Inpatient Hospital	Plan pays 90% after deductible
Outpatient Hospital	Plan pays 90% after deductible
Emergency Room	Plan pays 90% after deductible
Urgent Care	Plan pays 90% after deductible
Associated Lab Work	Plan pays 90% after deductible
MRI, CT, PET Scans	Plan pays 90% after deductible
Prescription Drug Copays Retail Mail Order	 Plan pays 90% after deductible Plan pays 90% after deductible

The table above is for illustrative purposes only. See your Cigna summary plan descriptions for a complete explanation of benefits and limitations.

***Non Embedded:** Each member of the family uses and pays for health care services and the amount they pay out-of-pocket for those services is credited toward the family's deductible. After the combined total of those expenses reaches the Non Embedded deductible, the health plan begins to pay health care expenses for the entire family. Ex] One family member satisfies a $300 individual deductible, another family member has $100 in expenses, another has $200 in expenses, the family Non Embedded deductible is then met and after-deductible benefits kick in.

Search for an in-network physician: https://hcpdirectory.cigna.com/web/public/consumer/directory/search?consumerCode=HDC001

CHOOSE A PLAN WITH CONFIDENCE

Cigna One Guide service can help.

Whether you're a current Cigna customer or considering Cigna for the first time, we understand how confusing and overwhelming it can be to review your health plan options. And we want to help by providing the resources you need to make a decision with confidence. That's why **Cigna One Guide® is available to you now**.

Call a Cigna One Guide representative during preenrollment to get personalized, useful guidance.

Your personal guide will help you:

- Easily understand the basics of health coverage
- Identify the types of health plans available to you that best meet the needs of you and your family
- Check if your doctors are in-network to help you avoid unnecessary costs
- Get answers on any other questions you may have about the plans or provider networks available to you

The best part is, during the enrollment period, your personal guide is just a call away.*

Don't wait until the last minute to enroll.

Call **888.806.5094** to speak with a Cigna One Guide representative today.*

After enrollment, the support continues for Cigna customers.

Your Cigna One Guide representative will be there to guide you through the complexities of the health care system, and help you avoid costly missteps. Our goal is a simpler health care journey for you and your family.

Cigna One Guide service provides personalized assistance to help you:

- Resolve health care issues
- Save time and money
- Get the most out of your plan
- Find the right hospitals, dentists and other health care providers in your plan's network
- Get cost estimates and avoid surprise expenses
- Understand your bills

Access Cigna One Guide – after enrollment – in the way that's most convenient for you:

App | Chat | Phone

Together, all the way.®

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Offered by: Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company or their affiliates.

* During enrollment, personal guides available Monday through Friday, 8:00 am–9:00 pm EST. Once your coverage begins, call the number on your ID card to speak with a personal guide. Additional customer service representatives are available 24/7.

Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. For costs and complete details of coverage, see your plan documents.

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MAKE MYCIGNA YOUR PERSONAL HEALTH PLACE

Enjoy a simple way to personalize, organize and access your important plan information.

Register on myCigna.com

Once you do, you can log in anytime, just about anywhere to:*

- **Manage** and track claims
- **View** ID card information
- **Find** in-network doctors and compare cost and quality ratings
- **Review** your coverage
- **Track** your account balances and deductibles
- **Order** your Cigna Home Delivery Pharmacy℠ prescriptions online and view order history

Register today! Visit **myCigna.com** or download the myCigna® App.**

GET IT ON Google play

Download on the App Store

amazon Available on kindle

Go to myCigna.com to go paperless!
After you register, you can set up paperless communications. Just log in to myCigna.com and select "Go Paperless".

* Actual myCigna features may vary by plan and individual security profile.

** The downloading and use of the myCigna App is subject to the terms and conditions of the App and the online stores from which it is downloaded. Standard mobile phone carrier and data usage charges apply.

