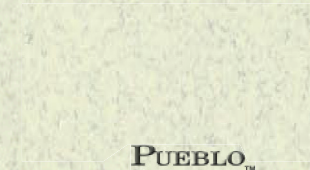


CHEIBA Trust Employee Benefit Plan

2012 Plan Year



METROPOLITAN STATE
COLLEGE of DENVER



UNIVERSITY of
NORTHERN COLORADO



IMPORTANT
INFORMATION INCLUDED INSIDE ABOUT
1) MEDICARE PART D - NOTICE OF CREDITABLE COVERAGE AND
2) CONTINUATION RIGHTS UNDER COBRA

CHEIBA Trust Members

ADAMS STATE COLLEGE

AURARIA HIGHER EDUCATION CENTER

COLORADO SCHOOL OF MINES

COLORADO STATE UNIVERSITY – PUEBLO

**COLORADO STATE UNIVERSITY SYSTEM AND
COLORADO STATE UNIVERSITY - GLOBAL CAMPUS**

FORT LEWIS COLLEGE

METROPOLITAN STATE COLLEGE OF DENVER

UNIVERSITY OF NORTHERN COLORADO

WESTERN STATE COLLEGE

2012 Benefit Plan Year

If you 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 21 and 22 for more details.

EMPLOYEE BENEFIT PLAN CONTACTS

Health Insurance

Anthem Blue Cross and Blue Shield	www.anthem.com
➤ BlueAdvantage Point of Service Plan (HMO/POS)	
➤ PRIME Health Plan (PPO) and Custom Plus Health Plan	
Phone.....	1-800-542-9402
Provider Directories for Health and Dental	www.anthem.com
 HMO Landmark Healthcare (chiropractor, acupuncture, massage therapy, nutritional counseling).....	www.landmarkhealthcare.com
Phone.....	1-800-638-4557
 Future Moms	1-800-828-5891
 24/7 NurseLine.....	1-800-337-4770
 Prescription Drug Benefit	
Express Scripts Mail Order	1-866-297-1011
Curascript (Specialty Drugs)	1-800-870-6419

Dental Insurance

Anthem Blue Cross and Blue Shield	www.anthem.com
➤ Anthem Blue Dental PPO Plus	
➤ Anthem Blue Dental PPO	
Phone.....	1-800-627-0004

Vision Service Plan (VSP)

Vision Service Plan	www.vsp.com
Phone.....	1-800-877-7195
Laser VisionCare	
Phone	1-800-877-7195

Basic Term Life Insurance & Voluntary Term Life

Anthem Life Insurance Company	www.anthem.com
Phone	1-800-551-7265

Voluntary Accidental Death & Dismemberment Insurance

Mutual of Omaha Insurance Company	www.mutualofomaha.com
Phone	1-800-524-2324

Flexible Benefit Plan

PayFlex Systems USA, Inc. www.healthhub.com
(Except Fort Lewis College - See Separate Insert)
Phone 1-800-284-4885
Claims Fax..... 1-402-231-4310
or 1-800-450-0016
Express Claim Service www.healthhub.com

Long Term Disability Insurance

Standard Insurance Company www.standard.com
Phone 1-800-368-1135

PERA Disability Program

PERA www.copera.org
Phone303-832-9550
or 1-800-759-7372

Travel Accident Insurance

Chubb
Phone 1-866-832-6930
E-Mail operations@medexassist.com

Retirement Plans

PERA www.copera.org
Phone303-832-9550
or 1-800-759-7372

Employer-Provided Plans (see Human Resources/Benefits Office)
Voluntary Tax-Deferred Retirement Plan Options (varies by location)

Participant Advocate Link (P.A.L.)

Gallagher Benefit Services, Inc
Phone303-889-2790
or 1-800-943-0650
Fax.....303-889-2693
E-Mail PAL_GBI@ajg.com

COBRA Coverage

HealthSmart
Phone 1-800-423-4445
E-Mail askcobra@healthsmart.com

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INTRODUCTION

The Colorado Higher Education Insurance Benefits Alliance Trust (CHEIBA Trust) and the CHEIBA Trust Members are pleased to announce your Employee benefit choices effective for 2012. The information in this manual is provided to answer your benefit questions so you may feel confident in selecting the benefit package that best meets your individual needs.

Please read the benefit summaries carefully before completing your Election Forms. There have been additions and changes to your benefits for the 2012 plan year. If you have questions or concerns, phone numbers and website addresses are included for your convenience.

Disclaimer:

These benefits are designed to meet your individual needs and preferences. While we expect to offer these benefits in future years, the CHEIBA Trust retains the right to discontinue or change the benefits at any time. Changes will be communicated, in writing, to all benefit-eligible Employees.

In preparing these written materials, every attempt has been made to convey accurate information. The materials provide a summary of your benefits to be used as reference throughout the plan year.

In the event of a discrepancy between the information contained herein and the Trust Agreement, a plan document or certificate of insurance under which a specific benefit or insurance is provided, the terms of the plan document or certificate of insurance shall take precedence over this booklet and shall prevail in settling any disputes or claims that may arise. If errors or discrepancies are found, contact your Human Resources/Benefits Office for the official plan document.

BENEFIT HIGHLIGHTS

BENEFIT ELIGIBILITY

Benefits under the CHEIBA Trust Plan are available to Eligible Employees and Dependents of the State colleges, universities and institutions of higher education who participate in the CHEIBA Trust.

Employee

"Employee" means all exempt faculty and administrative personnel of an Employer that are regularly scheduled to work at least .5 FTE and that are included on the payroll records of the Employer. Leased Employees, independent contractors and part-time Employees who work less than .5 FTE are not eligible. Eligible Employees on an authorized leave of absence not to exceed a 24 consecutive month period, including Employees on sabbatical and summer break, are included as Eligible Employees until the Employer notifies the insurance company of termination of eligibility.

Dependent

- A. "Dependent" means an Employee's (a) legal spouse; and (b) an Employee's married or unmarried child(ren), regardless of tax dependent status, until the end of the month of their 26th birthday; or an Employee's child(ren) of any age who are medically certified by a physician as disabled. Dependents must also satisfy the requirements of the Internal Revenue Code to qualify as tax dependents of the Employee for life insurance purposes and satisfy the eligibility requirements for coverage under a Benefit Plan. A Dependent may also include a qualified step-child(ren), qualified foster child(ren) or child(ren) for whom the Employee is required to provide health benefits pursuant to a court order or qualified medical child support order. A Dependent shall also include any dependent that is required by State insurance law to be covered or offered coverage under any insurance contract issued to the Trust for a Benefit Plan.
- B. For purposes of medical, dental, voluntary vision, voluntary life, and voluntary accidental death and dismemberment benefits (hereinafter collectively referred to as "Benefits"), including any COBRA rights related to such Benefits, a Dependent shall also include an Employee's Domestic Partner as described in paragraph 1 and the child of an Employee's Domestic Partner as described in paragraph 2.
 1. An Employee's Domestic Partner is an adult of the same or opposite gender as the Employee, whose personal relationship with the Employee meets the criteria established by the Trust Committee for domestic partnership. The Employee must follow the procedures established by the Trust Committee with regard to the enrollment and termination of a Domestic Partner, including the completion of an Affidavit for Domestic Partnership. A Domestic Partner is not a legal spouse of an Employee under Colorado law pursuant to C.R.S. 14-2-104.
 2. The natural or adopted child of a Domestic Partner who is not related by blood, adoption or court order to the Employee, is a child who satisfies the Dependent definition as stated under Dependent, Section A. Dependents must also satisfy the eligibility requirements for coverage under a Benefit Plan. A Dependent shall also include any dependent that is required by State insurance law to be covered or offered coverage under any insurance contract issued to the Trust for a Benefit Plan. The Employee must follow the procedures established by the Trust Committee with regard to enrollment and termination of coverage for the child(ren) of a Domestic Partner.

- C. For the purposes of an Anthem certificate of insurance evidencing medical, dental and voluntary life coverage, any reference to the term "spouse" shall also include a Domestic Partner.

Participant

"Participant" means an Eligible Employee, Dependent or Beneficiary who satisfies the requirements for participating in any Benefit Plan offered under the Trust, and includes any former Employee, former Dependent, qualified Beneficiary or Retiree whose coverage under any Benefits Plan is continued or extended in accordance with the provisions of the Benefit Plan and Trust.

Retiree

"Retiree" means a Participant in the CHEIBA Trust Health Benefit Plan who satisfies **all** of the following requirements: (1) on or after January 1, 1999, terminates employment with a College on or after age 50 and prior to age 65, due to retirement; (2) who is immediately eligible to commence receiving retirement benefits under a qualified retirement plan sponsored by an Employer; (3) was covered by the CHEIBA Trust Health Benefit Plan immediately prior to retirement; (4) upon termination of employment elects to continue coverage under the CHEIBA Trust Health Benefit Plan pursuant to the Consolidated Omnibus Budget Reconciliation Act (COBRA) and, (5) exhausts such COBRA coverage and timely elects to continue coverage under the CHEIBA Trust Health Benefit Plan as a Retiree.

The CHEIBA Trust Benefit Plans are fully insured, and benefits are provided under fully insured master contracts with several insurance companies. Entitlement and eligibility for benefits is governed by the terms of each insurance contract and certificate of insurance issued to you by an insurance company. In the event of a conflict between the provisions of this summary and the insurance contract or certificate, the terms of the certificate and insurance contract will control. Each certificate of insurance coverage contains a separate definition of Eligible Dependent. Your Eligible Dependents must also satisfy any requirements contained in a certificate of insurance coverage from the insurance companies providing benefits under the Benefit Plan.

Enrollment

Eligible Employees must complete and file an enrollment application within 31 days of their first day of employment and authorize payroll deductions for the coverage elected. Coverage under the Trust is effective on an Employee's date of hire unless coverage is waived. Eligible Employees may waive medical and dental coverage if they submit evidence of coverage under another group health plan and submit a signed waiver form during initial or annual enrollment. If coverage under the Medical and Dental Benefits Plans is waived, Dependent coverage must also be waived. If coverage is waived, Eligible Employees and their Dependents may enroll in coverage under a Benefits Plan only during the next annual open enrollment or within 31 days of a qualifying event under IRC section 9801.

NOTE ON MEDICAL AND DENTAL: Employees must enroll in both medical and dental insurance. If Employees waive medical insurance, dental insurance must also be waived. Coverage may also be waived due to religious affiliation. All waiver and enrollment requests must be approved by your Human Resources/Benefits Office.

NOTE ON BASIC TERM LIFE & AD&D (provided by Anthem Life) AND LONG TERM DISABILITY (provided by Standard Insurance): Employees must enroll in basic term life and accidental death and dismemberment insurance provided by Anthem Life and long term disability insurance provided by Standard Insurance. Such insurance coverages may not be waived.

Default Medical and Dental Coverage

If an Eligible Employee does not complete and file an enrollment application or waiver form within 31 days of the first day of employment, the Employee will automatically be enrolled in the medical benefits PRIME Health (PPO) Plan option and Anthem Blue Dental PPO Plus plan. Contributions will be deducted from the Employee's payroll on an after-tax basis as a condition of employment if the Employer requires Employee contributions. Changes to default coverage are only permitted during the annual open enrollment and within 31 days of a qualifying status change.

Annual Open Enrollment

Each fall the CHEIBA Trust and the CHEIBA Trust Members announce an annual open enrollment period, during which time Eligible Employees may make certain coverage changes. During open enrollment, Employees may add or delete Eligible Dependents from coverage under the Plan. Employees and qualified beneficiaries may add dependents only during open enrollment or during "special enrollment and qualifying status changes" described later in this summary.

