

**COLORADO EMPLOYER
BENEFIT TRUST**

ANNUAL NOTICES – 2017-2018 PLAN YEAR

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PATIENT PROTECTION MODEL DISCLOSURE

Colorado Employer Benefit Trust Benefits Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the **Colorado Employee Benefit Trust (CEBT)** at (303) 773-1373 or 1-800-332-1168 or www.cebt.org. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology contact **CEBT** at (303) 773-1373 or 1-800-332-1168 or www.cebt.org.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

The Women's Health and Cancer Rights Act of 1998 requires group health plans to make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits 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
- ◆ Treatment of physical complications of the mastectomy, including lymphedema

Our plan complies with these requirements. Benefits for these items generally are comparable to those provided under our plan for similar types of medical services and supplies. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by consultation between the attending physician and the patient. Our plan neither imposes penalties (for example, reducing or limiting reimbursements) nor provides incentives to induce attending providers to provide care inconsistent with these requirements. If you would like more information about WHCRA required coverage, you can contact Anthem at the number listed on the back of your ID card.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

The Newborns' and Mothers' Health Protection Act of 1996 prohibits group and individual health insurance policies from restricting benefits for any hospital length of stay for the mother or newborn child in connection with childbirth; (1) following a normal vaginal delivery to less than 48 hours; and (2) following a cesarean section, to less than 96 hours. Health insurance policies may not require that a provider obtain authorization from the health insurance plan or the issuer for prescribing any such length of stay. Regardless of these standards, an attending health care provider may, in consultation with the mother, discharge the mother or newborn child prior to the expiration of such minimum length of stay.

Further, a health insurer or health maintenance organization may not:

- ◆ Deny to the mother or newborn child eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely to avoid providing such length of stay coverage
- ◆ Provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum coverage
- ◆ Provide monetary incentives to an attending medical provider to induce such provider to provide care inconsistent with such length of stay coverage
- ◆ Require a mother to give birth in a hospital
- ◆ Restrict benefits for any portion of a period within a hospital length of stay described in this notice

These benefits are subject to the plan's regular deductible and co-pay. For further details, refer to your SPD.

GENETIC INFORMATION NONDISCRIMINATION ACT 2008

Title II of the Genetic Information Nondiscrimination Act of 2008 protects applicants and employees from discrimination based on genetic information in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment. GINA also restricts employers' acquisition of genetic information and strictly limits disclosure of genetic information. Genetic information includes information about genetic tests of applicants, employees, or their family members; the manifestation of diseases or disorders in family members (family medical history); and requests for or receipt of genetic services by applicants, employees, or their family members. Our Plan complies with these requirements.

NOTICE OF ADVERSE BENEFIT DETERMINATION

Employer-sponsored group health plans are required to provide notice of an adverse benefit determination when a claim is first denied.

- ◆ In the case of a claim filed after medical services are provided, notice of the adverse benefit determination is required within 30 days of filing, except that one 15-day extension is allowed if proper notice of the need for extension is provided.
- ◆ In the case of a claim filed before medical services are provided (e.g., if pre-authorization is required to obtain full benefits) the notice of adverse benefit determination with respect to a non-urgent claim is required within 15 days of filing, except that one 15-day extension is allowed if proper notice of the need for extension is provided.
- ◆ If the pre-service claim is for urgent care, the notice of adverse benefit determination generally is required within 24 hours of filing.

These timing rules are currently in effect for ERISA plans, except that the 24-hour deadline for urgent pre-service claims will become effective for plan years starting on or after September 23, 2010 (currently the requirement generally is to provide the notice within 72 hours). Available at: <http://www.dol.gov/ebsa/IABDModelNotice2.doc>. Spanish language version available at: <http://www.dol.gov/ebsa/IABDModelNotice2sp.doc>.

NOTICE OF FINAL INTERNAL ADVERSE BENEFIT DETERMINATION

For plan years starting on or after September 23, 2010, employer-sponsored group health plans are required to provide notice of a final internal adverse benefit determination when internal appeals procedures have been completed. This notice is similar to the notice of decision on appeal that is currently required of ERISA plans under DOL regulations. If a plan has only one level of appeal, the final internal adverse benefit determination is the only notice of the decision on appeal that is required (provided it also meets applicable ERISA requirements). Plans may have one or two levels of internal appeals and, if a plan has two appeal levels, this model notice is intended for use only after the second internal appeal if it results in an adverse benefit determination.