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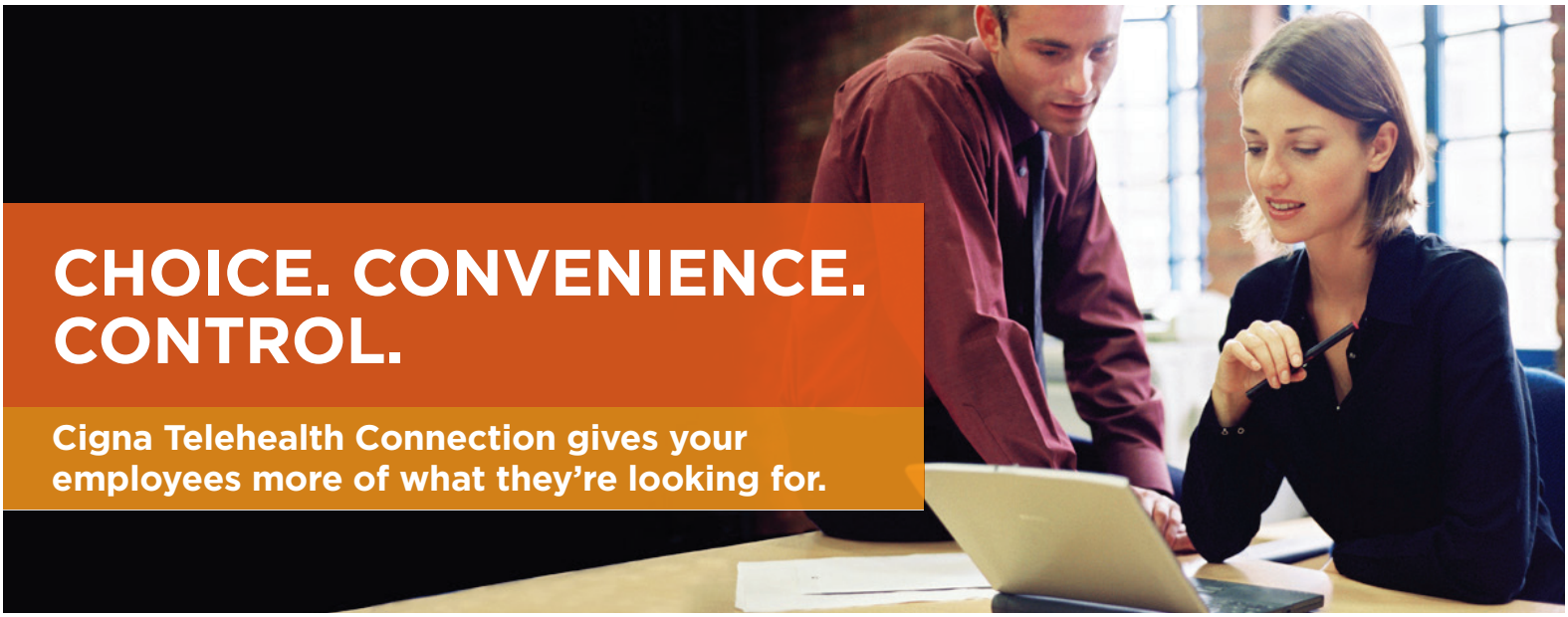


CHOICE. CONVENIENCE. CONTROL.

Cigna Telehealth Connection gives your employees more of what they're looking for.

Good news. Now, most Cigna medical plans provide covered employees with access to two telehealth services – American Well (Amwell) and MDLIVE. We call it Cigna Telehealth Connection, telehealth services designed to offer employees greater control when they need to see a doctor.

With Cigna Telehealth Connection, employees can get the care they need – including most prescriptions (when appropriate) – for a wide range of minor conditions. They can connect with a board-certified doctor when, where and how it works best for them – via video or phone – without having to leave home or work.

Choose when: Day or night, weekdays, weekends and holidays.

Choose where: Home, work or on the go.

Choose how: Phone or video chat.

Choose who: Amwell or MDLIVE doctors.

Amwell and MDLIVE televisits can be a cost-effective alternative to a convenience care clinic or urgent care center, and cost less than going to the emergency room. Costs are the same or less than a visit with a primary care provider. Giving employees an easy-to-use and cost-effective alternative to care can help reduce costs and nonurgent ER visits.

We encourage you to have your employees register for one or both services, so they're ready when, and if, they need care.

Your employees can seamlessly access both Amwell and MDLIVE with a single sign-on through myCigna.com.

Tell your employees about Cigna Telehealth Connection, so they'll be ready whenever they need these services.

They can also access Cigna Telehealth Connection:

