National Jewish Health®

Breathing Science is Life.®

BENEFIT ENROLLMENT GUIDE

2024

▸ Get Started

Be Ready for Enrollment

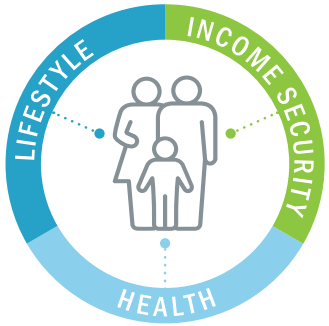
National Jewish Health provides a full range of benefits that address your needs now and in the future.

For Your Health

For Your Wealth

For Your Lifestyle

Open Enrollment Begins November 6, 2023



Now Is the Time to Focus on You.

National Jewish Health is committed to providing you with a comprehensive benefits package that provides you and your family with choice and flexibility.

Your benefits are a crucial part of your compensation package, and we encourage you to make the most of them by taking advantage of this Open Enrollment period.

What's New/What's Changing?

- Medical insurance plans will not be changing and National Jewish Health will continue to pay 95% of the Surefit $1000 plan premiums. Health insurance costs continue to increase due to inflation and increased drug costs. Though the institution will bear most of the increased expense, employees will see increases from $6.00 - $23.50 per paycheck depending on the medical plan they choose.
- All benefit eligible employees will now be provided with short-term disability coverage at no cost. Additional buy-up coverage may be purchased during enrollment.
- New York Life will be administering Life, STD, LTD and AD&D plans.
- Lower Rates for Supplemental Medical Insurance which includes Critical Illness, Accident Insurance and Hospital Indemnity.
- IdentityTheft Insurance provided by ID Watchdog will now be a voluntary benefit and paid fully by employees. Please review if this coverage is a fit for you or your

Take Action!

All employees are strongly encouraged to complete an Open Enrollment session to review, elect, or waive coverages for 2024. All elections made during Open Enrollment will become effective January 1, 2024.

Many of your 2023 elections will carry over. Please carefully review your elections. FSA participants are required to reelect their annual enrollment each year. Don't miss out!

THE IMPORTANCE OF ENROLLMENT

Enrollment Information

Do I Need to Enroll?

Before deciding whether you need to enroll in National Jewish Health's health and group benefits, take a close look at all the benefits and options we offer you. You may experience changes from year to year, and there likely will be changes to what you pay for coverage each year. It's a good idea to make sure your benefits still fit you — and that you're not paying for more coverage than you need.

To elect 2024 benefits, you must enroll during Open Enrollment! If you don't enroll, you will miss your opportunity to have benefits for the 2024 plan year.

When Can I Enroll?

As a benefits-eligible employee, you have the opportunity to enroll in or make changes to your benefit plans during our annual benefits enrollment period. Open Enrollment is November 6, 2023 to November 17, 2023 with your benefit choices being effective January 1, 2024. Our benefits plan year is January 1, 2024 to December 31, 2024.

If you are enrolling as a new employee, your coverage will begin the first of the month following your date of hire. New hires will have 31 days to complete their enrollment.

Who We Cover

Employees:

You are eligible to participate in the National Jewish Health benefit plans if you are a regular, full-time or part-time employee working 20 hours or more per week. Under the Affordable Care Act, employees deemed eligible for benefits due to working 30 hours per week or greater during The National Jewish Health standard measurement period are notified by Human Resources of their eligibility.

Dependents:

- Your legal spouse or domestic partner
- Your children up to age 26 (children may include biological, adopted, step-children, and children for whom you have legal guardianship)
- Your children over age 26 who are not able to support themselves due to a physical or mental disability

You'll be required to provide proof of eligibility for any new dependent you want to add to your coverage. Supporting documentation must be submitted by the end of your enrollment period.

How to Enroll

We offer different ways to enroll to give you the level of support that is best for you.

With a Benefits Counselor: Make an appointment at www.benefitsgo.com/nationaljewishhealthwebscheduler. Benefit Counselors are available Monday-Friday, 7 a.m.-7 p.m. (MT).

Online — From Work: To enroll in your benefits, please log in to Oz. Log in using your NJH network credentials. Select Employee Self Service from the top menu bar, then select the Benefit Details tile and Benefits Enrollment.

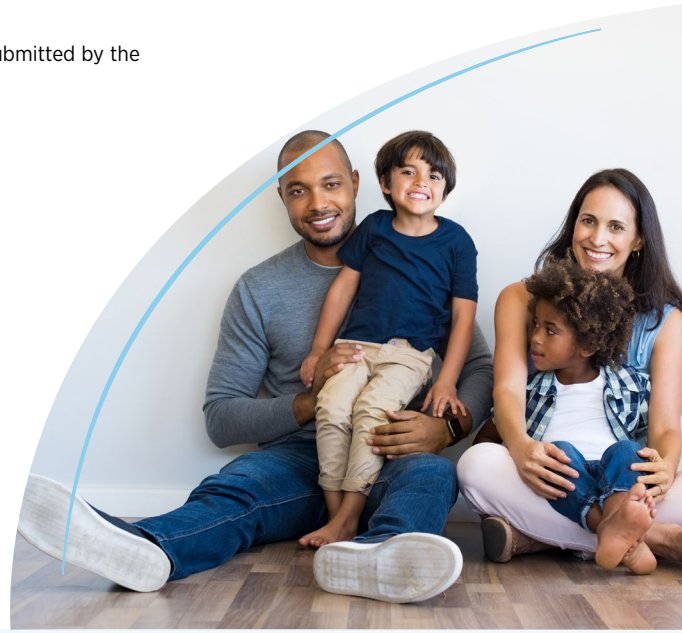
Online — From Home: Visit https://pshcm.njhealth.org/ps/signon.html to register or log in and follow the prompts to complete your self-service enrollment.

In Person-By Appointment: Please contact BenefitsDept@njhealth.org to schedule.

Additional Information

Spouse/Domestic Partner Coverage

If your spouse/domestic partner has access to other health coverage, such as through their employer, and that coverage meets the minimum requirements of the Affordable Care Act, you will be able to cover them under your National Jewish Health plans, but will be charged a spousal surcharge. The surcharge of $125 per pay check will apply. During enrollment, employees will be asked if their spouse has coverage through their own employer.



Medical Benefits

Each person's health care needs are different. That's why our medical plan offers multiple options so that you can choose the coverage level best-suited to your personal situation. NJH will now be offering 3 networks with Cigna! Choose the best network that fits you and your family's needs from the Surefit, LocalPlus, and Open Access networks.

