



**January 1, 2026 –
December 31, 2026**

2026 Employee Benefit Guide



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If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 25-26 where Notice of Creditable Coverage is for more details.

Benefits Overview

The Town of Dillon is proud to offer a comprehensive benefits package to eligible, full-time employees who work 30 or more hours per week. The complete benefits package is briefly summarized in this booklet. You will receive plan booklets, which give you more detailed information about each of these programs.

You share the cost of some benefits (medical, dental and vision), and the Town of Dillon provides other benefits at no cost to you (life, accidental death & dismemberment). In addition, there are voluntary benefits with reasonable group rates that you can purchase through payroll deductions.

- Medical
- Dental
- Vision
- Life Insurance
- Accidental Death & Dismemberment (AD&D) Insurance
- Long Term Disability (LTD)
- Flexible Spending Account (FSA)
- Health Savings Account (HSA)
- Retirement Benefits
- Down Payment Assistance
- Rental Assistance
- Monthly Cell Phone Allowance

Eligibility

You and your dependents are eligible for the Town of Dillon benefits on the first of the month following your date of hire.

Eligible dependents are your spouse, domestic partner, children under age 26, and disabled dependents of any age.

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



Medical Benefits

Administered by County Health Pool (CHP) Utilizing Anthem Network

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, they can often be treated at little cost.

In case of an illness or injury, you and your family are covered with an excellent medical plan through the Town of Dillon.

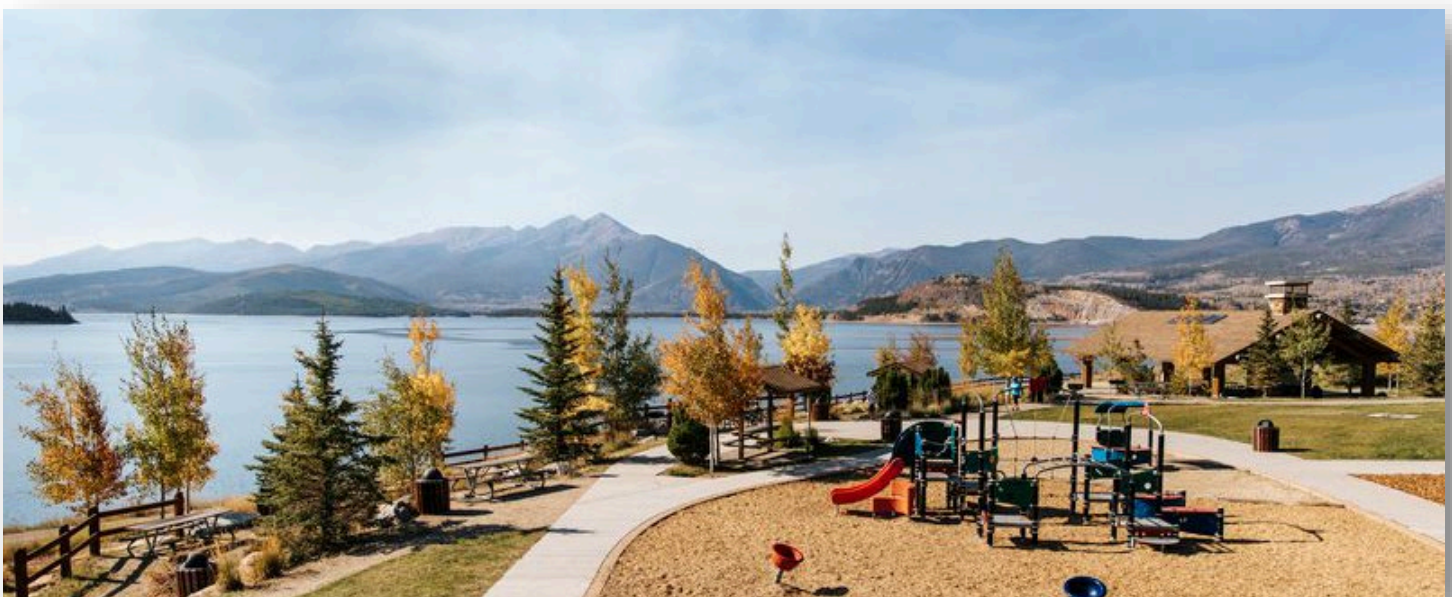
The Town of Dillon offers you the choice of three High-Deductible Health Plans (HDHP) through County Health Pool. With these plans, you may select where you receive your medical services, but if you use in-network providers, your costs will be less.