Directly with Amwell:*

- **Visit AmwellforCigna.com**
- **Call 855.667.9722**

amwell for Cigna®

Directly with MDLIVE:*

- **Visit MDLIVEforCigna.com**
- **Call 888.726.3171**

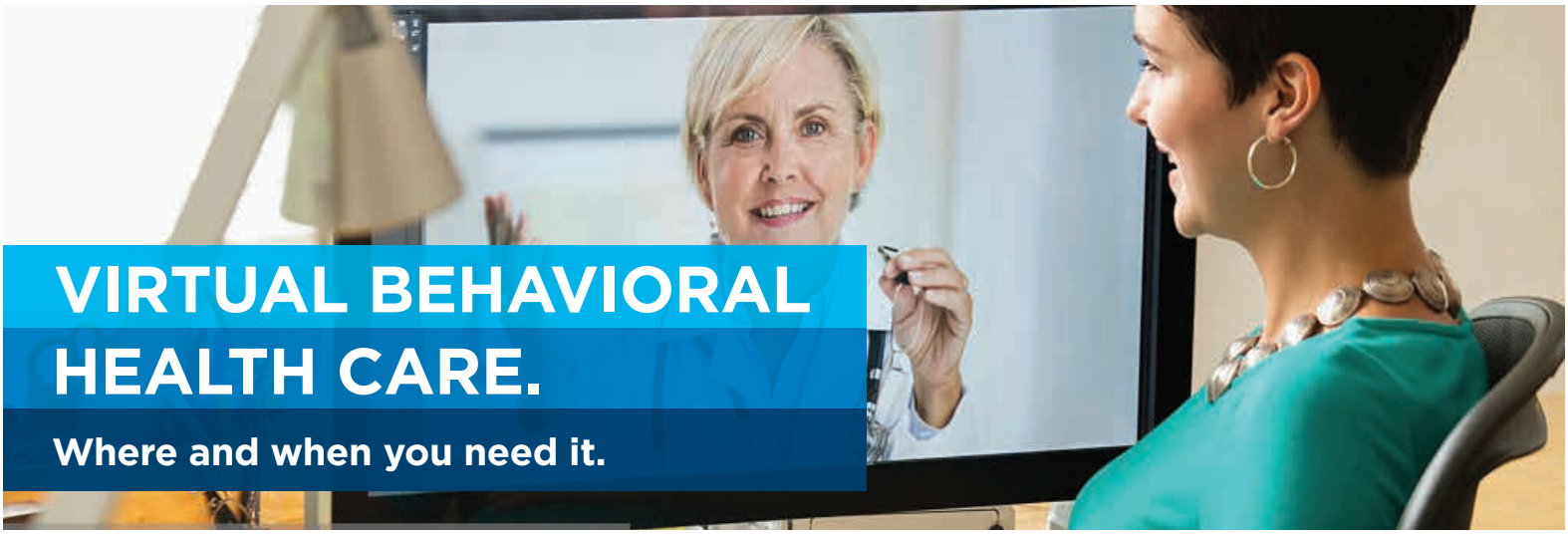
MDLIVE® for Cigna®

Your employees may also download the MyCigna® App and will be able to access both Telehealth providers through the app.

Together, all the way.®

Cigna®

Offered by: Cigna Health and Life Insurance Company or its affiliates.



VIRTUAL BEHAVIORAL HEALTH CARE.

Where and when you need it.

Get personal and confidential video-based mental health and/or substance use care through your employer's health plan.

Dealing with mental health or substance use issues can be a challenge. But with Cigna, you don't have to go it alone. And you don't have to go far for the care you need.

Access behavioral health outpatient care with a Cigna Behavioral Health network provider.* Get help when, where and how it works best for you. Get quality care with video-based services, in a way that may be more convenient than visiting an office.

Q. What kind of device can I use?

A. Use your smartphone, tablet or computer for online video conferencing.

Q. Will the provider need to see me in person first?

A. You can schedule video-based appointments based on your provider's availability. Depending on your reason for treatment, your provider might require that you been seen face-to-face first.

Q. How much will it cost?

A. Access this care as part of your behavioral health benefits under your employer's health plan. Your out-of-pocket cost is the same as a behavioral health outpatient office visit.**

Q. Does this include telephone sessions?

A. Video sessions do not require a prior authorization because they are seen as a substitute for face-to face therapy. However, if phone session is needed, an authorization is required.

The benefits of receiving care through video-based services.

- Convenience
- Choice
- Privacy
- May reduce or eliminate costs for things like childcare or travel associated with face-to-face visits

Connect with care today.

See how easy it is to use Behavioral Telehealth services. Watch the Behavioral Telehealth Customer Journey video on **Cigna.com** under, Find a Doctor and Additional Directories.

See your plan documents for a complete list of covered behavioral health services.

It's easy to find a Behaviorial Telehealth provider.
(See the details on the other side)

Together, all the way.®

Cigna®

WHEN LEAVING THE OFFICE IS EASIER SAID THAN DONE.

Employees can get care whenever and wherever with medical and behavioral/mental health virtual care.

Your employees' lives are demanding. It's hard for them to find time to take care of themselves as it is, never mind when they're not feeling well. That's why health plans through Cigna include access to medical and behavioral/mental health virtual care.

Whether they've got meetings all day, or they just don't have the time or energy to go anywhere but home after work, employees can:

- Access care from just about anywhere via video or phone.
- Get medical virtual care 24/7/365 – even on weekends and holidays.
- Schedule a behavioral/mental health virtual care appointment online in minutes.
- Access board-certified doctors and pediatricians, as well as licensed counselors and psychiatrists.
- Have a prescription sent directly to a local pharmacy, if appropriate.

Convenient, not costly.

Medical virtual care for minor conditions costs less than ER or urgent care center visits, and maybe even less than an in-office primary care provider visit.

Behavioral/mental health virtual care costs the same as an in-office behavioral/mental health visit.