Termination of Eligibility

Eligibility to participate in the Benefit Plans under the Trust shall terminate on the earliest of the following dates:

- ◆ The last day of the month following the month in which an Employee terminates employment for any reason including death and retirement,
- ◆ The last day of the month in which an Employee ceases to satisfy the definition of an Eligible Employee either because of a change in status or a reduction in the scheduled work hours per week falls below the minimum number of hours required for coverage under the Trust,
- ◆ The last day of the month for which contributions are paid in a timely manner,
- ◆ The date the Trust or any Benefit Plan under the Trust is terminated or amended to terminate benefits for any class of Participants,
- ◆ The effective date an Employee elects to waive coverage under any Benefit Plan,
- ◆ The date a Participant enters the armed forces of any country on active full-time duty,
- ◆ The date any certificate of insurance coverage issued under any Benefit Plan is terminated or amended to terminate coverage for any Participant, or
- ◆ The date a Participant falsifies or misuses documents or information relating to coverage or services under any Benefit Plan or any certificate.

Dependent coverage terminates on the earliest of the date coverage would otherwise terminate above, and the following:

- ◆ The date a Dependent enters the armed forces of any country on active full-time duty,
- ◆ The last day of the month in which the Dependent ceases to satisfy the definition of a Dependent under the Trust, any Benefit Plan under the Trust or any certificate of insurance coverage,
- ◆ The last day of the month a Dependent child turns age 26.

Leaves of Absence

Coverage under the Plan may continue for certain Employees on an Approved Leave of Absence, including but not limited to:

- ◆ Short Term Disability/Long Term Disability
- ◆ Workers Compensation Leave
- ◆ Family and Medical Leave Act
- ◆ Military Leave under the "Uniformed Services Employment and Reemployment Rights Act"

Domestic Partner Benefits

Effective as of January 1, 2009, the Colorado Higher Education Insurance Benefits Alliance Trust (the "CHEIBA Trust") modified the definition of "Dependent" to include Domestic Partners of covered Employees. This means that Domestic Partners are eligible for group medical, dental, voluntary vision, voluntary life, and voluntary accidental death and dismemberment benefits offered by the CHEIBA Trust Members.

A Domestic Partner is an adult who shares a committed relationship with a CHEIBA Trust Member's eligible Employee of the same or opposite gender, evidenced by an Affidavit of Domestic Partnership filed by the Employee with their respective employer.

- ◆ **Affidavit of Domestic Partnership:** The Affidavit of Domestic Partnership contains an affirmation by the Employee and the Domestic Partner of the following:
 - They are both at least 18 years of age and are mentally competent to contract;
 - Neither is legally married to another person, nor is either a member of another domestic partnership;
 - They are sole Domestic Partners and have been living together as Domestic Partners in a shared residence for at least 12 consecutive months preceding the date of the Affidavit, and they intend to remain sole Domestic Partners indefinitely;
 - They are not related by blood closer than permitted by state law for marriage in the State of Colorado;
 - They are jointly responsible for each other's common welfare as evidenced through two of the following: a joint deed, joint mortgage, joint lease, joint credit card, joint bank account, previous designation of Domestic Partner as beneficiary for a life insurance or retirement contract, designation of Domestic Partner as primary beneficiary in the Employee's will, joint designation of durable powers of attorney authorizing each of them to act on behalf of the other (such joint designation to constitute but one form of documentation), jointly named on auto, renters or homeowners insurance policies, and have attached copies of at least two of these documents to the Affidavit;
 - They understand and agree that if insurance benefits are fraudulently obtained or provided as a result of their declarations contained in the Affidavit, they will be jointly liable for any benefits received through insurance procured under the Affidavit, including attorneys' fees that may apply. In addition, the Employee may be subject to disciplinary action, up to and including termination of employment;
 - It has been at least 12 months since a previous Statement of Termination of Domestic Partnership from either individual has been filed (if applicable); and
 - They understand that a Domestic Partner enrolled as a dependent ceases to be an eligible member on the last day of the month in which the domestic partnership was terminated and that the Employee agrees to submit a Statement of Termination of Domestic Partnership form and an Enrollment Application/Change Form within 31 days of the termination of the domestic partnership.

The affidavit must be signed by both partners and witnessed by a notary public.

◆ **Legal Concerns**

The Affidavit of Domestic Partnership required to register a Domestic Partner includes an attestation of the relationship. Due to the legal obligations that may be created between the Employee and the Domestic Partner by submitting such an affidavit, both parties are advised to consult an attorney for advice.

◆ **Eligibility for Coverage**

Domestic Partners and their eligible dependents will be eligible for medical, dental, voluntary vision, voluntary life, and voluntary accidental death and dismemberment insurance in the same manner as for an Employee's spouse and other dependent children.

◆ **Enrollment Procedure**

Enrolling a Domestic Partner is subject to the same limitations that apply to a spouse or child. Enrollment is limited to:

- within 31 days of being hired into a benefits eligible appointed position, or
- during an annual Open Enrollment period for benefits effective the following January 1st, or
- within 31 days of all IRS-defined change of status (e.g., birth/adoption of a child or loss of a partner's coverage through his or her employer), or
- within 31 days of meeting the criteria to establish a domestic partnership as defined by the CHEIBA Trust.

To enroll, the Employee must file an Affidavit of Domestic Partnership to enroll a Domestic Partner and the Domestic Partner's children.

◆ **Termination of Domestic Partnership**

In the event a domestic partnership ends, the Employee is required to file a Statement of Termination of Domestic Partnership form within 31 days of the termination of the domestic partnership. If there is any change in status of the criteria set forth in the Affidavit of Domestic Partnership that would terminate the domestic partnership, the Employee must similarly complete a Statement of Termination of Domestic Partnership and return it to the Human Resources/Benefits Office within 31 days of the change.

Medical, dental, life, vision and accidental death and dismemberment benefits for the Domestic Partner and their eligible children, if any, will be discontinued on the first day of the month following the date of termination of the domestic partnership. The respective employer will provide any applicable notice of rights to continue benefit coverage to the former Domestic Partner.

The Employee must also mail a copy of the Statement of Termination of Domestic Partnership to the former Domestic Partner within ten days of completing the Statement. Once a Statement of Termination of Domestic Partnership has been submitted, the Employee may not establish another domestic partnership until 12 months after the termination of the previous domestic partnership.

◆ **Employee Liability**

If the Employee fails to file a Statement of Termination of Domestic Partnership on a timely basis, or otherwise supplies any false or misleading statements in order to obtain Domestic Partner benefits to which the Employee is not otherwise entitled, the Employee shall be liable to the CHEIBA Trust or his or her employer for all resulting monetary damages, costs and attorneys' fees which result from such actions. In addition, the Employee may be subject to disciplinary action, up to and including termination of employment.

- ◆ **Flex Plans**

If the Domestic Partner and his/her children are the Employee's tax dependents for health and dental plan purposes and the Employee has completed a Certification of Tax-Qualified Dependents, then the Employee may receive reimbursements of their expenses from the Employee's flexible spending account. If the Domestic Partner and his/her children are **not** the Employee's tax dependents, however, then their expenses are not eligible for reimbursement from the Employee's flexible spending account.

Benefits relating to the Domestic Partner and his/her children under dependent care spending accounts will depend on how the Domestic Partner and/or his or her children fit within the guidelines established by the tax code for these benefits.

- ◆ **COBRA**

While continuation of medical, dental and voluntary vision coverage is not required under federal COBRA laws, such coverage is allowed under the same terms that would apply to an Employee's spouse and children. A registered Domestic Partner and/or children of the Domestic Partner enrolled in medical, dental and voluntary vision plans have 60 days from the date that eligibility for coverage ends to enroll in COBRA coverage.

- ◆ **Tax Effect**

IRS regulations require the employer to tax the Employee for the excess of the fair market value of coverage provided to the Domestic Partner and his/her children over the amount the Employee pays, if any, for the coverage. In general, an Employee's premiums for coverage of a Domestic Partner or dependent of a Domestic Partner are paid on an after-tax basis. There is an exception to this rule if the Domestic Partner and his/her children are tax dependents for health and dental plan purposes. Please review the document titled, "Important Tax Information for Domestic Partner Health and Dental Benefits", and complete the Certification of Tax-Qualified Dependents, if appropriate.

- ◆ **Benefit Availability**

Although the CHEIBA Trust and the member schools intend to offer domestic partnership benefits for medical, dental, voluntary vision, voluntary life, and voluntary accidental death and dismemberment insurance indefinitely, such benefits are dependent, in part, on their availability in the group health insurance market. As always, the CHEIBA Trust and its member schools reserve the right to amend, suspend or terminate its benefit plans at any time in accordance with the Trust Agreement.

Contact your Human Resources/Benefits Office for more information.

Retiree Continuation of Coverage

Retirees and their dependents shall be eligible to continue medical insurance coverage only under the Anthem Blue Cross and Blue Shield fully insured Medical Benefit Plan coverage. Retirees are not eligible to participate in any other Benefit Plans offered under the Trust. An Eligible Retiree must enroll in the Medical Benefit Plan immediately after continuation of coverage under COBRA is exhausted with no lapse in coverage under the Medical Benefit Plan (electing and exhausting COBRA coverage is the only way a retiree is eligible for CHEIBA retiree health coverage). Once Retiree coverage under the Medical Benefit Plan terminates for any reason set forth above, coverage may not be reinstated. In addition to the termination provisions above, Retiree coverage terminates on the last day of the month in which a Retiree becomes covered under any other group medical plan, Medicare, or the Colorado Public Employees Retirement Association retiree health plan. Retirees and their Dependents may make enrollment changes during the Medical Benefit Plan open enrollment period each year and due to Qualifying Events. If the CHEIBA Trust terminates the Anthem Blue Cross and Blue Shield fully insured Medical Benefit Plan coverage, a Retiree's coverage shall also terminate with no guarantee of coverage under a new Medical Benefit Plan coverage option, nor any conversion or continuation rights.

Retirees must pay the entire contribution applicable to Retirees, including any Contribution rate increases, for Medical Benefit Plan coverage in a timely manner. Contributions are due on the first calendar day of the month of coverage and are considered timely paid if received by the Plan Administrator by the last calendar day of the month. If payment is not received by the last calendar day of the month, then coverage will terminate effective the last day for which a premium was paid.

Authority of the CHEIBA Trust Committee

The CHEIBA Trust Committee has the sole and absolute discretion to interpret the terms of the Plan and determine the right of any Participant to receive benefits under the CHEIBA Trust Plan. The right of any Participant to receive benefits under a fully insured benefit plan shall be determined by the insurance company pursuant to the terms of its insurance contract and certificate of insurance. The CHEIBA Trust Committee's decision is final, conclusive and binding upon all parties.

Assignment and Payment of Benefits

No benefit payable under the Plan can be assigned, transferred or subject to any lien, garnishment, pledge or bankruptcy. However, a Participant may assign benefits payable under this Plan to a provider or hospital pursuant to the term of the certificate. Ultimately, it is the Participant's responsibility to pay any hospital or provider. If the benefit payment is made directly to a Participant, for whatever reason, such payment shall completely discharge all liability of the Plan, the CHEIBA Trust Committee and the Employer.

If any benefit under this Plan is erroneously paid to a Participant, the Participant must refund any overpayment back to the Plan. The refund may be payment, reduction of future benefits otherwise payable under the Plan, or any other method as the CHEIBA Trust Committee in its sole discretion, may require.

Right to Information and Fraudulent Claims

The CHEIBA Trust Committee has the right to request information from any Participant to verify his/her eligibility and entitlement to benefits under the Plan. If a Participant falsifies any document in support of a claim or coverage under the Plan, the CHEIBA Trust Committee may, without the consent of any person, terminate coverage and refuse to honor any claims under the Plan for the Participant and Dependent, and the Participant may be liable to the CHEIBA Trust or his or her employer for all resulting monetary damages, costs and attorneys' fees which result from such actions. In addition, the Employee may be subject to disciplinary action, up to and including termination of employment.