To find an In-network provider or to view your ID card, please visit the Anthem website at www.anthem.com and create an account, call customer service at 868-698-0887 or download Anthem's mobile app.

	HDHP/ HSA 2000 Plan	
	In-Network	Out-of-Network
Calendar Year Deductible	\$2,000 individual / \$4,000 family	\$4,000 individual / \$8,000 family
Calendar Year Out-of-Pocket Maximum (includes deductible)	\$5,000 individual / \$6,850 family	\$10,000 individual / \$20,000 family
Coinsurance	20%	40%
Doctor's Office		
Primary Care Office Visit	20% after deductible	40% after deductible
Specialist Office Visit	20% after deductible	40% after deductible
Preventive Care Visits (www.healthcare.gov)	Covered 100%	40% after deductible
Prescription Drugs		
Retail—Generic Drug (30-day supply)	20% after deductible	Not Covered
Retail—Formulary Drug (30-day supply)	20% after deductible	
Retail—Nonformulary Drug (30-day supply)	20% after deductible	
Mail Order—All Tiers (90-day supply)	20% after deductible	
Hospital Services		
Emergency Room	20% after deductible	
Inpatient	20% after deductible	40% after deductible
Outpatient Surgery	20% after deductible	40% after deductible
Urgent Care	20% after deductible	40% after deductible

HDHP/ HSA 2500 Plan

	In-Network	Out-of-Network
Calendar Year Deductible	\$2,500 individual / \$5,000 family	\$5,000 individual / \$10,000 family
Calendar Year Out-of-Pocket Maximum (includes deductible)	\$5,000 individual / \$6,850 family	\$10,000 individual / \$20,000 family
Coinsurance	20%	40%
Doctor's Office		
Primary Care Office Visit	20% after deductible	40% after deductible
Specialist Office Visit	20% after deductible	40% after deductible
Preventive Care Visits (www.healthcare.gov)	Covered 100%	40% coinsurance
Prescription Drugs		
Retail—Generic Drug (30-day supply)	20% after deductible	Not Covered
Retail—Formulary Drug (30-day supply)	20% after deductible	
Retail—Nonformulary Drug (30-day supply)	20% after deductible	
Mail Order—All Tiers (90-day supply)	20% after deductible	
Hospital Services		
Emergency Room	20% after deductible	
Inpatient	20% after deductible	40% after deductible
Outpatient Surgery	20% after deductible	40% after deductible
Urgent Care	20% after deductible	40% after deductible



HDHP/ HSA 5000 Plan

	In-Network	Out-of-Network
Calendar Year Deductible	\$5,000 individual / \$10,000 family	\$5,000 individual / \$10,000 family
Calendar Year Out-of-Pocket Maximum (includes deductible)	\$5,000 individual / \$10,000 family	\$15,000 individual / \$30,000 family
Coinsurance	0%	30%
Doctor's Office		
Primary Care Office Visit	0% after deductible	30% after deductible
Specialist Office Visit	0% after deductible	30% after deductible
Preventive Care Visits (www.healthcare.gov)	Covered 100%	30% coinsurance
Prescription Drugs		
Retail—Generic Drug (30-day supply)	0% after deductible	Not Covered
Retail—Formulary Drug (30-day supply)	0% after deductible	
Retail—Nonformulary Drug (30-day supply)	0% after deductible	
Mail Order—All Tiers (90-day supply)	0% after deductible	
Hospital Services		
Emergency Room	0% after deductible	
Inpatient	0% after deductible	30% after deductible
Outpatient Surgery	0% after deductible	30% after deductible
Urgent Care	0% after deductible	30% after deductible



Health Savings Account (HSA)

A Health Savings Account (HSA) is an individually-owned, tax-advantaged account that you can use to pay for current or future IRS-qualified medical expenses.

Advantages of the High Deductible Health Plan (HDHP) with an HSA

The HDHP option is designed to encourage you to be more conscientious of your healthcare expenditures. It also offers a number of special features, for example:

- It has a lower monthly payroll contribution
- You have access to a Health Savings Account (HSA) that allows you to put aside money, tax-free, to pay for eligible medical expenses. You choose when to use the money in your HSA account. It rolls over from year to year, allowing the balance to increase.