In the case of a claim filed after medical services are provided, this notice is required within 60 days after the appeal is first filed (even if the plan has two appeal levels) and no extensions are allowed.

- ◆ In the case of a claim filed before medical services are provided (e.g., if pre-authorization is required to obtain full benefits), the notice of final internal adverse benefit determination with respect to a non-urgent claim is required within 30 days after the appeal is first filed (even if the plan has two appeal levels) and no extensions are allowed.
- ◆ If the pre-service claim is for urgent care, the notice of final internal adverse benefit determination generally is required within 72 hours after the appeal is first filed (even if the plan has two appeal levels) and no extensions are allowed.

These timing rules are the same as those currently in effect for ERISA plans. Available at: <http://www.dol.gov/ebsa/IABDModelNotice1.doc>. Spanish language version available at: <http://www.dol.gov/ebsa/IABDModelNotice1sp.doc>.

NOTICE OF FINAL EXTERNAL REVIEW DECISION

For plan years starting on or after September 23, 2010, employer-sponsored group health plans are required to maintain an external review procedure that meets certain requirements, including a notice of final decision. The agencies have provided a model notice for that purpose. Available at: <http://www.dol.gov/ebsa/IABDModelNotice3.doc>. Spanish language version available at: <http://www.dol.gov/ebsa/IABDModelNotice3sp.doc>.

SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Effective April 1, 2009 special enrollment rights also exist in the following circumstances:

- ◆ If you or your dependents experience a loss of eligibility for Medicaid or your State Children's Health Insurance Program (SCHIP) coverage;
or

- ◆ If you or your dependents become eligible for premium assistance under an optional state Medicaid or SCHIP program that would pay the employee's portion of the health insurance premium.

Note: In the two above listed circumstances only, you or your dependents will have 60 days to request special enrollment in the group health plan coverage.

As stated earlier in this notice, a special enrollment opportunity may be available in the future if you or your dependents lose other coverage. This special enrollment opportunity will not be available when other coverage ends, however, unless you provide a written statement now explaining the reason that you are declining coverage for yourself or your dependent(s). Failing to accurately complete and return this form for each person for whom you are declining coverage will eliminate this special enrollment opportunity for the person(s) for whom a statement is not completed, even if other coverage is currently in effect and is later lost. In addition, unless you indicate in the statement that you are declining coverage because other coverage is in effect, you will not have this special enrollment opportunity for the person(s) covered by the statement. (See the paragraph above, however, regarding enrollment in the event of marriage, birth, adoption or placement for adoption.)

To request special enrollment or obtain more information, contact [Colorado Employer Benefit Trust](#).

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) OFFER FREE OR LOW-COST HEALTH COVERAGE TO CHILDREN AND FAMILIES

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 and you live in a State listed below, 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 or dial **1-877-KIDS NOW** or www.insurekidsnow.gov 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.**

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 January 31, 2012. You should contact your State for further information on eligibility –

ALASKA – Medicaid	COLORADO – Medicaid and CHIP
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/	Medicaid Website: http://www.colorado.gov/
Phone (Outside of Anchorage): 1-888-318-8890	Medicaid Phone (In state): 1-800-866-3513
Phone (Anchorage): 907-269-6529	Medicaid Phone(Out of state): 1-800-221-3943
ARIZONA – CHIP	
Website: http://www.azahcccs.gov/applicants	
Phone(Outside of Maricopa County): 1-877-764-5437	
Phone(Maricopa County): 602-417-5437	
FLORIDA – Medicaid	GEORGIA – Medicaid
Website: http://www.flmedicaidprecovery.com/	Website: http://dch.georgia.gov/
Phone: 1-877-357-3268	Click on Programs, then Medicaid
	Phone: 1-800-869-1150
IDAHO – Medicaid and CHIP	INDIANA – Medicaid