Third Party Reimbursement and Subrogation

If you or a covered Dependent receive benefits under a CHEIBA Trust Plan for injury, sickness or disability that was caused by a third party, and you have a right to receive a payment from the third party, then the CHEIBA Trust has the right to recover payments for the benefits paid by the CHEIBA Trust Plans. If you recover any amount for covered expenses from a third party, the amount of benefits paid by the CHEIBA Trust Plans will be reduced by the amount you recover.

In making a claim for benefits from the CHEIBA Trust Plans, you and your covered Dependents agree that the CHEIBA Trust will be subrogated to any recovery, or right of recovery, you or your Dependent has against any third party, and that the CHEIBA Trust will be reimbursed and will recover 100% of any amount paid by the CHEIBA Trust Plans or amounts which the Plans are otherwise obligated to pay. You also agree that you will not take any action that would prejudice the CHEIBA Trust's subrogation rights and will cooperate in doing what is reasonably necessary to assist the CHEIBA Trust in any recovery. The CHEIBA Trust has a right to pursue all legal and equitable remedies to recover, without deduction for attorney's fees and costs or other expenses you incur, and without regard to whether you or a covered Dependent is fully compensated by the recovery or made whole. The Plan's right of recovery and reimbursement is a first priority and first lien against any settlement, judgment, award or other payment obtained by you or your Dependents, for recovery of amounts paid by the CHEIBA Trust Plans.

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

USERRA provides for, among other employment rights and benefits, continuation of medical, dental and voluntary vision coverage to a covered Employee and covered dependents, during a period of active service or training with any of the Uniformed Services. The Act provides that a covered Employee may elect to continue such coverages in effect at the time the Employee is called to active service.

The maximum period of coverage for the Employee and the covered Employee's dependents under such an election shall be the lesser of:

- ▶ the 24-month period beginning on the date the person's absence begins; or
- ▶ the period beginning on the date the covered Employee's absence begins and ending on the day after the date on which the covered Employee fails to apply for or return to a position of employment as follows:
 - ◆ for service of less than 31 days, no later than the beginning of the first full regularly scheduled work period on the first full calendar day following the completion of the period of service and the expiration of eight hours after a period allowing for the safe transportation from the place of service to the covered Employee's residence or as soon as reasonably possible after such eight-hour period;
 - ◆ for service of more than 31 days but less than 181 days, no later than 14 days after the completion of the period of service or as soon as reasonably possible after such period;
 - ◆ for service of more than 180 days, no later than 90 days after the completion of the period of service; or
 - ◆ for a covered Employee who is hospitalized or convalescing from an illness or injury incurred in or aggravated during the performance of service in the Uniformed Services, at the end of the period that is necessary for the covered Employee to recover from such illness or injury. Such period of recovery may not exceed two years.

A covered Employee who elects to continue health plan coverage under the Plan during a period of active service in the Uniformed Services may be required to pay not more than 102% of the full premium under the plan associated with such coverage for the employer's other Employees, except that in the case of a covered Employee who performs service in the Uniformed Services for less than 31 days, such covered Employee may not be required to pay more than the Employee share, if any, for such coverage. Continuation coverage cannot be discontinued merely because activated military personnel receive health coverage as active duty members of the Uniformed Services, and their family members are eligible to receive coverage under the Department of Defense's managed health care program, TRICARE.

In the case of a covered Employee whose coverage under a health plan was terminated by reason of services in the Uniformed Services, the pre-existing exclusion and waiting period may not be imposed in connection with the reinstatement of such coverage upon reemployment under this Act. This applies to the covered Employee who is reemployed and any dependent whose coverage is reinstated. The waiver of the pre-existing exclusion shall not apply to illness or injury which occurred or was aggravated during performance of service in the Uniformed Services.

"Uniformed Services" shall include full time and reserve components of the United States Army, Navy, Air Force, Marines, Coast Guard, Army National Guard, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

If you are a covered Employee called to a period of active service in the Uniformed Service, you should check with the Plan Administrator for a more complete explanation of your rights and obligations under USERRA. In the event of a conflict between this provision and USERRA, the provisions of USERRA, as interpreted by us or your former employer, will apply.

BENEFIT PLAN CHOICES

Employees must enroll in both Medical and Dental insurance. If Employees waive Medical insurance, Dental insurance must also be waived. Coverage may also be waived due to religious affiliation. All waiver and enrollment requests must be approved by your Human Resources/Benefits Office.

Medical Insurance Anthem Blue Cross and Blue Shield

You select your medical plan coverage during open enrollment or when you become a new benefit-eligible Employee. Three options are available:

- 1) **BlueAdvantage Point-of-Service Plan (HMO/POS)**
- 2) **PRIME Health Plan (PPO)**
- 3) **Custom Plus Health Plan** *(closed to new enrollment January 1, 2010)*

NEW:

The following benefit changes are effective January 1, 2012:

► **HMO/POS Plan**

	Current	New
Medical Office Visit copay for Primary Care Providers & Specialists	\$15 copay	\$20 copay
Outpatient Ambulatory Surgery	\$75 per procedure	\$85 per procedure

► **PRIME Health Plan (PPO)**

Deductible	In Network		Out of Network	
	Current	New	Current	New
Individual	\$350	\$400	\$840	\$960
Family	\$700	\$800	\$1,680	\$1,920

- Expanded list of exclusions (please see certificate booklet for detailed list of exclusions)

Reminders:

- The contracted lab provider for Anthem is LabCorp.
- Flu Shots received at other locations (other than an in-network provider's office) are reimbursable up to approximately \$25 using the Flu Shot claim form at www.anthem.com, Colorado, Answers@Anthem, Download Commonly Requested Forms, Large Group Forms, Flu Shot Clinic Form.

- ▶ PPO Plan Carryover Deductible Credit – If you have **not** met your required member's benefit year deductible, and your covered services during the last three months of the member's benefit year are less than or equal to the required deductible amount, the eligible expenses you incur during the last three-month period will be carried over to your individual deductible requirement for the new member's benefit year. If you have family membership, carryover deductible credit will be applied to each individual of the family contract as described above.
- ▶ Custom Plus Plan (closed to new enrollment effective January 1, 2010)

Dental Insurance Anthem Blue Cross and Blue Shield

You select your dental plan coverage during open enrollment or when you become a new benefit-eligible Employee. Two options are available:

→ Anthem Blue Dental PPO Plus

→ Anthem Blue Dental PPO

NOTE: Out-of-network services may be subject to balance billing. Out-of-network provider payments are based on a maximum allowable charge. If a provider's charge exceeds the maximum allowable charge, you, the member, pay the excess as an out-of-pocket.

Remember: Always verify in-network provider participation via the *Anthem.com Website* or by contacting your provider prior to receiving services.

Vision Insurance VSP

This is a voluntary Employee-paid option selected during open enrollment each year. LASIK discounts are included in this plan.

Basic Term life Insurance Anthem Life Insurance Company

Term Life and Accidental Death and Dismemberment coverage is provided as a basic plan. The basic coverage is two times your annual base salary (until age 65) to a maximum of \$500,000 in death benefits for all benefit-eligible Employees. Review Anthem Basic Term Life Insurance section for details regarding basic coverage for Employees 65 and older. There is Dependent life coverage included in the group life insurance premium (see Basic Term Life Insurance section for details).

Voluntary Employee-Paid Term Life Insurance Anthem Life Insurance Company

This plan is available for all benefit-eligible Employees, their spouses, Domestic Partners and children. An Employee can purchase coverage in \$10,000 increments to a maximum of \$300,000 in death benefits for yourself, your spouse and your Domestic Partner. Eligible Dependent children can be covered to a maximum of \$5,000 per child. (Restrictions apply. See Voluntary Term Life Insurance chapter for details).

Voluntary Employee-Paid Accidental Death & Dismemberment Insurance
Mutual of Omaha Insurance Company

Accidental Death and Dismemberment Insurance can be purchased as an Employee Only Plan or an Employee and Family Plan. Coverage for you is available to a maximum of \$500,000. Under the Family Plan, the benefit amount to your spouse or Domestic Partner will be 50% of yours and each eligible child's benefit amount will be 10% of yours.

Flexible Benefit Plan
PayFlex Systems USA, Inc.
(Except for Fort Lewis College)

The colleges, universities and institutions of higher education participating in the CHEIBA Trust offer a Flexible Benefit Plan under Section 125 of the Internal Revenue Code. There are three separate and optional components under the Plan: Pre-Tax Insurance Premium Payments, Health Care Spending Account, and Dependent Care Spending Account. These options provide you with the opportunity to pay some of your insurance premiums and other eligible family expenses with pre-tax dollars. Once selected, the Pre-Tax Insurance Premium Payment option will continue until a waiver is signed during open enrollment or as the result of a qualifying status change. Employees must re-enroll in the Health Care Spending Account and the Dependent Care Spending Account during open enrollment each year, or enroll as a new benefit-eligible Employee. The Spending Accounts are administered by PayFlex Systems, USA, Inc. (except for Fort Lewis College).

Reminder:

The definition of qualified medication expenses for purposes of Flexible Spending Accounts is now limited to prescribed medications and insulin. Prescribed medications include medications that are also available over the counter as long as participants have prescriptions from their physicians.

HEART Act (Heroes Earnings Assistance and Relief Tax Act of 2008)

Effective as of January 1, 2011, if you are a member of a reserve unit and are ordered or called to active duty, then you may be able to request a Qualified Reservist Distribution (QRD) from your Health Flexible Benefit Plan (Health FSA). A QRD is a taxable cash distribution of amounts from your Health FSA that is not dependent on whether you have incurred medical expenses. You can only request this distribution if you are ordered or called to active duty for a period in excess of 180 days or for an indefinite period. You may only request this distribution during the period beginning on the date of the order or call and ending on the last date that reimbursements could otherwise be made under the Plan for the Plan Year which includes the date of the order or call.

Long-Term Disability Insurance
Standard Insurance

Should you experience a long-term disability, the plan will pay 66 2/3% of your salary to a maximum benefit of \$7,000 per month, reduced by other income you receive or are eligible to receive because of your disability. You are eligible for benefits after you have been disabled for 90 days.

PERA Disability Program

(Requires five years of earned service credit to be vested in PERA)

PERA Disability Program

If you believe you may have a potentially disabling condition, you should discuss all of your options with your Human Resources/Benefits Office. One of those options is the PERA Disability Program. Once you have discussed your options with your employer, contact PERA's Customer Service Center to discuss the PERA Disability Program and to request a Disability Program booklet, which includes the program's application form. You can also obtain this information on PERA's website.

Travel Accident Insurance Chubb

This employer-paid insurance provides protection should you be seriously injured or die during employer-approved work-related travel (i.e. conferences, seminars and workshops etc).

Retirement Plans Choices are available based on your location.

Various types of retirement plans are funded on your behalf by your employer. Choices vary based on your specific educational facility options. You also have voluntary Employee-funded options available to help you save for your future retirement needs. These tax-deferred voluntary plans may vary based on your employer and may include: 401(k), 457 or 403(b) plan choices. These voluntary plans may be started and changed at any time.

CHANGING ELECTIONS DURING THE PLAN YEAR

After your institution's annual open enrollment period is closed, you may change your benefits election during the Plan Year only after a qualifying status change. Within 31 days of a qualifying status change, you must submit a written request to your Human Resources/Benefits Office specifying the change you are seeking. Upon approval of the change by your Human Resources/Benefits Office, the election change is then completed by you on a new Employee Election Form. This approved election change will continue until another eligible event occurs or until you change your election during the next annual open enrollment period.

► Eligible Events that May Allow Election Changes

All changes requested after open enrollment must be approved by the Human Resources/Benefits Office. Requested changes must be *on account of and corresponding with* a qualifying status change that affects eligibility for coverage under an employer's plan. Employee's transferring from one CHEIBA Trust institution to another may or may not be eligible for a plan change. See your Human Resources/Benefits Office for more details if you believe this applies to you.