Setting Up an HSA Account

You choose the bank, credit union or other entity qualified to administer your HSA. You can open and contribute to an HSA if you:

- Are covered by an HSA-qualified health plan (HDHP);
- Are not covered by other health insurance (with some exceptions);
- Are not enrolled in Medicare;
- Are not eligible to be claimed as a dependent on another person's tax return;
- Have not received health benefits from the Veterans Administration with the exception of services for a "service-related disability" or an Indian Health Services facility within the last three months; and
- Are not covered by your own or your spouse's Healthcare FSA.

SPECIAL CONSIDERATIONS:

1. You CANNOT use HSA dollars on Domestic Partners unless they are your legal tax dependent.
2. Your adult children up to 19 MUST be a tax dependent to be eligible to use your HSA dollars for their expenses. If they are not tax dependents, or are between ages 19-24, they may open and contribute to their own HSA.

Contributing to Your HSA

Health Savings Accounts have a triple tax advantage:

- Contribute tax-free
- Invest tax-free
- Make withdrawals for eligible medical expenses, or for any use after age 65 tax-free

The IRS sets a limit on how much can be contributed to this account each year. This is a combined limit for all parties contributing to the HSA, including your employer. **For 2026, the contribution limit is \$4,400 for employee only, and \$8,750 for employee plus dependents.**

The Town of Dillon will match your HSA contribution dollar for dollar up to a specified maximum depending on the medical plan enrolled in.

Medical Plan Enrolled In	HDHP 2000	HDHP 2500	HDHP 5000
Medical Deductible (in-network)	\$2,000/ \$4,000	\$2,500/ \$5,000	\$5,000/ \$10,000
Town of Dillon HSA Contribution (with match):	\$1,500/ \$3,000	\$2,000/ \$4,000	\$3,000/ \$7,000
Your Contribution <u>Required</u> for Match	\$1,500/ \$3,000	\$2,000/ \$4,000	\$1,400/ \$1,750
Your Max Allowed HSA Contribution	\$2,900/ \$5,750	\$2,400/ \$4,750	\$1,400/ \$1,750
Total	\$4,400/ \$8,750	\$4,400/ \$8,750	\$4,400/ \$8,750

Catch-Up Contribution

Employees age 55 or older may contribute an additional \$1,000 into their HSA account, known as the catch-up contribution. There is no employer match for this contribution.

Using Your HSA Funds

Money you use from your HSA to pay for qualified medical expenses is federally tax-free. If you use money for reasons other than qualified medical expenses before age 65, that money is taxable and subject to a 20% penalty. This isn't a complete list of rules and requirements for HSAs. More info can be found in the publication 969 of the IRS, at www.irs.gov.

Dental Benefits

Administered by County Health Pool Utilizing Anthem Network

Good oral care enhances overall physical health, appearance and mental well-being. Problems with the teeth and gums are common and easily treated health problems. Keep your teeth healthy and your smile bright with the Town of Dillon dental benefit plan.

Services	In-Network and Out-of-Network PPO
Calendar-Year Deductible	\$50 per person; \$150 family limit
Calendar-Year Benefit Maximum	\$1,500
Preventive Dental Services (2 cleanings per year, exams, 1 set of x-rays)	100%; no deductible
Basic Dental Services (fillings, root canal therapy, oral surgery)	20% after deductible
Major Dental Services (extractions, crowns, inlays, onlays, bridges, dentures, repairs)	50% after deductible
Orthodontia Services (covered to age 19)	50% to \$1,000 lifetime maximum

Vision Benefits

Administered by County Health Pool Utilizing VSP Network

Regular eye examinations can not only determine your need for corrective eyewear but also may detect general health problems in their earliest stages.

Service	In-Network (any VSP provider)	Out-of-Network (any qualified non-network provider of your choice)	Frequency
Eye Exam	\$15 copay	Up to \$45	Every 12 months
Lenses			
Single Vision Lenses	\$15 copay	Up to \$30	Every 12 months
Lined Bifocal Lenses	\$15 copay	Up to \$50	
Lined Trifocal Lenses	\$15 copay	Up to \$65	
Frames			
Wide Selection	\$175 allowance; plus 20% off	Up to \$70	Every 24 months
Featured Frames	\$195 allowance; plus 20% off	Up to \$70	
Costo/ Walmart Frames	\$95 allowance; plus 20% off	Up to \$70	
Contact Lenses			
Fitting & Evaluation	Up to \$60; plus 15% off	Not Covered	Every 12 months; in lieu of eyeglasses
Elective	\$175 allowance	Up to \$105	
Medically Necessary	\$15 copay; then 100% covered	Up to \$210	