Did You Know?

With an NJH medical plan, you will have access to Cigna One Guide. Cigna One Guide helps you navigate health care to make smart health care choices and achieve better outcomes.

BENEFIT	SUREFIT $1,000		LOCALPLUS $1,750 HDHP		OPEN ACCESS $2,000 HDHP	
NETWORK	SUREFIT		LOCAL ACCESS		OPEN ACCESS IN-NETWORK	OPEN ACCESS OUT-OF-NETWORK
Calendar Year Deductible (Individual/Family)	$1,000/$2,000		$1,750/$3,500		$2,000/$4,000	$4,000/$8,000
Out-of-Pocket Maximum (Individual/Family)	$3,000/$6,000		$3,500/$7,000		$4,000/$8,000	$8,000/$16,000
Physician Services						
Primary Care Office Visit	$50 copay		Deductible then 20%		Deductible then 20%	Deductible then 50%
Specialist Office Visit	$75 copay		Deductible then 20%		Deductible then 20%	Deductible then 50%
Hospital Services						
Inpatient & Outpatient	Deductible then 20%		Deductible then 20%		Deductible then 20%	Deductible then 50%
Emergency Room	Deductible then 20%		Deductible then 20%		Deductible then 20%	Deductible then 50%
Urgent Care	$100 copay		Deductible then 20%		Deductible then 20%	Deductible then 50%
MRI, CT, PET	Deductible then 20%		Deductible then 20%		Deductible then 20%	Deductible then 50%
PRESCRIPTION DRUG BENEFITS						
RX - Generic	$10 copay		Deductible then $10		Deductible then $10	Deductible then 50%
RX - Preferred	$50 copay		Deductible then $50		Deductible then $50	Deductible then 50%
RX - Non-Preferred	20% up to a maximum of $120		Deductible then 20% up to a maximum of $120		Deductible then 20% up to a maximum of $120	Deductible then 50%
PER PAYCHECK DEDUCTIONS	FULL-TIME	PART-TIME	FULL-TIME	PART-TIME	FULL-TIME	PART-TIME
Employee Only	$15.00	$120.32	$61.88	$167.87	$122.79	$197.41
Employee + Spouse/Domestic Partner	$37.68	$236.12	$221.90	$395.41	$308.47	$434.95
Employee + Child(ren)	$33.26	$224.48	$151.10	$334.20	$238.02	$373.08
Family	$50.96	$320.32	$265.00	$511.53	$398.40	$576.24

NOTE: Deductibles, copays, and coinsurance accumulate toward the out-of-pocket maximums. Usual, customary, and reasonable charges apply for all out-of-network benefits.

Cigna Motivate Me

Get motivated with Cigna's MotivateMe incentive program which combines rewards, technology and goal setting. This program is available for National Jewish Health employees enrolled in a Cigna medical plan. **Employees can earn up to $200 through Motivate Me!** Rewards are paid out on a Visa debit card and can be applied to any purchase of your choosing.

Earn rewards for:

- Preventative Care visits, either medical or dental
- Cigna Telephonic Coaching
- Participating in the Omada program
- Refilling your prescription through Express Scripts

Review and redeem the incentives at **www.myCigna.com**.

Health Savings Account (HSA)

Save for future medical costs and reduce your tax bill with this special savings account available to high-deductible health plan (HDHP) participants.

Out-of-pocket medical expenses can add up quickly. Over time, health care likely will be your largest household expense. A health savings account (HSA) allows you to build up protection for future health care expenses.

You can contribute money to your HSA and use it any time for qualified health care expenses. Whatever you don't use rolls over for future years and earns interest. Better yet, HSAs provide tax advantages.

Keys to Growing Your Health Savings Account (HSA):

- Try not to use your HSA for routine expenses. If you can pay out-of-pocket, leave your HSA funds alone so that they can grow for when you need them in the future.
- Consider electing supplemental medical benefits to cover big ticket expenses from unexpected serious illnesses or injuries and to ensure they don't wipe away the money in your HSA.
- Monitor your fund's growth. Like a 401(k), your HSA funds earn interest through investments. Make sure your money is growing at an acceptable and safe pace.

HOW MUCH CAN YOU CONTRIBUTE?	ANNUAL IRS CONTRIBUTION LIMIT	YOUR MAXIMUM CONTRIBUTION AMOUNT
Individual Coverage	$4,150*	$4,150
Family Coverage	$8,300*	$8,300

NOTE: If an individual reaches age 55 by the end of the calendar year, they can contribute an additional $1,000.

Health Reimbursement Arrangement (HRA)

The Health Reimbursement Arrangement (HRA) is used to offset the deductible and other eligible out-of-pocket medical expenses. It is only available to employees who enroll in the Surefit $1,000 plan.

Here's How it Works:

- National Jewish Health will contribute $300 for your HRA account when enrolling in the Surefit $1,000 plan.
- The above funds are based on an annual allocation but will be prorated by month for new hires and status changes that enroll during the plan year. Those enrolled on January 1st will have the full annual amount available for reimbursement.
- Employees will have a debit card to use for charges, or they can submit a claim to Rocky Mountain Reserve for reimbursement.
- The HRA funds will be shared among family members for those with dependent coverage (i.e. Employee + Spouse, Employee + Child(ren), Employee + Family).
- The HRA is administered by Rocky Mountain Reserve.
- You can access your account information, including your HRA balance and the status of claims, any time through Rocky Mountain Reserve at **www.rockymountainreserve.com**. Employee ID: RMRNJH.

Dental Benefits

Your dental health is an important part of your overall wellness. You may choose from the following dental insurance plan(s) through Cigna.

BENEFIT	DHMO	LOW PPO		HIGH PPO	
		IN-NETWORK	OUT-OF-NETWORK		
Annual/Calendar Year Maximum	Unlimited	$1,500	$1,500	$2,000	
Annual/Calendar Year Deductible (Individual/Family)	None	$50/$150	$100/$300	$50/$150	
Preventive Services	100% covered	100% covered	Covered person pays 30% after deductible	100% covered	
Basic Services	Flat fee	Covered person pays 20% after deductible	Covered person pays 70% after deductible	Covered person pays 20% after deductible	
Major Services	Flat fee	Covered person pays 50% after deductible	Covered person pays 70% after deductible	Covered person pays 50% after deductible	
EMPLOYEE PAYS PER PAYCHECK					
	FULL-TIME	PART-TIME	FULL-TIME	PART-TIME	FULL-TIME	PART-TIME
Employee Only	$2.50	$4.50	$12.32	$14.36	$20.09	$22.13
Employee + Spouse/Domestic Partner	$4.00	$7.90	$24.95	$28.92	$40.47	$44.44
Employee + Child(ren)	$5.00	$9.82	$36.88	$41.80	$58.62	$63.54
Family	$7.50	$14.99	$50.81	$58.54	$81.87	$89.51

What Does Preventive Dental Care Typically Cover?