Election changes must be requested within **31 days** of the qualifying status change event. Changes allowed under federal regulations must fit within one of these categories: HIPAA, FMLA, COBRA or Qualifying Status Change (see the following definitions).

Health Insurance Portability and Accountability Act (HIPAA)

Special enrollment provisions may allow you to enroll or add Dependents during the Plan Year and waive pre-existing condition exclusion waiting periods. This option applies only to insurance coverage changes. Special enrollment is only permitted if you properly waive coverage because you have other coverage and your other coverage involuntarily terminates. Special enrollment is also permitted when an Employee who was previously not enrolled marries or has a new child. You must request special enrollment in writing within **31 days** of the event. See your Human Resources/Benefits Office for more details if you believe this applies to you.

When you or a covered Dependent terminates coverage under the medical plan, the plan will send you a certificate of coverage that identifies the length of coverage under the plan. The HIPAA Certificate of Coverage may be needed if you enroll in another medical plan that imposes a pre-existing condition waiting period. If you are eligible for Medicare and did not enroll in the Medicare drug card program, Medicare Part D, during the initial open enrollment in November 2005, you are also entitled to a notice of creditable prescription drug coverage. You will need this notice to later enroll in Medicare Part D without penalty.

The CHEIBA Trust will not use or further disclose Protected Health Information (PHI) in a manner that would violate the requirements of state or federal law or regulation. The CHEIBA Trust and the CHEIBA Trust Members will use PHI to the extent of and in accordance with the uses and disclosures permitted by HIPAA.

Qualifying Status Changes

You are only allowed to change your election during a Plan Year, if certain life changes occur. Any approved election change must be *on account of and corresponding with* a qualifying change in status that affects eligibility for coverage under an employer's plan.

Eligible changes listed under IRS regulations include the following status changes:

- ◆ change in Employee's marital status; marriage, divorce, annulment, legal separation or death of a spouse;
- ◆ change in number of tax-eligible Dependents; birth, adoption, placement for adoption, court ordered change in legal custody status or Qualified Medical Child Support Order (QMCSO) or death of a Dependent;
- ◆ change in employment status: transition from full-time to part-time, part-time to full-time, strike or lockout, affecting an Employee, Employee's spouse or Eligible Dependent;
- ◆ commencement of/or return from an unpaid leave of absence Family Medical Leave Act (FMLA) or other approved unpaid leave of absence by an Employee, Employee's spouse or Eligible Dependent;
- ◆ commencement or termination of employment by an Employee, Employee's spouse or Eligible Dependent;
- ◆ attainment or loss of Dependent eligibility as defined by the Plan, i.e., exceeding the Plan's established age limitations, marriage or eligibility for coverage under another health plan would all qualify as an eligible change in status events;
- ◆ entitlement to/or loss of Medicaid or Medicare coverage by an Employee, Employee's spouse or Eligible Dependent;
- ◆ residence and/or worksite change: a required change in place of residence and/or work site of an Employee, Employee's spouse or Eligible Dependent, i.e., a move outside a health plan's service area would qualify as a change in status event;
- ◆ an Employee may revoke his/her election or make a prospective election change during the Plan Year if the change corresponds with an open enrollment period change made by the Employee's spouse or Eligible Dependent, provided that the election change is consistent with the changes under the group plan; or
- ◆ significant change in available benefits and/or their costs, i.e., if a fully insured health plan imposed a change in benefit coverage levels or increases premiums substantially, this would qualify as a change in status event. **NOTE:** This does not allow election changes in the Health Care Spending Account.
- ◆ Other eligible changes include the establishment of a domestic partnership.

NOTE: See your Human Resources/Benefits Office to request a change during the Plan Year and to help you determine if an election change is allowed based on your individual situation.

REQUIRED GOVERNMENT AND REGULATORY SECTION



► Michelle's Law

Michelle's Law allows seriously ill or injured college students to take up to one year of medical leave without losing their health insurance. Pursuant to the bill, group health plans cannot terminate coverage of a dependent child due to a medically necessary leave of absence before the date that is the earlier of:

- ◆ The date that is one year after the first day of the medically necessary leave of absence; or
- ◆ The date on which such coverage would otherwise terminate under the terms of the plan or health insurance coverage.

The effective date of Michelle's Law for the CHEIBA Trust is January 1, 2010.

► Grandfathered Status:

The CHEIBA Trust believes the CHEIBA Trust Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered medical plan can preserve certain basic medical coverage that was already in effect when that law was enacted. Grandfathered medical plans must comply with certain other consumer protections in the Affordable Care Act; for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply, which protections do not apply to a grandfathered medical plan and what might cause a plan to change from grandfathered medical plan status can be directed to your Human Resources/Benefits Office. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

NOTE: For additional information on Healthcare Reform, visit www.HealthCare.gov.



► **Women’s Health and Cancer Rights Act**

All health plans offered through the CHEIBA Trust provide coverage for certain reconstructive services under the Women’s Health and Cancer Rights Act. These services include:

- ◆ reconstruction of the breast upon which a mastectomy has been performed
- ◆ surgery/reconstruction of the other breast to produce a symmetrical appearance
- ◆ prostheses
- ◆ treatment related to physical complications during all stages of mastectomy, including lymph edemas

Refer to your certificate of coverage for specific information on coverage. The plans may apply deductibles and copays consistent with other coverage provided.

► **Participant Advocate Link “P.A.L.”**

You have a P.A.L.! This service is provided by the CHEIBA Trust (at no cost to you) to assist you in resolving benefit issues that you have been unable to resolve on your own. Your P.A.L. is an independent consultant located at Gallagher Benefit Services, Inc., the full-service benefit consulting firm for the CHEIBA Trust. If you have billing problems with your doctor or hospital, a claim or service denied in error, reimbursement problems, trouble seeing a specialist, disability insurance or life insurance problems, call your P.A.L. directly at 303-889-2790 or 1-800-943-0650; Monday through Friday from 8:00 a.m. to 5:00 p.m. When you call, have your Member ID number, name of the college or agency and other relevant information available (i.e. name of insurance company, group number, date of service, physician or hospital name, bills or letters from the insurance company).



CONTINUATION COVERAGE RIGHTS UNDER COBRA

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

The right to COBRA continuation coverage was created by a federal law, Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may become available to you and your dependents that are covered under the Plan when you would otherwise lose your group health coverage. This notice gives only a summary of your COBRA continuation coverage rights. 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 get a copy of the Plan Document from the HealthSmart COBRA Administrator listed below.

COBRA continuation coverage for the Plan is administered by:

HealthSmart

10303 E. Dry Creek Road, Suite 200
Englewood, CO 80112
1-800-423-4445

◆ **What is COBRA Continuation Coverage?**

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in the notice. COBRA continuation coverage must be offered to each person who is a “qualified beneficiary”. A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, Employees, spouses of Employees, Domestic Partners and dependent children of Employees/Domestic Partners may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

If you are the spouse or Domestic Partner of an Employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any one of the following qualifying events occurs:

- 1) The Employee dies;
- 2) The Employee’s hours of employment are reduced;
- 3) The Employee’s employment ends for any reason other than gross misconduct;
- 4) The Employee becomes enrolled in Medicare (Part A, Part B, or both);
- 5) You become divorced or legally separated from your spouse; or
- 6) The domestic partnership is terminated.

Your dependent children and the dependent children of a Domestic Partner will become qualified beneficiaries if they will lose coverage under the Plan because any one of the following qualifying events occurs:

- 1) The parent/Employee dies;
- 2) The parent/Employee's hours of employment are reduced;
- 3) The parent/Employee's employment ends for any reason other than his or her gross misconduct;
- 4) The parent/Employee becomes enrolled in Medicare (Part A, Part B, or both);
- 5) The parents become divorced or legally separated;
- 6) The domestic partnership is terminated; or
- 7) The child stops being eligible for coverage under the plan as a “dependent child”.

◆ **When is COBRA Coverage Available?**

The Plan will offer COBRA continuation to qualified beneficiaries only after the Plan Administrator has been notified in a timely manner that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Employee, or enrollment of the Employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

Employees Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the Employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator in writing within 60 days after the later of the qualifying event or the loss of coverage.

IF YOU, YOUR SPOUSE, DOMESTIC PARTNER OR DEPENDENT CHILDREN DO NOT ELECT CONTINUATION COVERAGE WITHIN THIS 60-DAY ELECTION PERIOD, YOU WILL LOSE YOUR RIGHT TO ELECT CONTINUATION COVERAGE.

◆ **How is COBRA Coverage Provided?**

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. **Covered Employees may elect COBRA continuation coverage on behalf of their spouses and Domestic Partners, and parents may elect COBRA continuation coverage on behalf of their children.** For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin either (1) on the date of the qualifying event or (2) on the date that Plan coverage would otherwise have been lost, depending on the nature of the Plan.

◆ **How long will COBRA Coverage Last?**

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Employee, your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months).

Otherwise, when the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-month Period of Continuation Coverage

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

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

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former Employee dies, or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. **In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the HealthSmart COBRA Administrator.**

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

- ◆ any required premium is not paid in full on time,
- ◆ a qualified beneficiary first becomes covered, after electing continuation coverage, under another group health plan that does not impose any preexisting condition exclusion for a preexisting condition of the qualified beneficiary,
- ◆ a qualified beneficiary first becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- ◆ the employer ceases to provide any group health plan for its employees.

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

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the HealthSmart COBRA Administrator at 1-800-423-4445 or send an email to askcobra@healthsmart.com.

COBRA Premium Payment Guidelines

COBRA Premium Payment guidelines will be provided at the time of COBRA enrollment.

The monthly premium for continuation of the Health Care Flexible Spending Account is based on the annual amount you choose to contribute to the account and the number of months remaining under COBRA coverage during the period for which the employee made the election. The Plan may charge additional administrative fees for continued participation.

Keep Your Plan Administrator Informed of Address Changes

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

► Important HIPAA Information:

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) includes some provisions that may affect decisions you make about your participation in the Group Health Plan under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). These provisions are as follows:

- 1) Under HIPAA, if a qualified beneficiary is determined by the Social Security Administration to be disabled under the Social Security Act at any time during the first 60 days of COBRA coverage, the 11-month extension is available to all individuals who are qualified beneficiaries due to the termination or reduction in hours of employment. The disabled individual can be a covered Employee or any other qualified beneficiary.

However, to be eligible for the 11-month extension, affected individuals must still comply with the notification requirements.

- 2) A child that is born to or placed for adoption with the covered Employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the employer's group health plan(s) and the requirements of Federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to the Plan Administrator of the birth or adoption.
- 3) HIPAA restricts the extent to which group health plans may impose pre-existing condition limitations.
- 4) If you were covered by a group health plan(s) prior to your employment with us, your previous employer or their insurance carrier should have provided you with a Certificate of Creditable Coverage, a form required by the HIPAA law that describes the health coverage you and your dependents, if any, have or had, and the dates you were covered. **IF YOU HAVE NOT RECEIVED A CERTIFICATE OF CREDITABLE COVERAGE AND ARE ENTITLED TO ONE, PLEASE CONTACT YOUR FORMER EMPLOYER.** Once you deliver the Certificate of Creditable Coverage to us, you are exempt from any pre-existing condition exclusions in our group health plan(s), provided you had six months of creditable coverage and have not had more than a 90-day gap in coverage.

Under COBRA, your right to continuation coverage terminates if you become covered by another employer's group health plan that does not limit or exclude coverage for your pre-existing conditions. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA continuation coverage cannot be immediately terminated. However, if the other plan's pre-existing condition rule does not apply to you by reason of HIPAA's restrictions on pre-existing condition clauses, the employer's group health plan(s) may terminate your COBRA coverage.