Life and Accidental Death & Dismemberment Insurance

Insured by Mutual of Omaha

Life Insurance – Town Paid

Life insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump sum payment if you die while employed by the Town of Dillon. The Town's basic life insurance of 2x your annual earnings up to a maximum of \$200,000 for you, \$25,000 of coverage for your covered spouse and \$10,000 for your covered dependents age 14 days to 26 years of age at no cost to you.

Accidental Death and Dismemberment (AD&D) Insurance – Town Paid

Accidental Death and Dismemberment (AD&D) insurance provides payment to you or your beneficiaries if you lose a limb or die in an accident. The Town of Dillon provides AD&D coverage of 2x your annual earnings up to a maximum of \$200,000, \$25,000 of coverage for your covered spouse and \$10,000 for your covered dependents age 14 days to 26 years of age at no cost to you. This coverage is in addition to your company-paid life insurance described above.

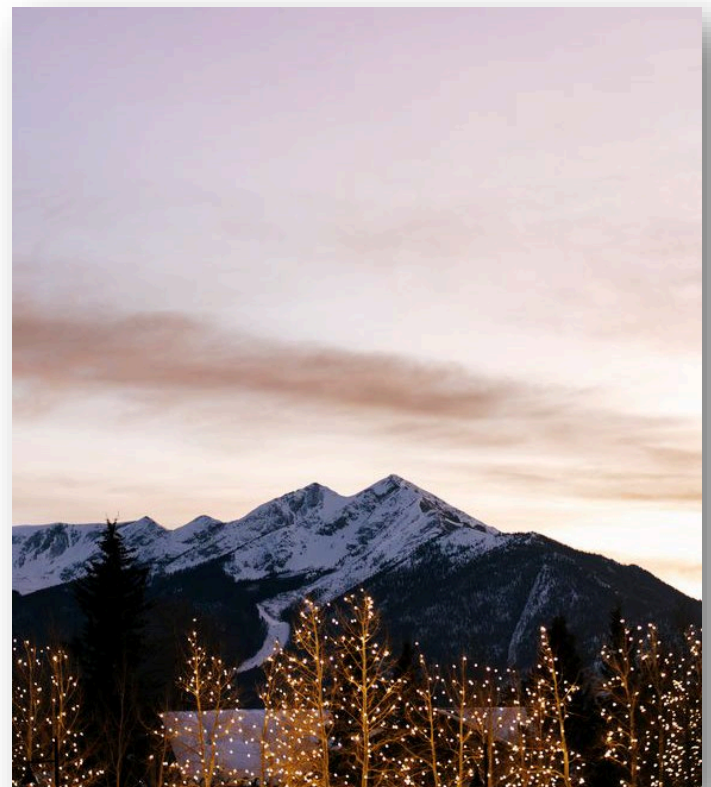
The Town's medical plan with the County Health Pool (Anthem) also includes an additional \$10,000 of Town paid Life and AD&D coverage for full-time employees that elect medical insurance through the town.

Long Term Disability Insurance – Town Paid

Insured by Mutual of Omaha

Meeting your basic living expenses can be a real challenge if you become disabled. Your options may be limited to personal savings, spousal income and possibly Social Security. Long Term Disability insurance provides protection for your most valuable asset — your ability to earn an income.

Town Paid Long Term Disability Basics	
Benefit Percentage	66.67% of Monthly Earnings
Maximum Benefit	\$5,000 per month
Elimination Period	90 Days
Benefit Duration	Social Security Normal Retirement Age



Flexible Spending Account (FSA)

Administered by Rocky Mountain Reserve

The Town of Dillon offers a voluntary Limited Purpose Flexible Spending Account and a Dependent Care Flexible Spending Account. Flexible Spending Accounts (FSAs) allow employees to use pretax dollars for out-of-pocket dental and vision expenses or child/dependent care expenses not covered by insurance plans. Employees contribute a portion of each paycheck to an FSA and save significantly on taxes.