Preventive care can save you money later on procedures that are more urgent, complex, and costly.

Routine dental checkups and cleanings should be scheduled every six months. Your dentist may recommend more frequent or fewer visits, depending on your dental health history.

Professional fluoride treatments can be a key defense against cavities. Professional fluoride treatments have significantly more fluoride than tap water or toothpaste and take only minutes to apply.

Dental sealants go a step beyond fluoride by providing a thin, coating to the surface of your teeth. Most dental plans cover sealants as preventive care for children under 18 on their first and second molars.

X-ray images of your mouth may be taken to better evaluate your oral health. These images provide a more detailed look inside your teeth and gums.

Vision Benefits

National Jewish Health offers vision coverage through VSP. Benefits include eye exams, affordable options for prescription glasses or contacts, and discounts for laser vision correction.

VSP Vision Savings Pass

All benefit eligible employees who do not elect vision benefits through the traditional VSP Insurance will have access to VSP Vision Savings Pass. Discounted exams, lenses, frames, sunglasses, contact lenses and laser vision correction are available by seeing a VSP provider. There is no cost for the discount program.

BENEFIT	VSP COVERAGE
Exam *Focuses on your eyes and overall wellness*	$15.00
Lenses *Single vision, lined bifocal, and lined trifocal lenses*	Single vision, lined bifocal, and lined trifocal lenses
Frames	▸ $155 allowance for a wide selection of frames ▸ $175 allowance for featured frame brands ▸ 20% savings on the amount over your allowance ▸ $80 Costco® frame allowance
Contact Lenses Instead of Glasses	
Conventional/Disposable	▸ Copay - up to $60 ▸ $155 allowance for contacts; copay does not apply ▸ Contact lens exam (fitting and evaluation)
Extra Savings	
Glasses & Sunglasses	▸ Extra $20 to spend on featured frame brands. Go to **vsp.com/specialoffers** for details ▸ 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam
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
BI-WEEKLY PAYCHECK DEDUCTIONS	
Employee Only	$4.12
Employee + Spouse/Domestic Partner	$7.31
Employee + Child(ren)	$7.51
Family	$12.00

NOTE: ID Card not required for vision services.

Flexible Spending Accounts (FSAs)

Reduce your tax bill while putting aside money for health care and dependent care needs.

Flexible spending accounts (FSAs) allow you to put aside money for important expenses and help you reduce your income taxes at the same time. National Jewish Health offers three types of accounts – a health care FSA, a limited purpose FSA, and a dependent care FSA.

Deductibles, copays, prescription drugs, medical equipment, etc.*

Works with HSA eligible medical plans to cover dental and vision expenses

Babysitters, day care, day camp, home nursing care, etc.*

How Flexible Spending Accounts (FSAs) Work

1. Each year during the Open Enrollment period, you decide how much to set aside for health care and dependent care expenses.
2. Your contributions are deducted from your paycheck on a before-tax basis in equal installments throughout the calendar year.
3. You can use your FSA debit card to pay for eligible expenses at the point of sale, or you can pay out-of-pocket and submit a claim form for reimbursement.

Please note that these accounts are separate — you may choose to participate in one, both, or neither. You cannot use money from the health care FSA to cover expenses eligible under the dependent care FSA or vice versa.

PLAN	ANNUAL MAXIMUM CONTRIBUTION	EXAMPLES OF COVERED EXPENSES
Health Care Flexible Spending Account	$3,200	Copays, deductibles, orthodontia, over-the-counter medications, etc.*
Limited Purpose Flexible Spending Account	$3,200	Eligible dental and vision expenses
Dependent Care Flexible Spending Account	$5,000 per household	Day care, nursery school, elder care expenses, etc.*

*See IRS Publications 502 and 503 for a complete list of covered expenses.
NOTE: Employees enrolled in the Dependent Care Flexible Spending Account will receive an employer match up to $1,000 annually.

Use It or Lose It!

Be sure to calculate your FSA contributions carefully. These funds do not roll over from year-to-year, and you must actively enroll on a yearly basis. You are not automatically re-enrolled. If you have any money left in your Health Care FSA at the end of the plan year, you may carry over up to $640 for use in the next plan year.

Disability Insurance

Your ability to bring home a paycheck is a valuable asset. We help you protect it.

If an injury or illness kept you out of work and prevented you from earning a paycheck, how would you cover your bills and other household expenses? Disability insurance provides income protection, paying a portion of your salary that you can use to offset out-of-pocket expenses and make up for lost wages.

Did You Know?

It's estimated that 1 in 4 20-year-olds will experience a disability for 90 days or more before they reach age 67.

Social Security Administration, Disability Insurance, Facts 2021

NEW Employer-Paid Short-Term Disability (STD)

NEW for 2024! National Jewish Health will be paying for your short-term disability plan! Short-Term Disability Insurance replaces a portion of your income if an injury or illness forces you out of work for an extended period of time. National Jewish provides basic short-term disability coverage at no cost to you and enrollment is automatic. If you are out of work for two weeks (14-day waiting period) and are declared disabled, you will receive 60% of your base earnings, up to a weekly maximum of $3,000.

Buy-Up Short-Term Disability

Depending on your household budget, you may need additional disability coverage. To help you increase your disability protection, National Jewish Health has negotiated a special rate that allows eligible employees to purchase additional short-term coverage at an affordable cost.

This plan does not cover pre-existing conditions. With the Buy-Up plan, if you are not able to work after 14 consecutive days of disability due to an eligible injury or illness, this benefit pays 66.67% of your weekly base earnings, up to a weekly maximum of $3,500 for up to 26 weeks.

- The plan costs $0.12 monthly per $10 of weekly covered benefit.

Long-Term Disability (LTD)

Long-term disability (LTD) insurance helps protect your finances when your disability continues beyond the period covered by the STD plan. This benefit is also fully paid for by the company and enrollment is automatic. The benefit is equal to 60% of your base monthly earnings to a maximum of $6,000 per month ($14,000 for Faculty and Executives). Benefits begin after six months.