If you have any questions about COBRA, or if you have changed marital status, or you or your spouse have changed addresses, please contact the HealthSmart COBRA Administrator or send an email to askcobra@healthsmart.com.

IMPORTANT NOTICE FROM THE CHEIBA TRUST ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE (CREDITABLE COVERAGE NOTICE)

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 the CHEIBA Trust and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and 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. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage. Please share this information with any other family member who is covered under the plan and who may be eligible for Medicare Part D.

- 1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription 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. The CHEIBA Trust has determined that the prescription drug coverage offered by the CHEIBA Trust for the HMO/POS, PRIME PPO and Custom Plus plans is, on average for all plan participants, expected to pay out as much as the 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 enroll in a Medicare prescription drug plan.**
-

Individuals can enroll in a Medicare prescription drug plan when they 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 be eligible for your two-month Special Enrollment Period (SEP) to join a Medicare drug plan.

If you decide to join a Medicare drug plan, your CHEIBA Trust coverage will be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

If you do decide to join a Medicare drug plan and drop your CHEIBA Trust prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

You should also know that if you drop or lose your coverage with the CHEIBA Trust 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 at least 1% of the 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, please reference the Colorado Health Plan Description Form included in the back pocket of the Benefit Booklet or contact your Human Resources/Benefits Office for further information. NOTE: You will receive this notice annually and at other times in the future such as before the next period you can join a Medicare drug plan, and if this coverage through the CHEIBA Trust 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 prescription 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.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) on the web at www.socialsecurity.gov, or you can 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).

<p>Date: 10/1/11 Name of Entity/Sender: Adams State College Contact--Position/Office: Human Resources/ Benefits Office Address: 208 Edgemont Blvd. Alamosa, CO 81102 Phone Number: 719-587-7990</p>	<p>Date: 10/1/11 Name of Entity/Sender: Fort Lewis College Contact--Position/Office: Human Resources/ Benefits Office Address: 1000 Rim Drive Durango, CO 81301-3999 Phone Number: 970-247-7428</p>
<p>Date: 10/1/11 Name of Entity/Sender: Auraria Higher Education Center Contact--Position/Office: Human Resources/ Benefits Office Address: Campus Box C, PO Box 173361 1201-5th Street, #370 Denver, CO 80217-3361 Phone Number: 303-556-3384</p>	<p>Date: 10/1/11 Name of Entity/Sender: Metropolitan State College Contact--Position/Office: Human Resources/ Benefits Office Address: Campus Box 47, PO Box 173362 1201 5th Street, #510 Denver, CO 80217-3362 Phone Number: 303-556-3120</p>
<p>Date: 10/1/11 Name of Entity/Sender: Colorado School of Mines Contact--Position/Office: Human Resources/ Benefits Office Address: 1500 Illinois Street Golden, CO 80401 Phone Number: 303-273-3052</p>	<p>Date: 10/1/11 Name of Entity/Sender: University of Northern Colorado Contact--Position/Office: Human Resources/ Benefits Office Address: Carter Hall, Rm. 2002 Campus Box 54 Greeley, CO 80639 Phone Number: 970-351-2718</p>
<p>Date: 10/1/11 Name of Entity/Sender: Colorado State University - Pueblo Contact--Position/Office: Human Resources/ Benefits Office Address: 2200 Bonforte Boulevard Pueblo, CO 81001 Phone Number: 719-549-2441</p>	<p>Date: 10/1/11 Name of Entity/Sender: Western State College Contact--Position/Office: Human Resources/ Benefits Office Address: Taylor Hall, Room 209 Gunnison, CO 81231 Phone Number: 970-943-3140</p>
<p>Date: 10/1/11 Name of Entity/Sender: Colorado State University System and Colorado State University - Global Campus Contact--Position/Office: Human Resources/ Benefits Office Address: 8000 E. Maplewood, Bldg. 5, Suite 250 Greenwood Village, CO 80111 Phone Number: 720-279-1142</p>	

MEDICAL INSURANCE



The CHEIBA Trust is pleased to continue to offer you three medical insurance plans with **Anthem Blue Cross and Blue Shield**. Part of Anthem's mission is to provide useful tools that help improve the lives of their members and assist them in making informed decisions about their health and are included with your medical coverage.

MyAnthem™

Tired of paperwork and phone calls? **MyAnthem™** takes the hassle out of your health care. Get your information when you need it. Access your health plan services online through the secure **MyAnthem™** site at www.anthem.com, Colorado, MyAnthem login. Use **MyAnthem™** to:

- ✓ Find a doctor or hospital
- ✓ View your benefits or check on a claim
- ✓ Change your primary care physician
- ✓ See if your medication is on the Anthem formulary
- ✓ **Visit MyHealth@Anthem®**, powered by **WebMD®**, for personalized health information, surveys and calculators
- ✓ Save money on health-related products and services with **SpecialOffers@Anthem™**
- ✓ Get help making medical choices with decision-support tools

Included in the medical plans is Anthem Blue Cross and Blue Shield's program



Listed below are some of the key resources:

□ **ConditionCare**

If you or one of your dependents have *diabetes, coronary artery disease (CAD), heart failure (HF), chronic obstructive pulmonary disease (COPD) or asthma*, ask Anthem about our programs to help manage these conditions. **ConditionCare** is included in your health plans and offers valuable tools and information that could make a real difference as you strive for better health.

- ☎ 24-hour, toll-free access to registered nurses to answer your questions and provide you with support and education on how to better manage your condition
- ☎ Specially designed condition-specific care diaries, self-monitoring charts, self-care tips and other easy-to-use empowerment materials.

For information about Anthem's ConditionCare programs, call toll-free 1-877-236-7486 or go to www.anthem.com and select Health & Wellness. Various conditions are listed for your information.

□ **Future Moms**

The program, **Future Moms**, is there for our moms-to-be. At such an important time in your life, you'll have access to extra pre- and post-natal, confidential support and education any time of the day or night! Even with terrific care from your doctor, you may have questions that come up between visits. Nurses are available for you to talk with around the clock. You may also benefit from:

- ☞ Maternity care materials including *Your Pregnancy Week By Week*, which is a helpful prenatal care book, free for just enrolling in the plan
- ☞ A confidential questionnaire to evaluate your risk for premature delivery
- ☞ Useful tools to help you, your doctor and your **Future Moms** nurse track your pregnancy and identify possible risks

Anthem's goal is to help you and your doctor work together to have a healthy pregnancy and a healthy new baby. Remember, your doctor is your best source of information about your pregnancy and your health, and Future Moms is here to help along the way.

To reach Future Moms, call toll-free 1-800-828-5891 or go to www.anthem.com and select Health & Wellness.

□ **24/7 NurseLine**

Whether it's 3 p.m. or 3 a.m., wouldn't it be great if you could speak with an experienced nurse about any of your health questions or issues? Now you can!

The **24/7 NurseLine** can assist you in making more informed health care decisions via confidential, one-on-one conversations with a registered nurse, any time of the day or night. Whenever you call, you can easily access a library of audio tapes on a range of topics related to your health care. Or, if you prefer, you can talk to a nurse about hundreds of health issues ranging from asthma to zinc, like: *Coughs • Abdominal Pain • Weight Loss • Colds • Children's Health • Sexually Transmitted Diseases • Fever • Food & Diet • Headache • Smoking • Women's Health . . . and much more!* Bilingual nurses, the Language Line and TTY/TDD relay services for the hearing impaired are also available.

For confidential health information from a registered nurse 24-hours a day, 365 days a year, call 1-800-337-4770 or go to www.anthem.com and select Health & Wellness.

24/7 NurseLine is not an emergency response system. In a medical emergency, call 911 or your local emergency service number.

□ **Colorado QuitLine**

Whether you are thinking about quitting tobacco or have already quit, Colorado QuitLine is a FREE program and here to help you. Join QuitLine today and receive free:

- ⊗ Personally tailored quit program
- ⊗ Nicotine replacement therapy
- ⊗ Support network
- ⊗ Telephone coaching
- ⊗ Tools and tips based on the latest research

Website:www.coquitline.org
Phone: 1-800-quit-now (1-800-784-8669)

The CHEIBA Trust and the CHEIBA Trust Members offer you three medical insurance plans from which to select (one is closed to new enrollment). Two of these choices are open to all benefit-eligible Employees and their Dependents. Please carefully review the Colorado Health Plan Description Form located in the pocket of this booklet regarding the various medical insurance plans before you make your selection. After you enroll you will receive your membership card. It will be mailed to your home. If you do not receive your card, call the Customer Service number as noted on the Phone Reference Page at the beginning of this book.

ANTHEM BLUE CROSS AND BLUE SHIELD/HMO COLORADO

Choices include



- 1) **BlueAdvantage Point-of-Service Plan, provided by HMO Colorado (HMO/POS)** (Health Maintenance Organization, HMO)
- 2) **PRIME Health Plan** (Preferred Provider Organization, PPO)
- 3) **Custom Plus Health Plan** (closed to new enrollment effective January 1, 2010) (Major **Medical/Traditional** Provider Network)

Premium Payments

To assist in reducing your insurance premium costs, your share of medical insurance premiums can be paid with pre-tax dollars under the CHEIBA Trust Pre-Tax Insurance Premium Payments Account under the Flexible Benefit Plan. If you and your spouse both work within the CHEIBA Trust system and choose the Dependent coverage option, you may choose to have one spouse pay for all premiums. If you and your spouse both work within the CHEIBA Trust system and Dependent coverage is not selected, you should enroll separately to maximize premium savings.

For Premium Payments involving Domestic Partners and the children of Domestic Partners, please review the document entitled, "Important Tax Information for Domestic Partner Health and Dental Benefits".

NOTE: If you are a Participant in PERA and are within three years of retirement, you may want to elect to pay your premiums with after-tax dollars to ensure your highest possible PERA benefit in retirement. PERA retirement benefits are based on your highest average salary. Please contact your Human Resources/Benefits Office for additional information.

HMO/POS

BlueAdvantage Point-of-Service (HMO/POS)

This choice is the Point-of-Service (HMO/POS) Plan which includes both in-network and out-of-network benefits. In-network benefits are available to all locations except Gunnison. A member has the option for both in-network and out-of-network benefits based on the provider rendering the service.

Services rendered by a non-HMO provider are processed under the POS benefits and are subject to the applicable deductible and coinsurance. This option is designed to give HMO members the choice to use a non-HMO provider and still receive a level of benefits. A referral from your HMO primary care provider is not needed to seek services from a non-HMO provider.

Additionally, out-of-network services may be subject to Balance Billing. If you have any questions regarding out-of-network services, please read the plan description carefully or call for assistance.

Physician Selection

Under the HMO/POS Plan, you must select a primary care physician (PCP) for yourself and each covered Dependent in order to be eligible for in-network benefits. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from Anthem Blue Cross and Blue Shield or from any other person (including a primary care provider) in order to obtain specialty care including obstetrical or gynecological care (OB/Gyn). 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. For information on how to select a primary care provider and for a list of the participating primary care providers and participating health care professionals, who specialize in obstetrics or gynecology, contact Anthem Blue Cross Blue Shield at 1-800-542-9402 or www.anthem.com. Members are not required to obtain a referral from their PCP to see an in-network specialist. However, Anthem does encourage you to ask your PCP for an in-network referral recommendation.

BlueAdvantage Point-of-Service (HMO/POS) Comparison

Description	HMO (HMO In Network)	POS (Out of Network)
Physician Selection	PCP Required	Any doctor of choice
Annual Deductible	None	\$500 Individual \$1,000 Family per calendar year
Office Visit Copayments	\$20 Copayment	70% after deductible (based on usual, customary & reasonable fees)

Deductibles and Copayments

In network there are no deductibles. When services are rendered by an HMO provider there is a \$20 copayment per visit and unlimited lifetime benefits.