Limited Purpose FSA

A Limited Purpose FSA (LPFSA) is a flexible spending account that reimburses you for eligible dental and vision expenses. A LPFSA is available to employees who are enrolled in a high-deductible health plan (HDHP); you may enroll in both the LPFSA and the HSA. By establishing a LPFSA, you can save money on taxes by using your LPFSA dollars for your dental and vision expenses while preserving your HSA funds for other purposes, including simply saving those funds for the future. The IRS sets a limit on how much you can contribute to this account each year. **For 2026, the spending limit is \$3,400.**

Dependent Care FSA

A Dependent care FSA is a pre-tax benefit account used to pay for dependent care services, such as preschool, summer day camp, before or after school programs, and child or elder daycare. A Dependent Care FSA is a smart, simple way to save money while taking care of your loved ones so that you can continue to work. The IRS sets a limit on how much you can contribute to this account each year. **For 2026, the spending limit is \$7,500 if married and filing jointly or head of household or \$3,750 if married and filing separately.**

Here's How an FSA Works

1. Decide the annual amount you want to contribute based on your expected health care and/or dependent childcare/elder care expenses.
2. Elections are deducted from each paycheck before income and Social Security taxes and deposited into your FSA. Your entire annual election is available immediately after the beginning of the plan year for the LPFSA. For the Dependent Care FSA you can only receive the amount that is in your account when your claim is paid.
3. For eligible health care expenses, you can pay with the LPFSA **debit card** or submit a claim form for reimbursement. For dependent care you pay for eligible expenses when incurred, and then submit a reimbursement claim form or file the claim online.
4. You are reimbursed from your FSA. So, you actually pay your expenses with tax-free dollars.
5. At the end of the calendar year, any unused amount in your Limited Purpose FSA will be forfeited with the exception of a maximum **\$500 rollover** to be used for the next calendar year.
 - a) The \$500 rollover does not apply to the Dependent Care FSA.
6. You can use the LPFSA **only** for dental and vision expenses.

Voluntary Benefits

Down Payment Assistance

The Town of Dillon offers a Down Payment Assistance Program (DPAP) to qualified, eligible full-time employees to assist with the purchase of a home within Summit County. The Town will lend up to \$125,000 or 10% of purchase price at 1% interest for 20 years for homes within Summit.

Cell Phone Allowance

The Town of Dillon offers a \$75.00 per month cell phone allowance to its year around, full-time employees.

457 Retirement Plan

A voluntary 457 plan is also offered to full-time employees. As an incentive for our employees to invest in their future, the town will match an employee's voluntary contribution, up to 3% to a new 457 account. The Town's match will be contributed to the employee's CRA 401(a) retirement fund.

LegalShield

Legal: LegalShield has been offering legal plan for 40 years, creating a world where everyone can access legal protection—and everyone can afford it. Unexpected legal questions arise every day and with LegalShield on your side, you will have access to a high- quality law firm. From real estate to document review, speeding tickets to will preparation, and more, our attorneys are here to advise you with any legal matter—no matter how traumatic or how trivial it may seem. Our law firms are paid in advance, so their sole focus is on serving you, rather than billing you. With our legal plan you will be protected and empowered to worry less and live more.



Identity Theft Shield: Identity theft affects millions of Americans each year. LegalShield offers two high quality identity theft plans. LegalShield Identity Theft Plan provides standard identity monitoring, and the Identity Theft Premium Plan has more comprehensive monitoring. Best of all, both services provide Comprehensive Identity Restoration from Kroll Advisory Solutions. So, in the unfortunate event something does happen to your identity, you'll have professional help in getting it restored to what it was before the fraud occurred. To endure you have the best coverage possible, the LegalShield plans include you and your spouse and an additional Safeguard fir minors, covering up to eight (8) dependent children under the age of 18.



Please contact a LegalShield representative for costs associated with these plans or see HR.

Supplemental Insurance

AFLAC

Aflac provides a variety of supplemental insurance policies to help pay expenses medical insurance doesn't cover. Optional policies include, but are not limited to, short term disability, accident, cancer/specified disease, critical illness, dental, vision, and hospitalization.

Not everyone's personal situation

is the same; your family needs may be different from the needs of your coworkers.