Buy-Up Long Term Disability

You may purchase additional LTD coverage through the Buy-Up LTD plan with after-tax dollars. This option pays a benefit equal to 66.67% of your base salary to a monthly maximum of $6,670 ($15,556 for Faculty and Executives).

- Buy-Up LTD: $0.22 per $100 monthly

Long-Term Care (LTC)

Long-term care (LTC) insurance provides nursing home, home-health, and personal or adult day care for individuals with chronic or disabling conditions that require constant supervision.

National Jewish Health provides you with a basic level of LTC coverage. You have an option to increase your coverage levels for yourself or your spouse/domestic partner at any time, subject to underwriting approval by Unum.

Visit **http://unuminfo.com/nationaljewish** for more information.

Life and Accidental Death and Dismemberment (AD&D) Insurance

Always be there financially for your loved ones.

Your family depends on your income for a comfortable lifestyle and for the resources necessary to make their dreams a reality. Life insurance ensures your family's future is financially secure if you're no longer there to provide for them.

National Jewish Health provides basic term life insurance and offers additional options to give you the ability to assemble a complete life insurance portfolio.

Basic Term Life and AD&D Insurance

National Jewish Health provides eligible employees with basic term life and accidental death and dismemberment (AD&D) coverage at no cost to you and enrollment is automatic.

- **Basic Term Life:** The benefit is equal to one times your base annual earnings to a maximum of $500,000.
- **AD&D:** If you are seriously injured or lose your life in an accident, you will be eligible for coverage in the amount of one times your annual salary (up to $500,000).

Supplemental Life

You may also choose to purchase supplemental life insurance coverage in addition to the company-paid benefit. You pay the total cost of this benefit through convenient payroll deductions.

- **Voluntary Employee:** One to six times your salary up to $1,000,000. Guaranteed issue is the lesser of 3 times annual compensation or $500,000.*
- **Voluntary Spouse/Domestic Partner**: Coverage available at $25,000, $50,000, $75,000 or $100,000. Guaranteed issue applies to $25,000 and $50,000.*
- **Voluntary Child(ren):** Units of $5,000 to $20,000 (Coverage for children between birth and 6 months of age is limited to $5,000). Guaranteed issue applies to all coverage levels.*

*Available during initial enrollment, no EOI.

Supplemental AD&D Insurance

You may choose to purchase supplemental AD&D insurance coverage in addition to the company-paid benefit. You pay the total cost of this benefit through convenient payroll deductions.

- **Voluntary Employee:** One to six times your salary up to $1,000,000.
- **Voluntary Spouse/Domestic Partner**: 50% of employee AD&D or 60% of employee AD&D if no children. Maximum benefit amount is $600,000.
- **Voluntary Child(ren):** 10% of employee AD&D or 15% of employee AD&D if no spouse/domestic partner. Maximum benefit amount is $35,000.

NOTE: When you or your spouse are age 65 or older, your Life Insurance Benefit will reduce to the percentage shown below:

- 65% of the Life Insurance Benefit at age 65.
- 50% of the Life Insurance Benefit at age 70.

LIFE INSURANCE PLAN COMPARISON CHART	
BASIC TERM LIFE	SUPPLEMENTAL LIFE
The premiums are fully company paid.	The premiums increase as you age.
This plan replaces your income so that your family can cover items like mortgage, tuition, and household expenses.	This plan replaces your income so that your family can cover items like mortgage, tuition, and household expenses.
Coverage ends when you leave the company.	You may have the option to change to an individual policy that you can continue.

SUPPLEMENTAL LIFE RATES PER $1,000 OF COVERAGE		
AGE	EMPLOYEE & SPOUSE	CHILD(REN)
<20	$0.05	$0.25
20-24	$0.05	
25-29	$0.06	
30-34	$0.08	
35-39	$0.09	
40-44	$0.13	
45-49	$0.22	
50-54	$0.36	
55-59	$0.53	
60-64	$0.67	
65-69	$1.27	
70+	$2.17	

SUPPLEMENTAL AD&D RATES PER $1,000 OF COVERAGE	
Employee	$0.02
Family	$0.04

Supplemental Medical Benefits

Did You Know?

Americans spend an average of $5,000 a year on out-of-pocket health care costs.

Bureau of Labor Statistics Consumer Expenditures Survey 2020

Medical insurance does not prevent all of the financial strain of a major illness or injury. Many families don't have enough in their savings to cover the deductible and coinsurance of a major medical event. Supplemental medical benefits can help cover this out-of-pocket financial exposure for a reasonable cost.

The benefits are paid directly to you, allowing you to use the funds however you choose. You receive the full benefit even if you have other insurance. National Jewish Health offers critical illness insurance, accident insurance, and hospital indemnity insurance.*

Critical Illness Insurance

New Lower Rates!

Group voluntary critical illness coverage from Cigna provides a lump-sum benefit to assist with the out-of-pocket expenses associated with certain medical conditions covered by the plan. For example, cancer, heart attack, stroke, blindness, and end-stage kidney failure. Spouse coverage can only be purchased if employee has purchased coverage. Children are automatically covered for 50% of coverage. Coverage now available up to $40,000!

Plan Features

- You do not have to be terminally ill to receive benefits.
- Coverage options are available for your spouse/domestic partner and children as riders to your coverage. Rates for additional family coverage are available during enrollment.
- Coverage is portable — you can take your policy with you if you change jobs or retire.

Health Screening Benefit

The critical illness plan provides a $50 benefit per covered person per calendar year if you or your covered dependents complete a covered health screening test such as a physical exam, total cholesterol blood test, mammogram, lipid panel, and more.

The cost of the benefit will vary depending upon factors such as your age, whether you use tobacco, and the dependent coverage you choose.

*The policies/certificates of coverage have exclusions and limitations which may affect any benefits payable. The policies/certificates of coverage or their provisions, as well as covered illnesses, may vary or be unavailable in some states for supplemental medical benefits.

**The coverage pays 25% of the face amount of the policy once per lifetime for coronary bypass surgery.

NON-TOBACCO	EMPLOYEE SEMI-MONTHLY RATES
Age 18	$2.21
Age 25	$2.35
Age 30	$3.09
Age 35	$4.20
Age 40	$5.18
Age 45	$7.10
Age 50	$9.43
Age 55	$12.61
Age 60	$15.61
Age 65	$19.54
Age 70	$28.18
Age 75	$35.22
Age 80	$47.87
Age 85+	$70.59

TOBACCO	EMPLOYEE SEMI-MONTHLY RATES
Age 18	$2.54
Age 25	$2.91
Age 30	$4.18
Age 35	$6.53
Age 40	$8.61
Age 45	$12.67
Age 50	$17.23
Age 55	$22.69
Age 60	$27.27
Age 65	$32.95
Age 70	$44.67
Age 75	$53.48
Age 80	$69.24
Age 85+	$84.95

IMPORTANT NOTE: Rates are determined based on Employee's Age and will increase when you attain a new age bracket.