<p>Medicaid Website: www.accesstohealthinsurance.idaho.gov</p> <p>Medicaid Phone: 1-800-926-2588</p> <p>CHIP Website: www.medicaid.idaho.gov</p> <p>CHIP Phone: 1-800-926-2588</p>	<p>Website: http://www.in.gov/fssa</p> <p>Phone: 1-800-889-9948</p>
IOWA – Medicaid	MONTANA – Medicaid
<p>Website: www.dhs.state.ia.us/hipp/</p> <p>Phone: 1-888-346-9562</p>	<p>Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml</p> <p>Phone: 1-800-694-3084</p>
KANSAS – Medicaid	NEBRASKA – Medicaid
<p>Website: http://www.kdheks.gov/hcf/</p> <p>Phone: 1-800-792-4884</p>	<p>Website: http://dhhs.ne.gov/medicaid/Pages/med_kidsconx.aspx</p> <p>Phone: 1-877-255-3092</p>
KENTUCKY – Medicaid	NEVADA – Medicaid and CHIP
<p>Website: http://chfs.ky.gov/dms/default.htm</p> <p>Phone: 1-800-635-2570</p>	<p>Medicaid Website: http://dwss.nv.gov/</p> <p>Medicaid Phone: 1-800-992-0900</p>
LOUISIANA – Medicaid	NEW HAMPSHIRE – Medicaid
<p>Website: http://www.lahipp.dhh.louisiana.gov</p> <p>Phone: 1-888-695-2447</p>	<p>Website: http://www.dhhs.nh.gov/ombp/index.htm</p> <p>Phone: 603-271-5218</p>
MAINE – Medicaid	NEW JERSEY – Medicaid and CHIP
<p>Website: http://www.maine.gov/dhhs/OIAS/public-assistance/index.html</p> <p>Phone: 1-800-572-3839</p>	<p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</p> <p>Medicaid Phone: 1-800-356-1561</p> <p>Chip Website: http://www.njfamilycare.org/index.html</p> <p>Chip Phone: 1-800-701-0710</p>
MASSACHUSETTS – Medicaid and CHIP	NEW YORK – Medicaid
<p>Website: http://www.mass.gov/MassHealth</p> <p>Phone: 1-800-462-1120</p>	<p>Website: http://www.nyhealth.gov/health_care/medicaid/</p> <p>Phone: 1-800-541-2831</p>
MINNESOTA – Medicaid	NORTH CAROLINA – Medicaid and CHIP
<p>Website: http://www.dhs.state.mn.us/</p> <p>Click on Health Care, then Medical Assistance</p> <p>Phone: 1-8000-657-3629</p>	<p>Website: http://www.ncdhhs.gov/dma</p> <p>Phone: 919-855-4100</p>
MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
<p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</p> <p>Phone: 573-751-2005</p>	<p>Website: http://www.nd.gov/dhs/services/medicalsev/medicaid/</p> <p>Phone: 1-800-755-2604</p>
OKLAHOMA- Medicaid and CHIP	UTAH – Medicaid and CHIP
<p>Website: http://www.insureoklahoma.org</p> <p>Phone: 1-888-365-3742</p>	<p>Website: http://health.utah.gov/upp</p> <p>Phone: 1-866-435-7414</p>
OREGON- Medicaid and CHIP	VERMONT – Medicaid
<p>Website: http://www.oregonhealthykids.gov http://hijosaludablesoregon.gov</p> <p>Phone: 1-888-314-5678</p>	<p>Website: http://www.greenmountaincare.org/</p> <p>Phone: 1-800-250-8427</p>
PENNSYLVANIA- Medicaid	VIRGINIA – Medicaid and CHIP
<p>Website: http://www.dpw.state.pa.us/hipp</p> <p>Phone: 1-800-692-7462</p>	<p>Medicaid Website: http://www.dmas.virginia.gov/rep-HIPP.htm</p> <p>Medicaid Phone: 1-800-432-5924</p> <p>CHIP Website: http://www.famis.org/</p> <p>CHIP Phone: 1-866-873-2647</p>

RHODE ISLAND- Medicaid Website: www.ohhs.ri.gov Phone: 401-462-0820	WASHINGTON – Medicaid Website: http://hrsa.dsha.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA- Medicaid Website: http://www.schhs.gov Phone: 1-888-549-0820	WEST VIRGINIA – Medicaid Website: www.dhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA- Medicaid Website: http://dss.sd.gov Phone: 1-888-828-0059	WISCONSIN – Medicaid Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS- Medicaid Website: http://www.gethipptexas.com/ Phone: 1-800-440-0493	WYOMING – Medicaid Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any more States have added a premium assistance program since January 31, 2012, or for more information on special enrollment rights, you can contact either:

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

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

COBRA CONTINUATION OF COVERAGE RIGHTS

Under the federal law, known as COBRA, you and your dependents generally may continue medical, dental, and vision if coverage ends due to either:

- ◆ A reduction in the number of hours you work or
- ◆ Termination of your employment for any reason other than gross misconduct.