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

Other Benefits

Employee Assistance Program – Mutual of Omaha

Employee Benefit	Offers confidential guidance and resources for you or an immediate household family member. In-person help with short-term issues; up to 4 face-to-face sessions per person, per issue, per year.		
Included Issues	Child/Elder Care	Alcohol/Drug Abuse	Life Improvement
	Relationship Difficulties	Stress/Anxiety	Depression
	Grief/Loss	Financial/Legal Concerns	Emotional Well-Being
Toll-Free phone at 800.316.2796 and 24/7 web access at www.mutualofomaha.com			

Other Benefits Provided by the Town of Dillon

Retirement Plan	Marina Store Discount
Sick Leave– 10 hours/ month; 480 hours max	Paid Vacation – 280 hours max
13 Paid Holidays	Silverthorne Recreation Center Discount

Retirement

Full-time employees (not sworn officers) are required to participate in Colorado Retirement Association (CRA), the Town’s retirement program beginning on their first day of employment. The Town of Dillon contributes 5% of the employee’s gross salary with a 5% employee match. Full vesting at 5 years.

Full-time sworn officers are required to participate in Fire Police Pension Association (FPPA) beginning on their first day of employment. The Town of Dillon contributes 10% of the officer's gross salary with a 10% officer match.



Employee Contributions

Coverage Tier	Per Pay Period
Medical – HDHP/HSA 2000 Plan	
Employee Only	\$99.32
Employee + One	\$186.18
Employee + Two or more	\$229.29
Medical – HDHP/HSA 2500 Plan	
Employee Only	\$94.71
Employee + One	\$177.42
Employee + Two or more	\$218.22
Medical – HDHP/HSA 5000 Plan	
Employee Only	\$82.43
Employee + One	\$154.34
Employee + Two or more	\$189.88

Coverage Tier	Per Pay Period
Dental Plan	
Employee Only	\$3.60
Employee + One	\$7.17
Employee + Two or more	\$9.31
Vision Plan	
Employee Only	\$2.86
Employee + One	\$5.70
Employee + Two or more	\$7.43
Life and AD&D/LTD	
Employee Only	No Cost



Contact Information

If you have specific questions about a benefit plan, please contact the administrator listed below, or your local human resources department.

Benefit Plan	Administrator	Phone	Website/ Email
Medical Plan	Anthem	866.698.0087	www.anthem.com
Dental Plan	Anthem	855.769.1467	www.anthem.com
Vision Plan	Vision Service Plan	800.877.7195	www.vsp.com
Life and AD&D Plan	Mutual of Omaha	800.775.8805	www.mutualofomaha.com
Long Term Disability Plan	Mutual of Omaha	800.775.8805	www.mutualofomaha.com
Flexible Spending Accounts	Rocky Mountain Reserve	303.945.3077	www.rockymountainreserve.com
Employee Assistance Program (EAP)	Mutual of Omaha	800.316.2796	www.mutualofomaha.com



Patient Protections Disclosure

The Town of Dillon Health Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Anthem designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Anthem at 866.698.0087 or www.anthem.com.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Anthem or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Anthem at 866.698.0087 or www.anthem.com.

Women's Health & Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

HDHP/ HSA 2000 Plan (Individual: 20% coinsurance and \$2,000 deductible; Family: 20% coinsurance and \$4,000 deductible)

HDHP/ HSA 2500 Plan (Individual: 20% coinsurance and \$2,500 deductible; Family: 20% coinsurance and \$5,000 deductible)

HDHP/ HSA 5000 Plan (Individual: 0% coinsurance and \$5,000 deductible; Family: 0% coinsurance and \$10,000 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 970.513.3345 or HRmanager@townofdillon.com.

Newborns' and Mothers' Health Protection Act

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

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, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
<p>Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442</p>	<p>Website: https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268</p>
GEORGIA – Medicaid	INDIANA – Medicaid
<p>GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2</p>	<p>Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584</p>
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
<p>Medicaid Website: iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562</p>	<p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660</p>
KENTUCKY – Medicaid	LOUISIANA – Medicaid
<p>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: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms</p>	<p>Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>