Out-of-network there is a \$500 individual deductible and a \$1,000 family deductible. These deductibles apply when services are rendered by a non-HMO provider. Your maximum out-of-pocket expenses for these services are \$2,500 plus deductible for the individual and \$5,000 plus deductible for family.

Prescription Drug Benefit

Your ID Card is your membership card for both doctor visits and prescriptions. The prescription drug benefit is provided through Anthem's Pharmacy Benefits Manager (PBM) and includes a formulary plan with four tiers. The formulary includes prescription drugs that have been approved for use by HMO Colorado and is updated on a quarterly basis. You can review this formulary by going to www.anthem.com.

The prescription copayments for up to a **30-day** supply when filled by Anthem's Pharmacy Benefits Manager (PBM) will be as follows:

- ▶ Tier 1 - \$15 copayment
- ▶ Tier 2 - \$30 copayment
- ▶ Tier 3 - \$45 copayment
- ▶ Tier 4 – The lesser of 30% or \$100 copayment per prescription drug

Diabetic supplies/prescriptions and asthma inhalers/prescriptions will be covered under Tier 1.

The prescription copayments for up to a **90-day** supply when filled through the mail order program will be as follows:

- ▶ Tier 1 - \$30 copayment
- ▶ Tier 2 - \$60 copayment
- ▶ Tier 3 - \$90 copayment
- ▶ Tier 4 – The lesser of 30% or \$200 copayment per prescription drug

To get started in the mail order program, simply call the Express Scripts Mail Order team at 1-866-297-1011 Monday through Friday 8:00 a.m. to 8:30 p.m. Eastern Time, TDD is 1-800-899-2114.

Prescription drugs purchased from out-of-network pharmacies are not covered.

NOTE: Always ask for a Tier 1 drug, if available, to ensure your highest possible benefit. When there is no Tier 1 drug available, the member will pay the higher tier copayment. **If the member chooses a Tier 2 or Tier 3 drug when a Tier 1 drug is available, the copayment of \$30 or \$45 (if mail order the copayment is \$60 or \$90) plus the difference in price between the Tier 1 and Tier 2 or Tier 3 drug will apply.** Services, supplies and prescriptions for the treatment of sexual dysfunction are not covered.

Members taking specialty drugs must order them through Curascript at 1-800-870-6419, which offers a full-service pharmacy that ships medications to members or their provider, up to a 30-day supply, by overnight mail or common carrier.

Routine Preventive Care

Preventive care services when rendered by a contracted HMO physician are covered at 100%.

Preventive care services when rendered by a non-HMO contracted physician are covered after a \$30 copayment per visit.

Routine exams related to an insurance application, licensing, employment, school or camps are not covered.

Routine Preventive Colonoscopies

Routine colonoscopies are covered at 100% of allowed amount from a contracted HMO provider with no age limit and no frequency limit. Out-of-network treatment is not subject to deductible but is subject to coinsurance.

Nervous/Mental Illness and Alcohol/Substance Abuse Care

Inpatient services must be pre-authorized by the HMO Colorado behavioral health administrator prior to receiving services. Outpatient services do not require pre-authorization.

Hospital Admission

A \$400 copayment applies to in-network hospital admissions, and the HMO Colorado Plan will cover your non-emergency inpatient hospital stay when you are admitted by your PCP, or by a PCP referred specialist, to an HMO Colorado-approved hospital. Hospital services that are referred by a non-HMO physician and/or performed at a non-HMO hospital are subject to out-of-network deductibles and coinsurance.

Outpatient / Ambulatory Surgery

An \$85 copayment applies to HMO in-network outpatient / ambulatory surgery.

Outpatient Lab

Outpatient lab services at an HMO in-network provider will have a separate \$100 copayment for the following lab tests: MRI, MRA, CT, and PET scans.

Emergency Care

If you experience a medical emergency, you may seek help at any facility and benefits will be based on in-network benefits. When you require immediate medical services, you will be covered at in-network benefits whether you are within or outside the HMO Colorado service area. Emergency care is defined as care that is needed, or appears to be needed, immediately, to prevent the death of the member or a serious impairment of the member’s health. See your HMO Colorado Plan Booklet for detailed procedures to follow in the event of a medical emergency.

The use of an emergency center for non-emergency medical care will not be covered. There is a \$100 copayment for ambulance service, a \$50 copayment for an urgent-care facility and a \$100 copayment for a hospital emergency room. The \$100 copayment for the hospital emergency room is waived if you are admitted to the hospital.

For questions, call Customer Service: 1-800-542-9402
Website www.anthem.com



PRIME Health Plan (PPO)

This choice is the Preferred Provider Organization (PPO) plan which includes in and out-of-network coverage. To obtain a higher level of benefits you can select a PPO provider within the network of PPO doctors or you can choose to go outside the network and see any doctor of your choice.

NOTE: If you live in a rural area and there are no PPO providers within a reasonable distance from you, you may request authorization to see an out-of-network provider and benefits will be applied at the in-network level. Call customer service to request the authorization.

Physician Selection

You can select PPO physicians who have entered into an agreement with Anthem Blue Cross and Blue Shield to provide care at negotiated rates, which saves you money on coinsurance charges, or you can select the physician of your choice outside of the PPO network. However, out-of-pocket expenses may be significantly higher if you select an out-of-network provider.

Deductibles and Coinsurance

If you use a PPO provider a \$400 individual deductible or an \$800 family deductible applies annually. If you use a non-PPO provider, a \$960 individual deductible or a \$1,920 family deductible applies annually. For physician services, PPO provider fees are paid at 85% of the maximum benefit allowance. Non-PPO provider fees are paid at 65% of the maximum benefit allowance after the deductible has been met. When using PPO network and/or non-PPO network services, the maximum lifetime benefit is unlimited.

Prescription Drug Benefit

Your ID Card is your membership card for both doctor visits and prescriptions. The prescription drug benefit is provided through Anthem's Pharmacy Benefits Manager (PBM) and includes a formulary plan with four tiers. The formulary includes prescription drugs that have been approved for use by Anthem Blue Cross and Blue Shield and is updated on a quarterly basis. You can review this formulary by going to www.anthem.com.

The prescription copayments for up to a **30-day** supply when filled by Anthem's Pharmacy Benefits Manager (PBM) will be as follows:

- ▶ Tier 1 - \$15 copayment
- ▶ Tier 2 - \$30 copayment
- ▶ Tier 3 - \$45 copayment
- ▶ Tier 4 – The lesser of 30% or \$100 copayment per prescription drug

Diabetic supplies/prescriptions and asthma inhalers/prescriptions will be covered under Tier 1.

The prescription copayments for up to a **90-day** supply when filled through the mail order program will be as follows:

- ▶ Tier 1 - \$30 copayment
- ▶ Tier 2 - \$60 copayment
- ▶ Tier 3 - \$90 copayment
- ▶ Tier 4 – The lesser of 30% or \$200 copayment per prescription drug

To get started in mail order, simply call the Express Scripts Mail Order team at 1-866-297-1011 Monday through Friday 8:00 a.m. to 8:30 p.m. Eastern Time, TDD is 1-800-899-2114.

Prescription drugs purchased from out-of-network pharmacies are not covered.

NOTE: Always ask for a Tier 1 drug, if available, to ensure your highest possible benefit. When there is no Tier 1 drug available, the member will pay the higher tier 2 copayment. **If the member chooses a Tier 2 or Tier 3 drug when a Tier 1 drug is available, the copayment of \$30 or \$45 (if mail order the copayment is \$60 or \$90) plus the difference in price between the Tier 1 and Tier 2 or Tier 3 drug will apply.** Services, supplies and prescriptions for the treatment of sexual dysfunction are not covered.

Members taking specialty drugs must order them through Curascript at 1-800-870-6419, which offers a full-service pharmacy that ships medications to members or their provider, up to a 30-day supply, by overnight mail or common carrier.

Routine Preventive Care

Preventive care services are covered at 100% of the allowed amount, not subject to deductible. Routine exams related to an insurance application, licensing, employment, school or camps are not covered.

Routine Preventive Colonoscopies

Routine colonoscopies are covered at 100% of allowed amount from a contracted PPO provider with no age limit and no frequency limit. Out-of-network treatment is not subject to deductible, but is subject to coinsurance.

Nervous/Mental Illness and Alcohol/Substance Abuse

Inpatient services must be pre-authorized by the PPO behavioral health administrator prior to receiving services. Outpatient services do not require pre-authorization.

Hospital Admission

Hospital charges are covered at 85% after deductible, if you stay in a PPO hospital and 65% after deductible, if you stay in a non-PPO hospital. All non-emergency hospital admissions require pre-authorization.

Failure by you to obtain a pre-authorization when using a non-participating provider may result in denial of the hospital room expenses, regardless of the medical necessity of the admission. Participating providers in Colorado are responsible for obtaining a pre-authorization. If using a provider outside of Colorado, it is your responsibility to ensure any needed pre-authorization is obtained.

NOTE: If, unknowingly, a covered service is received from a non-participating provider while at a PPO hospital, payment is made at the in-network PPO level. You will need to contact Customer Service to have the claim reprocessed at in-network benefit levels.

Physician pre-authorization is a program designed to help control medical costs by encouraging the use of outpatient services whenever possible. It is our goal to ensure you receive care in the most medically-appropriate and cost-effective setting possible. Your physician may obtain pre-authorization by calling Monday through Friday between 8:30 am - 5:00 pm.

Pre-authorization call: 1-800-782-7484

Emergency Care

Emergency Care and Urgent Care are covered as in-network benefits even if you are treated in an out-of-network facility. If your claim is processed at out-of-network benefits, contact Anthem Customer Service and request reprocessing of the claim. The facility must include the appropriate "emergency care" procedure codes in order to validate the emergency nature of the claim.

Ambulance benefits are also covered at in-network benefits, even if the ambulance provider is out of network.

For questions, call PRIME Customer Service: 1-800-542-9402
Website www.anthem.com



CUSTOM PLUS HEALTH PLAN

Closed to new enrollment effective January 1, 2010.

This choice is a traditional major medical plan.

Physician Selection

There are no restrictions regarding the choice of physicians under this plan. Please note, if you select a provider not participating in the Traditional Participating Network, you may be subject to Balance Billing.

Deductibles and Copayments

Deductibles are \$600 per individual or \$1,200 per family per year. Services are paid at 80% of the maximum benefit allowance after the deductible has been met. Maximum annual out-of-pocket expenses are \$2,000 per individual and \$4,000 per family plus the deductible. There are unlimited lifetime benefits under this plan.

Prescription Drug Benefit

Prescription drugs are covered at 80% after the deductible is met. There is no separate prescription card. Prescription benefits are reimbursed to you after you submit a medical expense claim form found on www.anthem.com. Claim forms are provided through Anthem Blue Cross and Blue Shield of Colorado or through your Human Resources/Benefits Office.

Routine Preventive Care

Preventive care services are covered at 100% of the allowed amount, not subject to deductible. Routine exams related to an insurance application, licensing, employment, school or camps are not covered.

Routine Preventive Colonoscopies

Routine colonoscopies are covered at 100% of allowed amount with no age limit, no frequency limit, no coinsurance and no deductible.

Hospital Admission

Pre-authorization is a program designed to help control medical costs by encouraging the use of outpatient services whenever possible. It is the goal of Anthem Blue Cross and Blue Shield of Colorado to ensure you receive care in the most medically appropriate and cost-effective setting possible.

Hospital charges are covered at 80% after your deductible. For all hospital visits, your physician must obtain a pre-authorization, completed by your physician and submitted for review. Failure by you to obtain a pre-authorization by a non-participating physician may result in denial of the hospital room expenses, regardless of the medical necessity of the admission.

Emergency Care

In the event of emergency care, hospital and urgent care expenses are paid at 80% after the deductible is met.

The maximum benefit for ground ambulance is \$2,000 per occurrence. The maximum air ambulance benefit is \$5,000.