Supplemental Medical Benefits

Accident Insurance

New Lower Rates!

Group voluntary accident coverage from Cigna provides a benefit when a covered person suffers covered injuries or undergoes a broad range of medical treatments or care resulting from an accident. Please see the flyer on the Spyderweb for more detailed plan information.

The benefit amount is calculated based on the type of injury, its severity, and the medical services required in treatment and recovery. The plan covers a wide variety of injuries and accident-related expenses, including:

- Injury treatment (fractures, dislocations, concussions, burns, lacerations, etc.)
- Hospitalization
- Physical therapy
- Emergency room treatment
- Transportation

Health Screening Benefit

Both the accident and hospital indemnity insurance plans provide a $50 benefit per covered person per calendar year if you or your covered dependents complete a covered health screening test such as a physical exam, total cholesterol blood test, mammogram, lipid panel, and more.

Plan Features

- **Guaranteed Acceptance:** There are no health questions or physical exams required to enroll.
- **Family Coverage:** You can elect to cover your spouse/domestic partner and children.
- **24/7 Coverage**: Benefits are paid for accidents that happen on and off the job.
- **Portable Coverage:** You can take your policy with you if you change jobs or retire.

TIER LEVEL	SEMI-MONTHLY RATES
Employee	$5.30
EE + Spouse	$9.40
EE + Child(ren)	$10.86
Family	$14.97

NOTE: The policy/certificate of coverage or its provisions may vary or be unavailable in some states. The policy/certificate of coverage has exclusions and limitations which may affect any benefits payable.

Hospital Indemnity Insurance

New Lower Rates!

Receive payments to help cover the cost of a hospital stay.

If you are admitted into a hospital, it doesn't take long for the out-of-pocket costs to add up. Hospital indemnity insurance from Cigna pays benefits directly to you if you are admitted into a hospital for care or childbirth. Benefits are paid even if you have other coverage.

You receive a benefit as soon as you are admitted and then an additional benefit based on the number of days you are confined to the hospital. The benefit increases if you are admitted and confined to an intensive care unit or inpatient rehabilitation.

NOTE: The policy/certificate of coverage or its provisions may vary or be unavailable in some states. The policy/certificate of coverage has exclusions and limitations, which may affect any benefits payable. The benefits explained in the example above are for illustrative purposes only. Please see your summary plan description (SPD) for complete details.

Plan Features

- **Guaranteed Acceptance:** There are no health questions or physical exams required to enroll.
- **Family Coverage:** You can elect to cover your spouse/domestic partner and children.
- **Payroll Deduction:** Premiums are paid through convenient payroll deductions.
- **Portable Coverage:** You can take your policy with you if you change jobs or retire.

TIER LEVEL	SEMI-MONTHLY RATES
Employee	$12.09
EE + Spouse	$23.40
EE + Child(ren)	$15.98
Family	$27.29

Additional Benefits

We offer a variety of additional benefits that give you options beyond health care and income protection.

Did You Know?

A child's Social Security number gives ID thieves a fraudulent "clean slate." Monitor you child's credit report as often as your own.

Identity Theft Insurance

Digital thieves constantly discover new ways to extract your personal information, open credit accounts in your name, sell your sensitive data on the dark web, and take over your financial accounts.

National Jewish Health has partnered with ID Watchdog to offer Identity Monitoring, Identity Theft Detection, and Resolution Services.

Protection Services Include:

- Credit reports and monitoring
- Court records monitoring
- Bank account takeover monitoring
- Sex offender monitoring
- Criminal bookings monitoring
- Credit application monitoring
- Real time authorization notifications
- Change of address monitoring Child Social Security number monitoring
- Full service identity restoration services
- Social Security number trace
- Unemployment Claims Fraud Watch

ID Watchdog is employee paid and is covered at $4.05 per employee and $7.10 for family members per pay period.

Legal Insurance

The LegalEase plan provides access to a network of participating attorneys for help with a wide range of legal matters, such as:

- Court appearances
- Document review and preparation
- Debt collection defense
- Will preparation
- Family law
- Real estate matters

The LegalEase Insurance plan is $8.47 per pay-period.

For more information visit **https://www.legaleaseplan.com/nationaljewish** or call **1-800-248-9000**.

Auto/Home Insurance

This voluntary program is offered as a payroll deduction and convenience to employees.

Depending on your individual circumstances, automobile and homeowners insurance may be discounted up to 10%. You are eligible to enroll in auto and home insurance at any time throughout the year. You can request a free quote from Farmers Auto & Home by visiting the NJH Benefits Spyderweb page.

Pet Insurance

Get coverage for every member of the family. With MetLife pet insurance, you'll have peace of mind knowing you can get help with some of your pet's medical bills, including treatments, surgeries, lab fees, X-rays, prescriptions, and more.

To enroll visit **www.metlife.com/getpetquote** or call **1-800-GET-MET8**.

Employee Discounts

National Jewish Health partners with many local companies, organizations and restaurants for discounted services. Please check the Benefits Spyderweb page for the most current partnerships.

Omada

National Jewish Health is now offering Omada to qualified Cigna medical plan members. The program offers a digital lifestyle change program that can help you lose weight, feel fantastic, and develop long-term healthy habits. For more information and to determine if you qualify, just take Omada's one-minute health screening questionnaire at **https://go.omadahealth.com/njhealth**.

Additional Benefits

SupportLinc Employee Assistance Program (EAP)

Balancing the demands of work, family, and personal needs can be challenging, especially during uncertain times. National Jewish Health knows how important it is to have support when you need it most. Our employee assistance program (EAP) with SupportLinc is available at no cost to you and your family members and provides confidential counseling and resources to help you with concerns such as:

- Anxiety and depression
- Grief and loss
- Substance abuse
- Financial and legal concerns
- Relationship and family matters
- Parenting
- Work-related issues
- Child and elder care

Plan Features

- Provided at no cost to you and your household members
- Includes up to five counseling sessions
- Includes mobile features such as Virtual Support Connect and texting options
- Confidential services provided by licensed professionals
- Available 24/7/365

To access the EAP, call **1-888-881-5462** or visit **www.supportlinc.com**, Username: njh.

