NOTICE TO ENROLLEES IN A SELF-FUNDED NONFEDERAL GOVERNMENTAL GROUP HEALTH PLAN

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must generally comply with the requirements listed below. However, the law also permits State and local governmental employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. The Boards of Education Self-funded Trust (BEST) has elected to exempt BEST Health Plan from the following requirements:

Parity in the application of certain limits to mental health benefits. Group health plans (of employers that employ more than 50 employees) that provide both medical and surgical benefits and mental health or substance use disorder benefits must ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applicable to substantially all medical and surgical benefits covered by the plan.

The exemption from these Federal requirements will be in effect for the plan year beginning July 1, 2014 and ending June 30, 2015. The election may be renewed for subsequent plan years.

HIPAA also requires the Plan to provide covered employees and dependents with a "certificate of creditable coverage" when they cease to be covered under the Plan. There is no exemption from this requirement. The certificate provides evidence that you were covered under this Plan, because if you can establish your prior coverage, you may be entitled to certain rights to reduce or eliminate a preexisting condition exclusion if you join another employer’s health plan, or if you wish to purchase an individual health insurance policy.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema?

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, call your plan administrator.

SPECIAL ENROLLMENT NOTICE

The BEST Health Plan is in compliance with health care laws that are included in Part 7 of the Employee Retirement Income Security Act (ERISA).
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) places certain limitations on a Group Health Plan's ability to impose pre-existing condition exclusions, provides special enrollment rights for certain individuals and prohibits discrimination in group health plans based on health status.

PLEASE BE ADVISED

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan if you qualify under special enrollment, provided that you request enrollment within 31 days after your other coverage ends.

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, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

For special enrollment upon birth, adoption or placement for adoption coverage can be made effective the date of the event, provided you request and complete the required enrollment materials within 31 days of the event.

For special enrollment upon the loss of eligibility for other coverage, (including legal separation, divorce, death, termination of employment, exhaustion of Continuation Coverage, reduction in hours, and "aging out" under the other parent's coverage), upon the loss of employer contributions toward other coverage, or upon marriage, coverage can be made effective the first day of the month following the date of the event provided you request and complete the required enrollment materials within 31 days of the event.

NEWBORNS' ACT NOTICE

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

CONTINUATION COVERAGE UNDER COBRA

This notice applies to everyone with healthcare coverage under the Plan. This notice contains important information about COBRA continuation coverage, which is a temporary extension of healthcare coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you and your family need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law called COBRA. COBRA continuation coverage can become available to you when you would otherwise lose healthcare coverage under the Pan. It can also become available to other members of your family who have healthcare coverage under the Plan, when they would otherwise lose their healthcare coverage. For additional information about your rights and obligations under the Plan and under federal law, you should contact the COBRA Administrator.

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

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

- Your hours of employment are reduced; or
- Your employment ends (other than because of your gross misconduct).

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

- The employee dies;
- The employee’s hours of employment are reduced;
- The employee’s employment ends (other than because of his/her gross misconduct);
- The employee becomes covered by Medicare (under Part A, Part B, or both); or
- You become divorced or legally separated by court order from the employee.

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

- The parent-employee dies;
- The parent-employee’s hours of employment are reduced;
- The parent-employee’s employment ends (other than because of his/her gross misconduct);
- The parent-employee becomes covered by Medicare (under Part A, Part B, or both);
- The parents become divorced or legally separated by court order; or
- The child stops being eligible for healthcare coverage under the Plan as a "dependent child."

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the COBRA Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment (other than because of the employee’s gross misconduct), reduction in hours of employment, death of the employee, or the employee becoming covered by Medicare (under Part A, Part B, or both), the employer must notify the COBRA Administrator of the qualifying event.

For the other qualifying events (i.e. divorce or legal separation of the employee and spouse; or a child’s losing eligibility for healthcare coverage as a “dependent child”), the employee, spouse and/or child must notify the COBRA Administrator within 60 days after the qualifying event occurs. Notice must be sent to the COBRA Administrator listed in the “Plan Information” section of this document. Failure to comply with this deadline will result in the loss of all rights to COBRA continuation coverage.

Once the COBRA 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.

CONTINUATION COVERAGE UNDER COBRA (continued)

COBRA continuation coverage is a temporary continuation of healthcare coverage. COBRA continuation coverage may last for up to a total of 36 months when the qualifying event is (i) the death of the employee, (ii) the employee's becoming covered by Medicare (under Part A, Part B, or both), (iii) the employee's divorce or court-ordered legal separation from the spouse, or (iv) a child's losing eligibility for healthcare coverage as a "dependent child." When the qualifying event is the end of employment (other than for the employee's gross misconduct) or reduction of the employee's hours of employment, and the employee became covered by Medicare less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee may last for up to a total of 36 months after the date that the employee's Medicare coverage began. For example, if an employee becomes covered by Medicare 8 months before the date on which his employment terminates (other than for his/her gross misconduct), COBRA continuation coverage for his spouse and children may last for up to a total of 36 months after the date that the employee's Medicare coverage began, which is equal to 28 months after the date of the qualifying event (i.e. 36 months minus 8 months). Otherwise, when the qualifying event is the end of employment (other than for the employee's gross misconduct) or reduction of the employee's hours of employment, COBRA continuation coverage generally may last for up to a total of 18 months.