Together, all the way.®

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Medical virtual care

Board-certified doctors and pediatricians can diagnose, treat and prescribe most medications for minor medical conditions, such as:

- Acne
- Allergies
- Asthma
- Bronchitis
- Cold and flu
- Constipation
- Diarrhea
- Earaches
- Fever
- Headaches
- Infections
- Insect bites
- Joint aches
- Nausea
- Pink eye
- Rashes
- Respiratory infections
- Shingles
- Sinus infections
- Skin infections
- Sore throats
- Urinary tract infections

Behavioral/mental health virtual care

Licensed counselors and psychiatrists can diagnose, treat and prescribe most medications for nonemergency behavioral conditions, such as:

- Addictions
- Bipolar disorders
- Child/adolescent issues
- Depression
- Eating disorders
- Grief/loss
- Life changes
- Men's issues
- Panic disorders
- Parenting issues
- Postpartum depression
- Relationship and marriage issues
- Stress
- Trauma/PTSD
- Women's issues

Virtual care options.

Cigna partners with two national virtual care providers: Amwell™ for medical virtual care and MDLIVE® for medical and behavioral/mental health virtual care.* Both are quality options, so your employees can feel confident in their care, no matter which one they choose.

Encourage your employees to access virtual care through myCigna.com whenever and wherever they need it.

Cigna Behavioral Health also provides access to behavioral virtual counseling through Cigna's network of providers.

Virtual medical care is available from both Amwell and MDLIVE. Behavioral/mental health virtual care is available from MDLIVE.

* Cigna provides access to virtual care through national telehealth providers as part of your plan. Providers are solely responsible for any treatment provided to their patients. Video chat may not be available in all areas or with all providers. This service is separate from your health plan's network and may not be available in all areas or under all plan types. A Primary Care Provider referral is not required for this service.

In general, to be covered by your plan, services must be medically necessary and used for the diagnosis or treatment of a covered condition. Not all prescription drugs are covered. Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. See your plan materials for costs and details of coverage, including other telehealth/telemedicine benefits that may be available under your specific health plan.

PATIENT ASSURANCE PROGRAM DRUG LIST

Medications that cost $25 or less for a 30-day supply.

The Patient Assurance Program℠ helps make medications more affordable – making it easier to stay on track with the medications that keep you healthy.

About this drug list.

This document shows the medications your plan makes available at $25 or less for a 30-day supply (and $75 or less for a 90-day supply) as of July 1, 2020.[1,2]

All of these medications are approved by the U.S. Food and Drug Administration (FDA). Medications are listed alphabetically by the condition they treat. **This list is updated often so it's important to know that this is not a complete list of the medications your plan covers.** Also, your specific plan may not cover all of the medications in this document. Log in to the **myCigna®** App or website and use Price a Medication to see how much your medication costs.[3]

Not taking a medication on this list?

Call your doctor's office and ask if one of these medications will work for you. If your doctor agrees, ask the office to send a new prescription electronically to your pharmacy.

Patient Assurance Program Drug List

Diabetes

Farxiga
Glyxambi
Jardiance
Synjardy
Synjardy XR
Trulicity
Xigduo XR

Diabetes – Insulins

Basaglar
Humalog
Humalog Mix
Humulin
Levemir

Together, all the way.®

Cigna®

Offered by Cigna Health and Life Insurance Company or its affiliates.

TheCignaDiabetesPreventionProgramincollaborationwithOmada

Digital support focused on reducing the risk of type 2 diabetes and heart disease through healthy weight loss, nutrition, sleep and exercise.

omada® for Cigna®

Personalized tools at no extra cost to you*

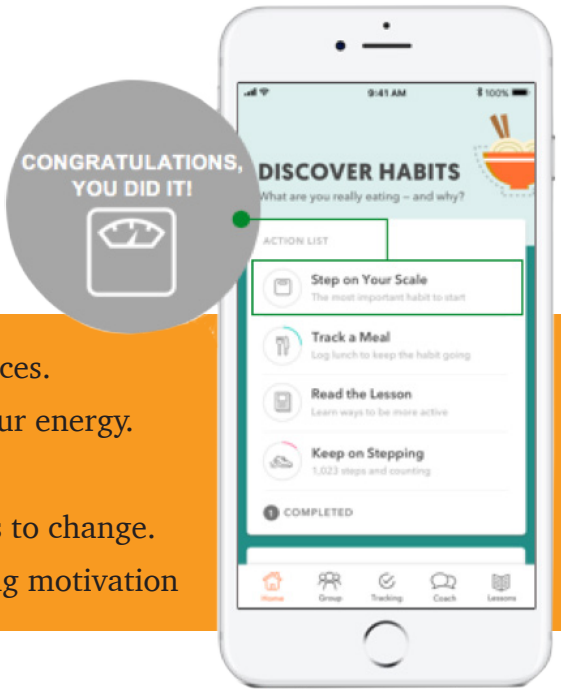
Digitally enabled scale

Omada professional health coach

Social support group

Interactive online training lessons on healthy eating, physical activity, sleep and stress

Cigna



- Eat healthier – Learn the fundamentals of making smart food choices.
- Increase activity – Discover easy ways to move more and boost your energy.
- Sleep better and stress less
- Overcome challenges – Gain skills that allow you to break barriers to change.
- Strengthen habits – Zero in on what works for you, and find lasting motivation

PREVENTIVE CARE GUIDELINES

Preventive care guidelines for children and adults.