Your dependents may continue their medical, dental and vision coverage under this plan if their coverage ends for any of the following reasons:

- ◆ Your death
- ◆ You become entitled to Medicare
- ◆ Your divorce, annulment, or legal separation, provided the company is notified within 60 days
- ◆ Your dependent loses dependent status, provided the company is notified within 60 days

This is not a complete description of all COBRA-related provisions. You should consult your SPD for more details.

The following chart shows how long you can continue your COBRA coverage:

If you lose coverage because . . .	Then you can continue coverage for . . .
You are no longer eligible	18 months
You are no longer eligible and either you or your dependent is disabled (according to the Social Security Administration) within 60 days of your loss of eligibility	29 months

If your dependent loses coverage because . . .	Then your dependent can continue coverage for . . .
Of your death	36 months
You become eligible for Medicare after your COBRA election begins	36 months
You and your spouse divorce	36 months
He or she is no longer a dependent (because of age or divorce)	36 months

**Notice of Availability
Special Notice of Privacy Practices**

THIS NOTICE DESCRIBES HOW YOU MAY OBTAIN A COPY OF THE PLAN'S NOTICE OF PRIVACY PRACTICES, WHICH DESCRIBES THE WAYS THAT THE PLAN USES AND DISCLOSES YOUR PROTECTED HEALTH INFORMATION.

Colorado Employer Benefit Trust (the "Plan") provides health benefits to eligible employees of City of Gunnison (the "Company") and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains and discloses health information about participating employees and dependents in the course of providing these health benefits. The Plan is required by law to provide notice to participants of the Plan's duties and privacy practices with respect to covered individuals' protected health information, and has done so by providing to Plan participants a Notice of Privacy Practices, which describes the ways that the Plan uses and discloses protected health information. To receive a copy of the Plan's Notice of Privacy Practices you should contact Colorado Employer Benefit Trust, who has been designated as the Plan's contact person for all issues regarding the Plan's privacy practices and covered individuals' privacy rights. You can reach customer service at: Colorado Employer Benefit Trust, 2000 South Colorado Blvd, Tower II, Suite 900, Denver, CO 80222 or 303-773-1373 / 1-800-332-1168

Colorado Employer Benefit Trust	
Date:	October 2017
Name of Entity/Sender:	Colorado Employer Benefit Trust
Contact-Position/Office:	Customer Service
Address:	2000 South Colorado Blvd., Tower II, Suite 900 Denver, CO 80222
Phone Number:	(303) 773-1373 or 1-800-332-1168

Important Notice From City of Gunnison About Your Prescription Drug Coverage and Medicare Creditable Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City of Gunnison 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. City of Gunnison has determined that the prescription drug coverage offered by CEBT 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 to decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

What Happens To Your Current Coverage If You Decide To Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current City of Gunnison coverage will not be affected. You can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage; [See pages 7-9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at <http://www.cms.hhs.gov/CreditableCoverage/>), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.]

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 City of Gunnison 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...

For further information call [\(970-641-8248\)](tel:970-641-8248). **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 City of Gunnison changes. You may also request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

Date: 9/27/2017
Name of Entity/Sender: City of Gunnison
Address: Po Box 239
Gunnison, Co 81230
Phone Number: (970-641-8248)



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General Information

When key parts of the health care law took effect in 2014, there was a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by your employer.

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. You may also be eligible for a tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in November each year for coverage starting as early as the immediately following January 1.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax 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 meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5%¹ of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.²

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution –as well as your employee contribution to employer-offered coverage– is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Willis [Towers Watson at 1-800-332-1168 or 303-773-1373](https://www.towerswatson.com).

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.healthcare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹ As that percentage is adjusted by inflation from time to time.

² 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.

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 City of Gunnison Po Box 239 Gunnison, Co 81230 970-641-8248	4. Employer Identification Number (EIN) 84-6000673
5. Employer address	6. Employer phone number

7. City
Gunnison

8. State
Co

9. ZIP code
81230

10. Who can we contact about employee health coverage at this job?

Tammy Shelafo

11. Phone number (if different from above)
970-641-8248

12. Email address
tshelafo@gunnisonco.gov

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:
Full time employees hired and regular work a 30 or more hours each workweek and 52 workweeks each year

Some employees. Eligible employees are:

- With respect to dependents:
 - We do offer coverage. Eligible dependents are:
Spouse's and children

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)