There are four ways in which the 18-month period of COBRA continuation coverage can be extended. First, the employee, spouse, and children may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months, if the employee, spouse, or child with healthcare coverage under the Plan is determined by the Social Security Administration to be disabled, and the employee, spouse, and/or child notifies the COBRA Administrator in a timely fashion (as described below). The disability would have to have started at some time on or before the 60th day of COBRA continuation coverage, and must last at least until the end of the first 18 months of continuation coverage. **To qualify for this extension, the employee, spouse, and/or child must notify the COBRA Administrator of the disability determination within 60 days of the date of the determination, and satisfactory evidence regarding the disability determination must be furnished to the COBRA Administrator by the end of the first 18 months of COBRA continuation coverage. Failure to comply with this deadline will result in the loss of all rights to the 11-month disability extension of COBRA continuation coverage.**

Second, the spouse and children may be entitled to receive up to an additional 18 months of COBRA continuation coverage, for a total maximum of 36 months, if the spouse and children experience a second qualifying event (as described below) while receiving 18 months of COBRA continuation coverage, and the employee, spouse, and/or child notifies the COBRA Administrator in a timely fashion (as described below). This extension is available to the spouse and children receiving continuation coverage if the employee or former employee dies, becomes covered by Medicare (under Part A, Part B, or both), or gets divorced or legally separated by court order from the spouse, but only if the event would have caused the spouse and children to lose healthcare coverage under the Plan had the first qualifying event not occurred. **To qualify for this extension, the employee, spouse, and/or child must notify the COBRA Administrator of the second qualifying event within 60 days of the date that it occurs. Failure to comply with this deadline will result in the loss of all rights to the 18-month extension of COBRA continuation coverage.**

Third, the employee's child may be entitled to receive up to an additional 18 months of COBRA continuation coverage, for a total maximum of 36 months, if the child experiences a second qualifying event (as described below) while receiving 18 months of COBRA continuation coverage, and the employee, spouse, and/or child notifies the COBRA Administrator in a timely fashion (as described below). This extension is available to the employee's child receiving continuation coverage if the child stops being eligible for healthcare coverage under the Plan as a "dependent child," but only if the event would have caused the child to lose healthcare coverage under the Plan had the first qualifying event not occurred**. To qualify for this extension, the employee, spouse, and/or child must notify the COBRA Administrator of the second qualifying event within 60 days of the date that it occurs. Failure to comply with this deadline will result in the loss of all rights to the 18-month extension of COBRA continuation coverage.**

Fourth, the employee, spouse, and children may be entitled to receive up to an additional 18 months of COBRA continuation coverage, for a total maximum of 36 months, if their COBRA continuation coverage is provided under a group health insurance policy issued or renewed in California (or under an agreement with a health maintenance organization in California), and the employee, spouse, and children are current or former residents of California.

CONTINUATION COVERAGE UNDER COBRA (continued)

This extension is available to the employee, spouse, and children receiving continuation coverage if their continuation coverage would otherwise end at the expiration of the original 18 month continuation period. Questions concerning the Plan or your COBRA continuation coverage rights should be addressed to the COBRA Administrator. For more information about your rights under COBRA, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration in your area, or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.

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

Loss of Benefits

The following circumstances may result in disqualification, or denial, loss, forfeiture, suspension, offset, reduction or recovery of any benefit that a Plan participant or dependent might otherwise reasonably expect the Plan to provide:

- an employee's cessation of active service for the employer;
- a participant's failure to pay his/her share of the cost of coverage, if any, in a timely manner;
- a dependent ceases to meet the Plan's eligibility requirements (e.g., a child reaches a maximum age limit or a spouse divorces the employee);
- a participant or dependent is injured by a third party, and expenses for treatment may be paid by or recovered from the third party or its insurer; or
- a claim for benefits is not filed within the Plan's applicable time limits.

MEDICARE PART D
CREDITABLE COVERAGE DISCLOSURE NOTICE

Important Notice from BEST 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 BEST 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. BEST has determined that the prescription drug coverage offered by the BEST Health 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 through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two 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 BEST Health Plan coverage will not be affected. You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current BEST Health Plan coverage, be aware that you and your dependents will 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 [Insert Name of Entity] 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 November 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 BEST changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: October 15, 2013
Name of Entity/Sender: Colorado Choice Health Plans for BEST Health Plan
Contact--Position/Office: Health Plan
Address: 1200 Grant St. Denver CO 80203
Phone Number: 800.475.8466

MEDICAID AND CHIP

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 January 31, 2014. Contact your State for more information on eligibility – ALABAMA – Medicaid

Website: http://www.medicaid.alabama.gov
Phone: 1-855-692-5447

ALASKA – Medicaid

Website: http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529

ARIZONA – CHIP

Website: http://www.azahcccs.gov/applicants
Phone (Outside of Maricopa County): 1-877-764-5437
Phone (Maricopa County): 602-417-5437

GEORGIA – Medicaid

Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: 1-800-869-1150

IDAHO – Medicaid

Medicaid Website: http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx
Medicaid Phone: 1-800-926-2588

COLORADO – Medicaid

Medicaid Website: http://www.colorado.gov/
Medicaid Phone (In state): 1-800-866-3513
Medicaid Phone (Out of state): 1-800-221-3943

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/
Phone: 1-877-357-3268

MONTANA – Medicaid

Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml
Phone: 1-800-694-3084