403(b) Retirement Plan

National Jewish Health provides a 403(b) Retirement Savings plan to help you secure your financial future and makes it convenient to save through payroll deductions.

After two years of service, National Jewish Health will begin making contributions to your account whether you contribute your own money or not. If you do not make an investment election, these contributions will be invested in a default fund selected by National Jewish Health. You're 100% vested in your own contributions immediately and in the company's contributions when they are made. You can enroll at any time during the year. Employees may choose to invest their contributions with Fidelity or TIAA. For more information, visit the NJH Spyderweb.

Faculty/Executives

NJH contributes 6% of earnings up to the Social Security wage base, then 11% of earnings up to the IRS compensation limit.

Staff

NJH contributes 5% of earnings up to the Social Security wage base, then 10% of earnings up to the IRS compensation limit.

457 Plan

Eligible employees who earn a minimum of the Social Security Wage Base are able to participate in this plan. In addition to participating fully in the 403(b) plan, the 457 plan allows eligible employees to defer additional contributions on a pre-tax basis.

Tuition Reimbursement

After 6 months of service, benefit eligible employees are able to apply for tuition reimbursement up to $5,250 annually. Please review the policy for plan information.

Get More Information

BENEFIT	GROUP	WHO TO CALL	WEBSITE	PHONE NUMBER
Medical & Prescription Drug				
Pre-Enrollment	3339271	Cigna Medical Plans - Cigna One Guide (Pre-enrollment)	www.Cigna.com	1-888-806-5042
Post-Enrollment	3339271	Cigna Medical Plans - Cigna One Guide (Post-enrollment)	www.myCigna.com	1-800-244-6224
Dental	3339271	Cigna Dental	www.Cigna.com	1-800-244-6224
Vision	12065169	Vision Service Plan	www.vsp.com	1-800-877-7195
Health Reimbursement Account, Flexible Spending Accounts, & Health Savings Account		Rocky Mountain Reserve HRA, FSA, & HSA	www.rockymountainreserve.com Employer ID: RMRNJH	1-888-722-1223 Fax: 1-866-557-0109
Basic Life & Accidental Death		New York Life Life, AD&D	https://www.newyorklife.com/	1-800-362-4462
Short-Term Disability & Long-Term Disability		New York Life Short-Term Disability & Long-Term Disability	https://www.newyorklife.com/	1-800-238-2125
Long-Term Care	553798	Unum Long-Term Care	https://services.unum.com/SelfReg/SelfReg_Claimant.aspx	1-800-331-1538
Accident, Critical Illness, & Hospital Indemnity		Cigna Accident, Critical Illness, & Hospital Indemnity	www.supphealthclaims.com supphealthclaims@cigna.com	1-800-754-3207
ID Theft Protection	2539	ID Watchdog	www.idwatchdog.com	1-866-513-1518
Legal Services	1000447	LegalEase Legal Plan	https://www.legaleaseplan.com/nationaljewish	1-800-248-9000
Auto & Home Insurance		Farmers Auto & Home	NJH Benefits Spyderweb	
Pet Insurance		MetLife Pet Insurance	www.metlife.com/getpetquote	1-800-GET-MET8
Employee Assistance Program		SupportLinc Employee Assistance Program	www.supportlinc.com Username: njh	1-888-881-5462
Retirement 403(b) Savings Plan				
Fidelity Investments	56826	Fidelity Investments	www.fidelity.com	1-800-343-0860
TIAA	407042	TIAA	www.tiaa.org/njh	1-800-842-2776

ABOUT THIS GUIDE: This guide highlights all employee benefits. Official plan and insurance documents govern your rights and benefits under each plan. For more details about your benefits, including covered expenses, exclusions, and limitations, please refer to the individual summary plan description (SPD), plan document, or certificate of coverage for each plan. If any discrepancy exists between this guide and the official documents, the official documents will prevail.

Updated: February 2024

Important Notices

About This Guide

This guide highlights your benefits. Official plan and insurance documents govern your rights and benefits under each plan. For more details about your benefits, including covered expenses, exclusions, and limitations, please refer to the individual summary plan descriptions (SPDs), plan document, or certificate of coverage for each plan. If any discrepancy exists between this guide and the official documents, the official documents will prevail. National Jewish Health reserves the right to make changes at any time to the benefits, costs, and other provisions relative to benefits.

Reminder of Availability of Privacy Notice

This is to remind plan participants and beneficiaries of the National Jewish Health Health and Welfare Plan (the "Plan") that the Plan has issued a Health Plan Privacy Notice that describes how the Plan uses and discloses protected health information (PHI). You can obtain a copy of the National Jewish Health Health and Welfare Plan Privacy Notice upon your written request to the Human Resources Department, at the following address:

National Jewish Health, Human Resources
1400 Jackson Street G113
Denver, CO 80206

If you have any questions, please contact the National Jewish Health Human Resources Office at **1-303-398-1035.**

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator **1-800-244-6224**.

Newborns' and Mothers' Health Protection Act Disclosure

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

USERRA

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted and you will continue to pay the same amount as if you were not absent. If the absence is for more than 31 days and not more than 24 months, you may continue to maintain your coverage under the Plan by paying up to 102% of the full amount of premiums. You and your dependents may also have the opportunity to elect COBRA coverage. Contact Human Resources at **1-303-398-1035** for more information.

Also, if you elect not to continue your health plan coverage during your military service, you have the right to be reinstated in the Plan upon your return to work, generally without any waiting periods or pre-existing condition exclusions, except for service connected illnesses or injuries, as applicable.

Medicare Part D Notice of Creditable Coverage

Your Options

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with National Jewish Health and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. National Jewish Health has determined that the prescription drug coverage offered by the Medical Plan through Cigna 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 through 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 NJH coverage will not be affected. You can keep the NJH Cigna medical/drug plan even if you elect Part D and this plan will coordinate with Part D coverage as long as you remain an enrolled, active employee of NJH.

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 National Jewish Health 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 National Jewish Health 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 for personalized help. See the inside back cover of your copy of the "Medicare & You" handbook for their telephone number.
- 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: **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).

Name of Entity/Sender: National Jewish Health
Contact: Employee Benefits
National Jewish Health
Address: 1400 Jackson St, Denver, CO 80206
Phone Number: **(303) 398-1740**

Your ERISA Rights

As a participant in the National Jewish Health benefit plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all plan participants shall be entitled to receive information about their plan and benefits, continue group health plan coverage, and enforce their rights. ERISA also requires that plan fiduciaries act in a prudent manner.