Under the Affordable Care Act (CA), you can get certain preventive health care services, covered at 100 percent, without any cost to you. Just obtain your preventive care from a health plan network provider. Diagnostic (non-preventive) services are also covered, but you may have to pay a copayment, coinsurance or deductible.

Preventive care guidelines for children:

- Age-appropriate well-child examination
- Anemia screening
- Cholesterol screening for children 24 months and older
- Metabolic screening panel for newborns
- Age-appropriate immunizations
- Vision screening by primary care physician
- Oral health risk assessment by primary care physician
- Fluoride application
- Hearing screening by primary care physician
- Autism and Developmental screening for children under age 3
- Counseling on the harmful effects of smoking and illicit use of drugs
- Counseling for children on promoting improvements in weight
- Screening certain children at high risk for sexually transmitted diseases, lead, depression and tuberculosis

Preventive care guidelines for adults:

- Wellness Examinations
- Well-Women Visits—including routine prenatal visits
- Abdominal Aortic Aneurysm Screening—for age 65-75 years who have ever smoked
- Alcohol Screening and Brief Counseling—screening during wellness examination
- Bacteriuria Screening—during pregnancy
- Blood Pressure Screening—at each wellness examination
- Breastfeeding Primary Care Interventions, Counseling, Support and Supplies—during pregnancy and after birth. Includes personal use of an electric breast pump.
- Cervical Cancer Screening (Pap Smear)—women age 21-65 years old
- Chemoprevention of Breast Cancer, Counseling—for women at high risk of breast cancer
- Chlamydia and Gonorrhea Infection Screening—for sexually active women age 24 and younger
- Cholesterol Screening—for age 40-75 years
- Colorectal Cancer Screening—for age 50-75 years
- Contraceptive Methods—FDA-approved methods of contraception for women
- Depression Screening—for all adults, in a primary care setting
- Diabetes Screening—for age 40-70 who are overweight or obese or for those of any age with a history of gestational diabetes
- Falls Prevention Counseling—during wellness examination, for community-dwelling older adults
- Genetic Counseling and Evaluation for BRCA Testing & BRCA Lab—lab testing requires prior authorization
- Gestational Diabetes Mellitus Screening—during pregnancy
- Healthy Diet Behavioral Counseling—for persons with cardiovascular disease risk factors
- Hepatitis B Virus Infection Screening—for persons at high risk
- Hepatitis C Virus Infection Screening—one-time screening for adults born between 1945-1965 or high risk
- Human Immunodeficiency Virus (HIV) Screening—for all adults
- Human Papillomavirus DNA Testing—for women age 30-65
- Immunizations—FDA approved and have explicit ACIP recommendations for routine use
- Intimate Partner Violence, Interpersonal and Domestic Violence, Counseling and Screening—during wellness examination
- Latent Tuberculosis Infection Screening—for persons at increased risk
- Lung Cancer Screening with Low-Dose CT Scan—for age 55-80 years with at least a 30 pack-year history (prior authorization)
- Mammography Screening
- Obesity Screening and Counseling—at each wellness examination
- Osteoporosis Screening—women age 65 and older, and younger women at increased risk
- Rh Incompatibility Screening—during pregnancy
- Sexually Transmitted Infections, Behavioral Counseling to Prevent—behavioral counseling for adults who are sexually active or otherwise at increased risk, in primary care setting
- Skin Cancer, Behavioral Counseling to Prevent—at each wellness examination, for young adults up to age 24 years
- Syphilis Screening—for adults at increased risk
- Tobacco Cessation, Screening, Behavioral Counseling—screening, and behavioral counseling for adults who smoke

Cigna
Dental

Dental		
Key Points Summary	**Cigna DPPO**	**Out-of-Network**
Calendar Year Deductible	$50 per individual / max $150 per family	$50 per individual / max $150 per family
Deductible Applies to	Type III & IV	Type III & IV
Dental Calendar Year Maximum	$2,000	$2,000
Orthodontia Lifetime Maximum	$2,000 for children only	$2,000 for children only
Key Points Summary	**In-Network**	**Out-of-Network**
Type I - Preventive & Diagnostic	100%	100%
Type II - Basic Services	100%	100%
Type III - Major Services	80%	80%
Type IV - Orthodontic Services	50%, No Ortho Deductible	50%, No Ortho Deductible

San Isabel Electric offers you a dental plan through Cigna. The table above shows the plan details. Please refer to your plan descriptions for a full list of covered services and limitations.