<p align="center">MAINE – Medicaid</p> <p>Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofl/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711</p>	<p align="center">MASSACHUSETTS – Medicaid and CHIP</p> <p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com</p>
<p align="center">MINNESOTA – Medicaid</p> <p>Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672</p>	<p align="center">MISSOURI – Medicaid</p> <p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>
<p align="center">MONTANA – Medicaid</p> <p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov</p>	<p align="center">NEBRASKA – Medicaid</p> <p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>
<p align="center">NEVADA – Medicaid</p> <p>Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900</p>	<p align="center">NEW HAMPSHIRE – Medicaid</p> <p>Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov</p>
<p align="center">NEW JERSEY – Medicaid and CHIP</p> <p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)</p>	<p align="center">NEW YORK – Medicaid</p> <p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>
<p align="center">NORTH CAROLINA – Medicaid</p> <p>Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100</p>	<p align="center">NORTH DAKOTA – Medicaid</p> <p>Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825</p>
<p align="center">OKLAHOMA – Medicaid and CHIP</p> <p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>	<p align="center">OREGON – Medicaid and CHIP</p> <p>Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075</p>
<p align="center">PENNSYLVANIA – Medicaid and CHIP</p> <p>Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)</p>	<p align="center">RHODE ISLAND – Medicaid and CHIP</p> <p>Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)</p>

SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	Utah’s Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights

Town of Dillon is committed to the privacy of your health information. The administrators of the Town of Dillon Health Plan (the “Plan”) use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan’s policies protecting your privacy rights and your rights under the law are described in the Plan’s Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Human Resources at 970.513.3345 or HRmanager@townofdillon.com.

HIPAA Special Enrollment Rights

Town of Dillon Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Town of Dillon Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its “special enrollment provision” if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children’s Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents’ other coverage). However, you must request enrollment within 30 days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children’s Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children’s health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents’ coverage ends under Medicaid or a state children’s health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children’s Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children’s health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents’ determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan’s special enrollment provisions, contact Human Resources at 970.513.3345 or HRmanager@townofdillon.com.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children’s health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children’s health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan’s annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children’s health insurance program with respect to coverage under this plan.

Notice of Creditable Coverage

Important Notice from Town of Dillon

About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Town of Dillon 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. Town of Dillon has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

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

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

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Town of Dillon coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current Town of Dillon coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Town of Dillon 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 Town of Dillon changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: January 1, 2026
Name of Entity/Sender: Town of Dillon
Contact—Position/Office: Human Resources
Office Address: 275 Lake Dillon Dr, PO BOX 8
Dillon, Colorado 80435-0008
United States
Phone Number: 970.513.3345

COBRA General Notice

Model General Notice of COBRA Continuation Coverage Rights (For use by single-employer group health plans)

** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

What is COBRA continuation coverage?

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

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

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

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

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: HRManager@townofdillon.com.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

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

Second qualifying event extension of 18-month period of continuation coverage

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

Are there other coverage options besides COBRA Continuation Coverage?

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period¹ 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.

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

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

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

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

Keep your Plan informed of address changes

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

Plan contact information

Town of Dillon

Human Resources

275 Lake Dillon Dr, PO BOX 8

Dillon, Colorado 80435-0008

United States

970.513.3345

Marketplace Notice

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

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

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

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

¹ Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-22-34.pdf> for 2026.

² An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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

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

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

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

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

Marketplace-eligible individuals who live in states served by [HealthCare.gov](https://www.healthcare.gov) and either- submit a new application or update an existing application on [HealthCare.gov](https://www.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](https://www.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 Jo-Anne Tyson.

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.

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 Town of Dillon		4. Employer Identification Number (EIN) 84.0526980	
5. Employer address 275 Lake Dillon Dr, PO BOX 8		6. Employer phone number 970.513.3345	
7. City Dillon		8. State Colorado	9. ZIP code 80435-0008
10. Who can we contact about employee health coverage at this job? Human Resources			
11. Phone number (if different from above)		12. Email address HRmanager@townofdillon.com	

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 who work 30 or more hours per week.
 - Some employees. Eligible employees are:
- With respect to dependents:
 - We do offer coverage. Eligible dependents are: Your spouse, domestic partner, children under age 26, and disabled dependents of any age.
 - 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](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.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)

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is “balance billing” (sometimes called “surprise billing”)?

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

“Out-of-network” means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called “balance billing.” This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services

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

Certain services at an in-network hospital or ambulatory surgical center

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

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

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

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

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

If you believe you've been wrongly billed, contact

<https://www.cms.gov/nosurprise> or call 1-800-985-3059 to obtain more information and complaints.

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

Visit [State Balance-Billing Protections | Commonwealth Fund](#) for more information about your rights under applicable state laws.

NOTES

NOTES

This benefit summary prepared by



Gallagher

Insurance | Risk Management | Consulting

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.