Receive Information About Your Plan and Benefits

You are entitled to:

- Examine, without charge, at the plan administrator's office, all plan documents—including pertinent insurance contracts, trust agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;
- Obtain, upon written request to the plan's administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series), and updated summary plan description. The administrator may make a reasonable charge for the copies;
- Receive a summary report of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

Continued Group Health Plan Coverage

You are entitled to:

- Continued health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description governing the plan on the rules governing your COBRA continuation coverage rights.
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have credible coverage from another plan. You should be provided a certificate of credible coverage, free of charge, from your group health plan or health insurance issuer when:
  - ✔ You lose coverage under the plan;
  - ✔ You become entitled to elect COBRA continuation coverage;
  - ✔ You request it up to 24 months after losing coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plans. The people who operate your plans are called "fiduciaries," and they have a duty to act prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to:

- Know why this was done;
- Obtain copies of documents relating to the decision without charge; and
- Appeal any denial.

All of these actions must occur within certain time schedules.

Under ERISA, there are steps you can take to enforce your rights. For instance, you may file suit in a federal court if:

- You request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator;
- You have followed all the procedures for filing and appealing a claim (as outlined earlier in this summary) and your claim for benefits is denied or ignored, in whole or in part. You may also file suit in a state court;
- You disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order; or
- The plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights. You may also seek assistance from the U.S. Department of Labor.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees. This should occur if the court finds your claim frivolous.

Assistance With Your Questions

If you have questions about how your plan works, contact the Human Resources Department. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office listed on EBSA's website: **https://www.dol.gov/agencies/ebsa/about-ebsa/about-us/regional-offices**.

What Is COBRA Continuation Coverage?

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

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

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

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

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

- You become divorced or legally separated from your spouse.

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

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

When Is COBRA Coverage Available?

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

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility or coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: National Jewish Health Human Resources or COBRA Administrator.

How Is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. Any qualified beneficiary who does not elect COBRA within the 60-day election period specified in the election notice **will lose his or her right to elect COBRA**.

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

Continuation Coverage Rights Under COBRA

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

The disability extension is available only if you notify the Plan Administrator in writing of the Social Security Administration's determination of disability within 60 days after the latest of the date of the Social Security Administration's disability determination; the date of the covered employee's termination of employment or reduction in hours; and the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination or reduction in hours. You must also provide this notice within 18 months after the covered employee's termination or reduction in hours in order to be entitled to this extension.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Other Coverage Options

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Or you may write to the:
Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Employee and Employer Hotline of the Employee Benefits Security Administration at: **1-866-444-3272**. You may also visit the EBSA's web site on the Internet at: **https://www.dol.gov/agencies/ebsa**.

Continuation Coverage Rights Under COBRA

Introduction

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

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage.

It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace (**www.healthcare.gov**). By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

Can I Enroll in Medicare Instead of COBRA Continuation Coverage After My Group Health Plan Coverage Ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit **https://www.medicare.gov/medicare-and-you**.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at **https://www.dol.gov/agencies/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

For further information regarding the plan and COBRA continuation, please contact:

National Jewish Health
Benefits Department
BenefitsDept@NJHealth.org
1-303-398-1740

Summaries of Benefits and Coverage (SBCs)

As required by the Affordable Care Act, Summaries of Benefits and Coverage (SBCs) are available on the National Jewish Health website at **https://www.nationaljewish.org/employee-benefits-hr/overview**. If you would like a paper copy of the SBCs (free of charge), you may also call National Jewish Health benefits department at **1-303-398-1740**.

National Jewish Health is required to make SBCs available that summarize important information about health benefit plan options in a standard format, to help you compare across plans and make an informed choice. The health benefits available to you provide important protection for you and your family and choosing a health benefit option is an important decision.

Glossary

Affordable Care Act and Patient Protection (ACA)

Also called Health Care Reform, the ACA requires health plans to comply with certain requirements. The ACA became law in March 2010. Since then, the ACA has required some changes to medical coverage—like covering dependent children to age 26, no lifetime limits on medical benefits, reduced FSA contributions, covering preventive care without cost-sharing, etc, among other requirements.

Brand Name Drug

The original manufacturer's version of a particular drug. Because the research and development costs that went into developing these drugs are reflected in the price, brand name drugs cost more than generic drugs.

Coinsurance

A percentage of costs you pay "out-of-pocket" for covered expenses after you meet the deductible.

Copayment (Copay)

A fee you have to pay "out-of-pocket" for certain services, such as a doctor's office visit or prescription drug.

Deductible

The amount you pay "out-of-pocket" before the health plan will start to pay its share of covered expenses.

Generic Drug

Lower-cost alternative to a brand name drug that has the same active ingredients and works the same way.

High-Deductible Health Plan (HDHP)

High-deductible health plans (HDHPs) are health insurance plans with lower premiums and higher deductibles than traditional health plans. Only those enrolled in an HDHP are eligible to open and contribute tax-free to a health savings account (HSA).

Health Savings Account (HSA)

A health savings account (HSA) is a portable savings account that allows you to set aside money for health care expenses on a tax-free basis. You must be enrolled in a high-deductible health plan in order to open an HSA. An HSA rolls over from year to year, pays interest, can be invested, and is owned by you—even if you leave the company.

Out-of-Pocket Maximum

The most you pay each year "out-of-pocket" for covered expenses. Once you've reached the out-of-pocket maximum, the health plan pays 100% for covered expenses.

Plan Year

The year for which the benefits you choose during Annual Enrollment remain in effect. If you're a new employee, your benefits remain in effect for the remainder of the plan year in which you enroll, and you enroll for the next plan year during the next Annual Enrollment.

Preventive Care

Health care services you receive when you are not sick or injured—so that you will stay healthy. These include annual checkups, gender- and age-appropriate health screenings, well-baby care, and immunizations recommended by the American Medical Association.