Features of the PDP Dental Plan

- Use any dentist (keep in mind, your greatest savings will be with dentists participating in the Cigna PPO network)
- Preventive cleanings are covered at 100% and may be scheduled every six months

Search for a Dentist Online

You can search for a dentist online at https://hcpdirectory.cigna.com/web/public/consumer/directory/search?consumer-Code=HDC001 Select the "continue as guest" option as members are not active at this time. If prompted, click the employer/ school button. When prompted to select a plan, the options will drop down for medical and dental. Select the network and search.

Provider networks change, so it is always a good idea to call and confirm your dentist's participation in the network.

VSP
Vision

Vision		
Key Points Summary	**In-Network**	**Out-of-Network**
Eye Exam	$10 copay	$45 allowance
Prescription Glasses: Lenses	$10 copay	$30 - $100 allowance
Prescription Glasses: Frames	$150 retail allowance	$70 allowance
Contact Lenses	$150 allowance	$105 allowance
Benefit Frequency	**In-Network**	**Out-of-Network**
Eye Exam	Every 12 months	Every 12 months
Prescription Glasses: Lenses	Every 12 months	Every 12 months
Prescription Glasses: Frames	Every 12 months	Every 12 months
Contact Lenses	Every 12 months in lieu of glasses	Every 12 months in lieu of glasses
Network Discounts	**In-Network**	**Out-of-Network**
Laser Vision Correction	15% Savings	N/A
Prescription Glasses	20% Savings	N/A
Contact Lenses	15% off evaluation	N/A

Need to find an eye doctor in the VSP Network?

For a complete list of providers near you, use the VSP Provider Locator on https://www.vsp.com/eye-doctor and search by location. You may also call VSP at 1-800-877-7195

Using your vision benefits

You will not receive a VSP ID card. When you schedule your appointment, simply tell them that you have VSP for your vision benefits. That's all you need to do!

HEALTH SAVINGS ACCOUNT

A Health Savings Account (HSA) is an account funded to help you save for future medical expenses. There are certain advantages to putting money into these accounts, including favorable tax treatment.

Who Can Have an HSA?

Any adult can have an HSA if you:

- Have coverage under an HSA-qualified, high deductible health plan
- Are not enrolled in Medicare
- Cannot be claimed as a dependent on someone else's tax return

Contributions to your HSA can be made by you, your employer, or both. However, the total contributions are limited annually. If you make a contribution, you can deduct the contribution (even if you do not itemize deductions) when completing your federal income tax return. Alternatively, some employers will allow you to make your HSA contributions as tax-free salary reductions.

Contributions to the account must stop once you are enrolled in Medicare. However, you can still use your HSA funds to pay for medical expenses tax-free.

In general, the deductible must apply to all medical expenses (including prescriptions) covered by the plan. However, the plan can pay for preventive care services on a first-dollar basis. Preventive care can include routine prenatal and well-childcare, child and adult immunizations, annual physicals, mammograms and more.

Annual HSA Contribution Limits

You can make a contribution to your HSA each year that you are eligible.

- Single coverage: $3,850
- Family coverage: $7,750

Individuals ages 55 and older can also make additional "catch-up" contributions for up to $1,000 annually.

Determining Your Contribution

Your eligibility to contribute to an HSA is determined by the effective date of your HDHP coverage. Individuals who are eligible to contribute to an HSA in the last month of the taxable year are allowed to contribute an amount equal to an annual HSA contribution amount provided they remained covered by the HSA for at least the 12-month period following that year. Contributions can be made as late as April 15th of the following year.

Using Your HSA

You can use money in your HSA to pay for any qualified health-care expense permitted under federal tax law. This includes most medical care services, dental and vision care. Money contributed to an HSA is portable. If you leave employment, the account is yours to keep.

FLEXIBLE SPENDING ACCOUNT

A Flexible Spending Account (FSA) is an account you put money into that you use to pay for certain out-of-pocket health care costs. You don't pay taxes on this money. This means, you'll save an amount equal to the taxes you would have paid on the money you set aside.

Program Basics

- FSAs are limited to $3,050 per year per employee. If you're married, your spouse can put up to $3,050 in an FSA with their employer, too.
- You can use funds in your FSA to pay for certain medical and dental expenses for you, your spouse if you're married, and your dependents.
    - You can spend FSA funds to pay deductibles and copayments, but not for insurance premiums.
    - You can spend FSA funds on prescription medications, as well as, over-the-counter medicines with a doctor's prescription. Reimbursements for insulin are allowed without a prescription.
    - FSAs may also be used to cover costs of medical equipment like crutches, supplies like bandages, and diagnostic devices like blood sugar test kids.