For questions, call Customer Service: 1-800-542-9402
Website www.anthem.com

Medical Choices Comparison

Description	BlueAdvantage Point-of-Service		PRIME	Custom Plus
	In-Network (HMO)	Out-of-Network (POS)	PPO In-Network Non-PPO Out-of-Network	No Defined Network
Annual Deductible	None	\$500 Individual \$1,000 Family	PPO \$400 Individual \$800 Family Non-PPO \$960 Individual \$1,920 Family	\$600 Individual \$1,200 Family
Annual Maximum Out-of-Pocket	Individual \$2,000 Family \$4,000	Individual deductible plus \$2,500 Family deductible plus \$5,000	PPO Individual deductible plus \$750; Family deductible plus \$1,500 Non-PPO Individual deductible plus \$2,000; Family deductible plus \$4,000	Individual deductible plus \$2,000 Family deductible plus \$4,000
Physician Selection	PCP required	Unrestricted	Unrestricted; greater benefits with PPO provider	Unrestricted; greater benefits with Traditional Participating Network provider
Physician Services Outpatient Surgery Outpatient Lab	\$20 copayment per visit \$85 copayment Separate \$100 copayment for MRI, MRA, CT and PET scans	70% reimbursements after deductible	85% PPO 65% Non-PPO reimbursements after deductible (for Non-PPO, based on the maximum benefit allowance)	80% after deductible (based on the maximum benefit allowance)
Prescriptions (see chapter for details; mail order available)	Anthem's Pharmacy Benefits Manager (PBM) Tier 1-\$15 Tier 2-\$30 Tier 3-\$45 Tier 4-The lesser of 30% or \$100 copayment per prescription drug.	Not Covered	Anthem's Pharmacy Benefits Manager (PBM) Tier 1-\$15 Tier 2-\$30 Tier 3-\$45 Tier 4-The lesser of 30% or \$100 copayment per prescription drug. Out-of-Network not covered.	80% after deductible
Hospital	\$400 copayment per admission	70% reimbursements after deductible	85% PPO 65% Non-PPO after deductible (for Non-PPO, based on the maximum benefit allowance)	80% after deductible (based on the maximum benefit allowance)

**Anthem Blue Cross and Blue Shield
Medical Plan Website Name References**

Name of Plan on Enrollment Form Health Benefit Plan Description Form & Benefit Booklet	Name of Plan on www.anthem.com Website When Searching Networks
BlueAdvantage Point-of-Service (HMO/POS) Plan	Point-of-Service
PRIME HealthPlan (PPO)	PPO
Custom Plus	Major Medical/Traditional Provider Network

NOTE: This is only an overview of your insurance plan choices. Review the Colorado Health Benefit Plan Description Form (back pocket of this book) and the specific certificate booklets pertaining to each plan for further details and explanations. **If discrepancies are found, depend upon the certificate of coverage itself for accuracy.**

DENTAL INSURANCE

ANTHEM BLUE CROSS AND BLUE SHIELD



You may select from two separate dental care plans to meet your individual needs. Premium cost is the same for each plan and is payable on a pre- or post-tax basis. These plans provide you with comprehensive dental care benefits. However, each plan has special features and a variety of ways to manage your personal dental care and the dental care of your family.

Your two choices are:

- 1) *Anthem Blue Dental PPO Plus*
- 2) *Anthem Blue Dental PPO*

NOTE: Children are eligible for coverage before, on or within 31 days of their third birthday. Please remember to enroll them within 31 days of their third birthday or at open enrollment.

After enrollment, you will receive a combined medical/dental membership card. It will be mailed to your home.

Premium Payments

To assist in reducing your insurance premium costs, your share of dental insurance premiums can be paid with pre-tax dollars under the CHEIBA Trust Pre-Tax Insurance Premium Payments Account under the Flexible Benefit Plan.

For Premium Payments involving Domestic Partners and the children of Domestic Partners, please review the document entitled, "Important Tax Information for Domestic Partner Health and Dental Benefits".

NOTE: If you are a Participant in PERA and are within three years of retirement, you may want to elect to pay your premiums with after-tax dollars to ensure your highest possible PERA benefit in retirement. PERA retirement benefits are based on your highest average salary. Please contact your Human Resources/Benefits Office for additional information.



Anthem Blue Dental PPO Plus

This dental plan offers you flexibility by allowing you to select the dentist of your choice or a dentist within the extensive Anthem Dental PPO network of over 2,200 providers throughout Colorado.

Dentists within the network have agreed to a Maximum Allowable Charge for reimbursement and will not bill you for any difference with the exception of the applicable deductible and coinsurance amounts. By choosing one of these in-network providers, your costs are kept at a minimum and you do not have to file any claim forms.

Pre-determination of benefits is suggested on all major services and should be submitted, in writing, by the dentist performing the service prior to the date on which services are to be performed.



Anthem Blue Dental PPO

This choice is a Preferred Provider Organization (PPO) plan consisting of a network of over 1,400 dentists in Colorado. You have a reduction in fees when selecting a PPO network dentist. These dentists will submit all paperwork to Anthem Dental on your behalf.

However, you can also go outside the network to select a dentist of your choice. When doing this you may pay significantly higher deductible and coinsurance payments, and you will be responsible for submitting claim forms to Anthem Dental for reimbursement. Claim forms are available by calling the Anthem Dental Customer Service number at the end of this section.

Pre-determination of benefits is suggested on all major services and should be submitted, in writing, by the dentist performing the service prior to the date on which services are to be performed.

Pre-Authorization

For both dental plans, if services are provided without prior authorization, benefits will only be provided for those services that would be approved if authorization had been completed. Approved benefits may be for less costly procedures and services, than those actually received, and may result in a greater out-of-pocket cost to you. Therefore, it is always advisable to receive prior authorization for major services.

Balance Billing

For both dental plans, if you select an out-of-network dentist, you will be subject to balance billing. Out-of-network dental reimbursements are based on a maximum allowable fee schedule. If the provider's charge exceeds the maximum allowable fee schedule amount, you pay the excess amounts as out-of-pocket expenses. You may want to discuss this with your dentist prior to treatment. You also may be required to pay the dentist at the time of service and then submit a claim form for reimbursement. Claim forms are available by calling the Anthem Dental Customer Service number at the end of this section or at www.anthem.com.

Dental Plan Comparison

Descriptions	Anthem Blue Dental PPO Plus In-Network & Out-of-Network	Anthem Blue Dental PPO	
		In-Network	Out-of-Network
Annual Maximum	\$1,500	\$1,500	\$1,500
Annual Deductible	\$25/\$75	\$0	\$50/\$150
Diagnostic & Preventive Services* (No Deductible)	100%	100%	80%
Restorative/General Services (Fillings, Composites, Anesthesia, Emergency, Oral Surgery)	80%	80%	60%
Endodontic Services (root canal therapy, etc.)	80%	80%	60%
Periodontal Services* (gingivectomy, osseous surgery, periodontal scaling & root planing and maintenance)	80%	80%	60%
Major Services (Crowns, Bridges, Dentures, Approved Implants)	50%	50%	40%
Orthodontia Lifetime Maximum for Eligible Dependent children to age 19	50% up to \$1,000	50% up to \$1,000	40% up to \$1,000

*Limited to two cleanings per year, whether routine or for Periodontal maintenance.

NOTE: For both dental plans, if you select an out-of-network dentist you will be subject to balance billing.

Anthem Blue Cross and Blue Shield Dental Website Reference Names

Name of Plan on Enrollment Form Benefit Booklet	Name of Plan on www.anthem.com Website When Searching Networks
Anthem Blue Dental PPO Plus	Dental PPO Plus
Anthem Blue Dental PPO	Dental PPO

For questions, call Anthem Blue Cross and Blue Shield Dental Plan Customer Service:
1-800-627-0004

Website www.anthem.com

NOTE: This is only an overview of your dental plan choices. Review the "Dental Plan Comparisons" chart and the specific brochures pertaining to each plan for further details and explanations. **If discrepancies are found, depend upon the certificate of coverage itself for accuracy.**

VISION INSURANCE



VISION SERVICE PLAN (VSP)

The CHEIBA Trust and the CHEIBA Trust Members are pleased to offer you a comprehensive managed vision care program. Vision Service Plan (VSP) is the nation's leading managed vision care benefits program whose primary goal is to promote wellness through routine eye exams and quality cost-effective vision care products and services.

Premium Payments

Vision coverage is voluntary and premiums are entirely paid by the Employee. To assist in reducing your insurance premium costs, your vision premiums can be paid with pre-tax dollars if applicable at your institution. If you and your spouse both work within the CHEIBA Trust system, you can choose to have one spouse pay for all premiums, or you can each cover your premiums separately.

For Premium Payments involving Domestic Partners and the children of Domestic Partners, please review the document entitled, "Important Tax Information for Domestic Partner Health and Dental Benefits".

NOTE: If you are a Participant in PERA and are within three years of retirement, you may want to elect to pay your premiums with after-tax dollars to ensure your highest possible PERA benefit in retirement. PERA retirement benefits are based on your highest average salary. Please contact your Human Resources/Benefits Office for additional information.

How VSP Works:

- STEP ONE:** To obtain vision care services, call your VSP doctor. To locate a VSP network doctor, call VSP at 1-800-877-7195, visit their Website at www.vsp.com or contact the Human Resources/Benefit Office.
- STEP TWO:** When making an appointment, **identify yourself as a VSP member**, provide your member identification number (last four numbers of Employee's Social Security number and member's birthdate) and the covered member-Employee's group name. The VSP network doctor will contact VSP to verify eligibility and plan coverage and obtain authorization for services and eyewear. If you are not eligible for benefits, the VSP network doctor will notify you.
- STEP THREE:** When you arrive at your appointment, the VSP network doctor will provide an eye exam and determine if eyewear is necessary. If so, the doctor will coordinate the prescription with a VSP approved lab. The doctor will itemize any non-covered charges and have you sign a form to document that you received services.

NOTE: You will **not** receive a VSP membership card when enrolling in this voluntary benefit option. However, you may download a card at www.vsp.com which has your group number, copays and coverage level.

Summary of Benefits

Description	Level of Coverage from a VSP doctor	Non-VSP Doctor or Provider Reimbursement
Exam - Once every 12 months	Covered in full after \$15 copay	Reimbursed up to \$50
Basic Lenses - Once every 12 months	One-time materials copay of \$15	
Single Vision	Covered in full after \$15 copay	Reimbursed up to \$50
Lined Bifocal	Covered in full after \$15 copay	Reimbursed up to \$75
Lined Trifocal	Covered in full after \$15 copay	Reimbursed up to \$100
Frames / Once every 12 months	Covered up to \$130 allowance	Reimbursed up to \$70
Contact lenses / Once every 12 months *	Covered up to \$130 allowance	Reimbursed up to \$110

* You are not eligible for glasses and contacts in the same benefit period.

Eyeglasses

VSP covers in full single vision, lined bifocal, lined trifocal lenses and polycarbonate lenses for children (up to age 26). Photo chromic or tinted lenses are covered at a VSP network doctor. In addition to the coverage provided, VSP network doctors extend cost controls on lens options, which average 35-40% off the network doctor's usual fees. Cost controlled lens options include but are not limited to, blended lenses, scratch coating, UV protection and progressive (no line) lenses.

Frames are covered in full up to \$130 allowance. If a frame is selected over the VSP allowance, the patient pays the additional amount. VSP doctors provide a 20% discount on the frame overages. Typically if a patient selects a frame that is not in the VSP doctor's inventory, the doctor can order the frame.

Contact Lenses

Contact lens services and materials are covered instead of frames and lenses. If a patient chooses to purchase contacts instead of glasses, the plan will cover up to \$130 towards the doctor's professional services and materials. Any costs exceeding this allowance are the patient's responsibility. You cannot receive both glasses and contacts in the same service period. VSP doctors provide a 15% discount off their professional services for contact lenses (fitting and evaluation).