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, 2023. Contact your state for more information on eligibility –

1. ALABAMA – Medicaid
   Website: http://myalhipp.com/
   Phone: 1-855-692-5447
2. ALASKA – Medicaid
   The AK Health Insurance Premium Payment Program
   Website: http://myakhipp.com/
   Phone: 1-866-251-4861
   Email: CustomerService@MyAKHIPP.com
   Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
3. ARKANSAS – Medicaid
   Website: http://myarhipp.com/
   Phone: 1-855-MyARHIPP (1-855-692-7447)
4. CALIFORNIA – Medicaid
   Health Insurance Premium Payment (HIPP) Program
   Website: http://dhcs.ca.gov/hipp
   Phone: 1-916-445-8322
   Fax: 1-916-440-5676
   Email: hipp@dhcs.ca.gov
5. COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
   Health First Colorado Website: https://www.healthfirstcolorado.com/
   Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
   CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
   CHP+ Customer Service: 1-800-359-1991/ State Relay 711
   Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
   HIBI Customer Service: 1-855-692-6442
6. FLORIDA – Medicaid
   Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
   Phone: 1-877-357-3268
7. GEORGIA – Medicaid
   A HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
   Phone: 1-678-564-1162, Press 1
   GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party- liability/childrens-health-insurance-program-reauthorization- act-2009-chipra
   Phone: 1-678-564-1162, Press 2
8. INDIANA – Medicaid
   Healthy Indiana Plan for low-income adults 19-64
   Website: http://www.in.gov/fssa/hip/
   Phone: 1-877-438-4479
   All other Medicaid
   Website: https://www.in.gov/medicaid/
   Phone 1-800-457-4584
9. IOWA – Medicaid and CHIP (Hawki)
   Medicaid Website: https://dhs.iowa.gov/ime/members
   Medicaid Phone: 1-800-338-8366
   Hawki Website: http://dhs.iowa.gov/Hawki
   Hawki Phone: 1-800-257-8563
   HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
   HIPP Phone: 1-888-346-9562
10. KANSAS – Medicaid
    Website: https://www.kancare.ks.gov/
    Phone: 1-800-792-4884
11. KENTUCKY – 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://kidshealth.ky.gov/Pages/index.aspx
    Phone: 1-877-524-4718
    Kentucky Medicaid Website: https://chfs.ky.gov
12. LOUISIANA – Medicaid
    Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
    Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
13. MAINE – Medicaid
    Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
    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
14. MASSACHUSETTS – Medicaid and CHIP
    Website: https://www.mass.gov/masshealth/pa
    Phone: 1-800-862-4840
15. MINNESOTA – Medicaid
    Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
    Phone: 1-800-657-3739
16. MISSOURI – Medicaid
    Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
    Phone: 1-573-751-2005
17. MONTANA – Medicaid
    Website: http://dphhs.mt.gov MontanaHealthcarePrograms/HIPP
    Phone: 1-800-694-3084
18. NEBRASKA – Medicaid
    Website: http://www.ACCESSNebraska.ne.gov
    Phone: 1-855-632-7633
    Lincoln: 1-402-473-7000
    Omaha: 1-402-595-1178
19. NEVADA – Medicaid
    Medicaid Website: http://dhcfp.nv.gov
    Medicaid Phone: 1-800-992-0900
20. NEW HAMPSHIRE – Medicaid
    Website: https://www.dhhs.nh.gov/oii/hipp.htm
    Phone: 1-603-271-5218
    Toll free number for the HIPP program: 1-800-852-3345, ext 5218
21. NEW JERSEY – Medicaid and CHIP
    Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
    Medicaid Phone: 1-609-631-2392
    CHIP Website: http://www.njfamilycare.org/index.html
    CHIP Phone: 1-800-701-0710
22. NEW YORK – Medicaid
    Website: https://www.health.ny.gov/health_care/medicaid/
    Phone: 1-800-541-2831
23. NORTH CAROLINA – Medicaid
    Website: https://medicaid.ncdhhs.gov/
    Phone: 1-919-855-4100
24. NORTH DAKOTA – Medicaid
    Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
    Phone: 1-844-854-4825
25. OKLAHOMA – Medicaid and CHIP
    Website: http://www.insureoklahoma.org
    Phone: 1-888-365-3742
26. OREGON – Medicaid
    Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html
    Phone: 1-800-699-9075
27. PENNSYLVANIA – Medicaid
    Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
    Phone: 1-800-692-7462
28. RHODE ISLAND – Medicaid and CHIP
    Website: http://www.eohhs.ri.gov/
    Phone: 1-855-697-4347, or 1-401-462-0311 (Direct RIte Share Line)
29. SOUTH CAROLINA – Medicaid
    Website: https://www.scdhhs.gov
    Phone: 1-888-549-0820
30. SOUTH DAKOTA - Medicaid
    Website: http://dss.sd.gov
    Phone: 1-888-828-0059
31. TEXAS – Medicaid
    Website: http://gethipptexas.com/
    Phone: 1-800-440-0493
32. UTAH – Medicaid and CHIP
    Medicaid Website: https://medicaid.utah.gov/
    CHIP Website: http://health.utah.gov/chip
    Phone: 1-877-543-7669
33. VERMONT– Medicaid
    Website: http://www.greenmountaincare.org/
    Phone: 1-800-250-8427
34. VIRGINIA – Medicaid and CHIP
    Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp
    Medicaid Phone: 1-800-432-5924
    CHIP Phone: 1-800-432-5924
35. WASHINGTON – Medicaid
    Website: https://www.hca.wa.gov/
    Phone: 1-800-562-3022
36. WEST VIRGINIA – Medicaid and CHIP
    Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/
    Medicaid Phone: 1-304-558-1700
    CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699- 8447)
37. WISCONSIN – Medicaid and CHIP
    Website: https://www.dhs.wisconsin.gov badgercareplus/p-10095.htm
    Phone: 1-800-362-3002
38. WYOMING – Medicaid
    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, 2023, 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

National Jewish Health®

Breathing Science is Life.®

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

_____

_____.

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	4. Employer Identification Number (EIN)
National Jewish Health	74-2044647
5. Employer address	**6. Employer phone number**
1400 Jackson Street G 103	

7. City	8. State	9. ZIP code
Denver	CO	80206

10. Who can we contact about employee health coverage at this job?	
Employee Benefits	
11. Phone number (if different from above)	**12. Email address**
303-398-1740	

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:
  - ☒ Some employees. Eligible employees are:

    You are eligible to participate in the National Jewish Health benefit plans if you are a regular, full-time or part-time employee working 20 hours or more per week. Under the Affordable Care Act, employees deemed eligible for benefits due to working 30 hours per week or greater during The National Jewish Health standard measurement period are notified by Human Resources of their eligibility.

- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:

    Your legal spouse or domestic partner
    Î Your children up to age 26 (children may include biological, adopted, step-children, and children for whom you have legal guardianship)
    Î Your children over age 26 who are not able to support themselves due to a physical or mental disability

  - ☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)