FSA Limits, grace periods, and carry-overs

- San Isabel Electric provides a "grace period" of up to 2 $^{1/2}$ extra months to use the money in your FSA.

At the end of the year or grace period, you lose any money left over in your FSA. So it's important to plan carefully and not put more money in your FSA than you think you'll spend within a year on things like copayments, coinsurance, drugs, and other allowed health care costs.ing that year. Contributions can be made as late as April 15th of the following year.

	HEALTHCARE FSA	DEPENDENT CARE FSA
ANNUAL MAXIMUM CONTRIBUTION AMOUNT	$3,050	$5,000
COVERED EXPENSES INCLUDE:	• Health related expenses like deductibles, copays & coinsurance • Elective surgeries like Lasik • Orthodontia expenses • Eyeglasses, contacts & other vision supplies	• Out-of-pocket care expenses for your children under age 13 or mentally or physically disabled dependents of any age • Daycare or in-home care not provided by a dependent claimed on your tax return • Day camp expenses • Preschool expenses
QUALIFYING EXPENSES MUST BE:	• Incurred between your plan start date & December 31 of the plan year or during the 2$^{1/2}$ month extension after end of year to incur and submit expenses • Medically necessary • Not reimbursable under any other plan • Considered tax-deductible by the IRS	• Incurred between your plan year start date & December 31 of the plan year • Incurred by you • Incurred while you (and your spouse/domestic partner) are at work • You and your spouse/domestic partner must work or attend school full-time to be eligible

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Special Enrollment

Loss of Other Coverage

If you are declining coverage 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 and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward you 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).

Marriage, Birth, or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

CHIP

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage but need assistance in paying their health premiums. If you or your dependents are already enrolled in Medicaid or CHIP, you can 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, you can contact your State Medicaid or CHIP office at www.insurekidsnow.gov or dial toll free 1-877-KIDSNOW to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan -- as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

Break Time For Nursing Mothers Under The FLSA

Time and Location of Breaks

Employers are required to provide a reasonable amount of break time to express milk as frequently as needed by the nursing mother. The frequency of breaks needed to express milk as well as the duration of each break will likely vary.

A bathroom, even if private, is not a permissible location under the Act. The location provided must be functional as a space for expressing breast milk. If the space is not dedicated to the nursing mother's use, it must be available when needed in order to meet the statutory requirement. A space temporarily available when needed by the nursing mother is sufficient, provided that the space is shielded from view, and free from any intrusion from co-workers and the public.

Coverage and Compensation

Only employees who are not exempt from section 7, which includes the FLSA's overtime pay requirements, are entitled to breaks to express milk. While employers are not required under the FLSA to provide breaks to nursing mothers who are exempt from the requirements of Section 7, they may be obligated to provide such breaks under State Law.

Employers with fewer than 50 employees are not subject to the FLSA break time requirement if compliance with the provision would impose an undue hardship by causing the employer significant difficulty or expense when considered in relation to the size, financial resources, nature, or structure of the employer's business. All employees who work for the covered employer, regardless of work site, are counted when determining whether this exemption may apply.

Employers are not required under the FLSA to compensate nursing mothers for breaks taken for the purpose of expressing milk. However, where employers already provide compensated breaks, an employee who uses that break time to express milk must be compensated in the same way that other employees are compensated for break time. In addition, the FLSA's general requirement that the employee must be completely relieved from duty or else the time must be compensated as work time applies.

Newborns' & Mothers' Health Protection Act of 1996

The group health coverage provided by Public Sector Health Care Group complies with the Newborns' and Mothers' Health Protection Act of 1996.

Under this law group health plans and health insurance insurers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother of newborn to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother and her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 ours (or 96 hours).

Women's Health & Cancer Rights Act

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a covered mastectomy is also entitled to the following benefits:

- All stages of reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications of the mastectomy, including lymphedemas

Health plans must provide coverage of mastectomy-related benefits in a manner determined in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan. Therefore, deductibles and coinsurance apply.

Model General Notice of COBRA Continuation Coverage Rights

What is COBRA Continuation Coverage?

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

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

IMPORTANT INFORMATION ABOUT YOUR INSURANCE RIGHTS

- Your hours of employment are reduced
- Your employment ends of any reason other than your gross misconduct

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

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

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

- The parent-employee dies
- The parent-employee's hours of employment are reduced
- The parent-employee become entitled to Medicare benefits (Part A, Part B, or both)
- The parents become divorced or legally separated
- The child stops being eligible for coverage under the plan as a "dependent child"

When is COBRA Continuation Available?

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment, reduction of hours of employment, death of the employee or the employee's becoming entitled to Medicare Benefits (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

COBRA continuation coverage is a temporary continuation of coverage. The continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries under the Plan, including special enrollment rights.

How long will continuation coverage last?

In the case of a loss of coverage due to the end of employment or reduction in hours of employment, coverage generally may be continued for up to a total of 18 months. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation or a dependent child's losing eligibility as a dependent child, COBRA continued coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee last until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to qualified beneficiaries.

Can you extend the length of an 18 period of continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify Human Resources of a disability or second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability: An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the plan of that fact within 30 days after SSA's determination.

Second Qualifying Event: An 18-month extension will be available to spouses and depended children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both, or a dependent child's ceasing to be eligible for coverage as a depended under the Plan). These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event has not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

Loss of Eligibility for COBRA Continuation Coverage

Continuation coverage will be terminated before the end of the maximum period if any of the following occur:

- Any required premium is not paid in full on time
- A qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary (note: there are limitatio on plans' imposing a pre-existing condition exclusion and such exclusion with become prohibited beginning in 2014 under the Affordable Care Act)
- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage
- The employer ceases to provide any group health plan for its employees

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant of beneficiary not receiving continuation coverage (such as fraud).

How do you elect COBRA Continuation Coverage?

To elect continuation coverage, you must complete an election form and return it to Human Resources. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. The employee can elect continuation coverage on behalf of a qualified spouse. A parent, the employee or his or her spouse may elect to continue coverage on behalf of any dependent children. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

When key parts of the health care law take effect, you'll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

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Important Notice About Your Prescription Drug Coverage & Medicare

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- 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.
- Public Sector Health Care Group has determined the United medical plans, 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.

HIPAA Basics - Your Right to Privacy

In April 2003, the final regulations that place restrictions on how personally identifiable health information (PHI) may be used and disclosed by certain organizations became effective.

These regulations (the Privacy Rules) implement the privacy requirements contained within the Administrative Simplification subtitle of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). While some states have laws that protect health information, the HIPAA Privacy Rules establish a uniform, minimum level of privacy protections for all health information. In summary, the HIPAA Privacy Rules:

- Set limits on how health information may be used and disclosed
- Require that individuals be told how their health information will be used and disclosed
- Provide individuals with a right to access, amend or copy their medical records
- Give individuals a right to receive an accounting of disclosures, to request special restrictions, and to receive confidential communications
- Impose fines where the requirements contained within the regulations are not met

Patient Protection Model

Health insurance companies generally require the designation of a primary care provider for services and claims to be covered. You have the right to designate any primary care provider who participates in your selected plan's network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider.

If you do not choose a primary care physician upon enrolling in a health insurance plan, the insurance company may randomly designate one for you. Some insurance plans will not cover any claims or services if you see a primary care physician or specialist that is not assigned to you and the correct referral process followed.

For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your group administrator.

If you're nearing retirement age, or are over 65 and still working, you may have questions about Medicare.

What is Medicare?

Medicare is health insurance for people are age 65 or older, under 65 with certain disabilities, or any age with End-stage Renal Disease (permanent kidney failure).

Types of Medicare

There are four types of Medicare. Medicare Part A helps cover impatient care in hospitals, skilled nursing facilities, and hospice and home health care. Generally, there is no monthly premium if you qualify and paid Medicare taxes while working.

Medicare Part B helps cover medical services like doctors' services, outpatient care and other medically necessary services that Part A doesn't cover. You need to enroll in Medicare Part B and pay a monthly premium determined by your income, along with a deductible.

Many people also purchase a supplemental insurance policy, such as a Medigap plan, to handle any Part A and B coverage gaps.

Medicare Advantage Plans, also known as Medicare Part C, are combination plans managed by private insurance companies approved by Medicare. They typically are a combination of Part A, Part B and sometimes Part D coverage, but must cover medically necessary services. These plans have discretion to assign their own copays, deductibles and coinsurance.

Medicare Part D is prescription drug coverage and is available to everyone with Medicare. It is a separate plan provided by private Medicare-approved companies, and you must pay a monthly premium.

Getting Started

Medicare sends you a questionnaire about three months before you're entitled to Medicare coverage. Your answers to these questions, including whether you have group health insurance through an employer or family member, help Medicare set up your file and make sure your claims are paid correctly.

Coordination of Coverage

If you have Medicare and another type of insurance, the question of who should pay or who should pay first can be tricky. For example, generally a group health plan would pay before Medicare, but there are several exceptions. Visit www.medicare.gov for additional information.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when can't control who is involved in your care - like when have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

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You are protected from balance billing for:

Emergency Services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for the post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles, that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact:
Department of Health and Human Services at 1-800-985-3059.

Visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.