Current soft contact wearers may qualify for a special contact lens program. Learn more from your VSP network doctor or visit www.vsp.com.

Laser VisionCare Program

Potential candidates for laser vision correction surgery can learn about this procedure and be evaluated by a VSP doctor. VSP has arranged for its members to receive laser vision correction procedures at a discounted fee that averages 15% off the regular price or 5% off the promotional price. After surgery, members can also use their frame allowance (if eligible) for sunglasses from any VSP provider. To learn more about these procedures visit our Website at www.vsp.com or call 1-800-877-7195.

Laser vision correction services are available with many of the nation’s finest laser surgery facilities and doctors. VSP’s contracted laser centers offer a discount off PRK, LASIK and custom LASIK surgeries. Visit www.vsp.com for more information.

NOTE: These procedures are eligible expenses within the Flexible Benefit Plan Health Care Spending Account.

Additional Eyewear Benefits

Additional sets of glasses can be obtained on the same date of exam by the same doctor at a 30% discount or from any VSP network doctor at a 20% discount. This discount applies to any glasses or sunglasses for 12 months following the date of the exam. VSP doctors provide a 15% discount on their contact lens professional services (contact lens fitting and evaluation). Contact lens materials are not discounted.

Low Vision Benefit

The Low Vision benefit is available to covered persons who have severe visual problems that are not correctable with regular lenses and is subject to prior approval by VSP’s Optometric Consultants

	Member Doctor Benefit	Non-Member Doctor Benefit
Supplementary Testing Complete low vision analysis and diagnosis that includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.	Covered in Full	Up to \$125.00*
Supplementary Care Subsequent low vision therapy as Visually Necessary or appropriate.	75% of Cost	75% of Cost*
Copayment 75% of the authorized benefits payable by the Company and 25% payable by Covered Person.		

*Non-Member Benefit

The maximum benefit available is \$1,000 (excluding copayment) every two years.

Low Vision benefits secured from a non-member provider are subject to the same time limits and copayment arrangements as described above for a member doctor. The covered person should pay the non-member provider his/her full fee. The covered person will be reimbursed in accordance with an amount not to exceed what VSP would pay a member doctor in similar circumstances.

NOTE: There is no assurance that this amount will be within the 25% copayment feature.

Non-VSP Providers

If a patient chooses a non-VSP doctor, they should pay the entire bill and submit a copy of the receipt to VSP along with a claim form that can be downloaded from www.vsp.com. If the patient prefers, they can contact Customer Service at 1-800-877-7195 to have a form sent directly to them. Claims must be submitted to VSP within six months of the date of service. The address for submitting the claims is located directly on the form.

VSP Plan Limitations

This plan is designed to cover your visual needs rather than cosmetic eyewear. You will be responsible for any additional charge on services or eyewear other than those deemed necessary by VSP.

There is no benefit for professional services or eyewear for the following:

- ▶ Orthoptics or vision training and non-prescription lenses or glasses.
- ▶ Lenses and frames furnished under the plan which are lost, stolen or broken during a current 12-month benefit period.
- ▶ Medical or surgical treatment of the eyes.
- ▶ Services or eyewear provided as the result of a Worker’s Compensation Law or similar legislation, or obtained through or required by any government agency or program whether Federal, state or any subdivision thereof.
- ▶ Any service or eyewear provided by any other vision care plan or group benefit plan containing benefits for vision care.

Exceptions to these limitations may be considered on an individual basis upon the request of the eyecare professional. Exceptions must be granted through prior authorization of VSP and will only be considered when the exception is deemed necessary to the patient’s visual welfare.

For questions, call VSP Member Services:..... 1-800-877-7195
Website www.vsp.com

NOTE: This is only an overview of your VSP plan. Read the policy for specific details and provisions. If discrepancies are found, depend upon the policy for accuracy.

BASIC TERM LIFE INSURANCE

ANTHEM LIFE INSURANCE COMPANY



Protection and security for you and your family is important, especially in the event of a death or accident. Therefore, the CHEIBA Trust is pleased to offer you this Basic Term Life Insurance Plan.

Maximum Benefits

The amount of life insurance benefit for active Employees is calculated on your annual base salary (ask your Human Resources/Benefits Office for specific definitions of base salary).

This plan provides the following coverage:

Under age 65	Two times annual base salary to a maximum of \$500,000
Age 65 through 69.....	Two times annual base salary to a maximum of \$50,000
Age 70 +	\$10,000

Coverage is rounded up to the nearest \$1,000.

NOTE: If an Employee takes a sabbatical and receives a lower salary during the time of the sabbatical, the life insurance benefit will be calculated at that salary level.

Dependent Coverage

Under this plan, your spouse and your Eligible Dependent children have a maximum benefit of \$2,000 per person. The term Dependent means:

- ▶ an Employee's legal spouse under age 70,
- ▶ any married or unmarried Eligible Dependent of an Employee, either natural or legally adopted, not in military services, over 14 days of age and until the end of the month of their 26th birthday, regardless of tax dependent status.
- ▶ Eligible Dependent children age 14 days to six months are insured for \$200.
- ▶ Dependent coverage excludes the following:
 - ◆ any person who is an Employee as defined in the policy,
 - ◆ any person residing outside the United States or Canada,
 - ◆ Domestic Partners and the children of Domestic Partners,
 - ◆ any person whose evidence of good health, furnished in accordance with provisions hereof is **not satisfactory**.

Beneficiary Changes

You must submit any changes in your beneficiary designation through the Human Resources/Benefits Office.

Accidental Death and Dismemberment Benefits

Should you experience an unexpected loss due to accidental death or dismemberment, Anthem Life will pay the amount of insurance specified in the loss Schedule of Indemnities as explained in your Anthem Life brochure.

Accelerated Benefit

If a covered person is terminally ill, he or she may be eligible for the Accelerated Benefit payment, subject to conditions and approval. If approved, a lump sum payment of 50% of the life insurance policy or \$250,000, whichever is the lesser amount, will be issued to the insured, and further premiums will be waived.

Conditions for approval are as follows. The terminal illness diagnosis must be made:

- ▶ after the covered person’s Terminal Illness Accelerated Benefit Certificate Rider effective date, if the medical condition is due to an accident or
- ▶ at least 31 days after the covered person’s Certificate Rider effective date, if the medical condition is due to an illness

Terminally ill is defined as being diagnosed with a life expectancy of six months or less (must be certified by a physician). Age at time of illness and other restrictions may apply. Please contact the Human Resources/Benefit Office if this benefit applies to you.

When an Employee retires on or after January 1, 1997, the Retiree (who meets the CHEIBA Trust definition of Retiree) may elect to continue Group Term Life Insurance under the terms of the policy by paying premiums quarterly, semiannually or annually direct to Anthem Life.

Conversion Privileges

You or your spouse may convert the current group policy to an individual policy under certain conditions. This privilege is not available for dependent children. See your Anthem Life brochure for details.

Insurance Premium Waiver

If you are under age 60 and become totally disabled for nine consecutive months, your insurance will continue to age 65, without further premium payments.

Claim Notification

Written notice of the death of the person covered under the policy must be provided to Anthem Life within two years after the date of death. If such notice is not given, Anthem Life will not be liable for any benefit payments.

Imputed Income

Under IRS tax regulations, the imputed value of group term life insurance coverage in excess of \$50,000 is included as taxable income to an Employee. The amount of imputed income is computed based on IRS tables and is included in taxable income each payroll period.

For questions, call Anthem Life Insurance Customer Service: 1-800-551-7265
Website www.anthem.com

VOLUNTARY TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

ANTHEM LIFE INSURANCE COMPANY



VOLUNTARY TERM LIFE

Our voluntary Employee-paid term life insurance plan can be designed to meet the needs of each individual or family. This insurance allows you to add protection, above the Basic Term Life Insurance coverage.

Employee Benefit

You may enroll in additional age-rated coverage in \$10,000 increments to a maximum of \$300,000 for yourself. Guaranteed coverage is available to \$30,000 if you are under age 60, provided you apply within your initial eligibility period. Amounts in excess of the guaranteed amount, if you are over age 60, and if you apply after your initial eligibility period are subject to evidence of insurability. Rates are factored in five-year bands.

Spousal and Domestic Partner Coverage

You can enroll in additional coverage for your spouse or your Domestic Partner (under age 70) even if you do not enroll yourself. Spousal or Domestic Partner coverage is also available in \$10,000 increments to a maximum of \$300,000. Guaranteed coverage is available to \$30,000, if the spouse or Domestic Partner is under age 60, during the Employee's initial eligibility period only. Amounts in excess of the guaranteed amount, spouses or Domestic Partners over age 60, and if the spouse or Domestic Partner applies after the Employee's initial eligibility period are subject to evidence of insurability.

Dependent Children

For a flat rate of \$1.50 per month for all legally dependent children, ages six months to 26 years, you can enroll in additional life insurance, provided you or your spouse are accepted for insurance coverage. Children are covered at \$5,000 per child.

Children of Domestic Partners

For a flat rate of \$1.50 per month for all legally dependent children of your Domestic Partner, ages six months to 25 years, you can enroll in additional life insurance, provided you or your Domestic Partner are accepted for insurance coverage. Children are covered at \$5,000 per child.

Portability

Upon termination of employment, you can keep your coverage at the same group rates, provided you or your covered spouse, or your covered Domestic Partner are under age 70 and as long as the group continues coverage with Anthem Life. You have the option of paying premiums quarterly, semi-annually or annually. In order to continue coverage following termination you must apply within 31 days of your termination date. You can obtain a form by contacting Anthem Life at 1-800-551-7265.

Accelerated Benefit

If the covered person is terminally ill, he or she may choose the Accelerated Benefit, subject to conditions and approval. If approved, a lump sum payment of 50% of the life insurance policy or \$100,000, whichever is the lesser amount, will be issued to the insured. The same conditions apply as under Basic Term Life plan. See your Human Resources/Benefits Office if this applies to you.

Insurance Premium Waiver

If you, your spouse or Domestic Partner are under age 60 and become totally disabled for nine consecutive months, your insurance will continue to age 65, without further premium payments.

Suicide Exclusion

If an Employee, Employee’s spouse or Employee’s Domestic Partner dies by suicide, while sane or insane, within one year after the effective date of the person’s coverage, Anthem Life will refund premiums only.

Claim Notification

Written notice of the death of the covered person must be provided to Anthem Life within two years after the date of death. If such notice is not given, Anthem Life will not be liable for any benefit payments.

For questions, call Anthem Life Insurance Customer Service: 1-800-551-7265
Website www.anthem.com

NOTE: This is a general summary of your Basic & Voluntary Term Life Insurance Plans. Final interpretations and a complete listing and description of any and all benefits, limitations and exclusions are found in, and governed by, the Anthem Life Master Contracts.

MUTUAL OF OMAHA INSURANCE COMPANY

ACCIDENTAL DEATH & DISMEMBERMENT



This voluntary Employee-paid supplemental Accidental Death and Dismemberment Insurance is designed to offer you high limit protection against covered accidents.

Maximum Limits

You can choose to purchase coverage from \$10,000 to \$500,000. If you choose the Employee and family plan you can include coverage on your spouse, Domestic Partner, your Eligible Dependent children and the Eligible Dependent children of your Domestic Partner. The amount of your purchase cannot exceed ten times your annual salary. Under the family plan, spousal and Domestic Partner coverage is 50% of the Employee coverage and dependent children are covered at 10% of the Employee-elected amount. If there are no children, the spouse and Domestic Partner coverage increases to 60% and if there is no spouse or Domestic Partner, the children are covered at 20%.

Benefit Payments

When covered injuries result in a loss of life within 12 months after the date of an accident the full benefit amounts are payable for loss of life. The full amount is also payable for the loss of two limbs, the sight of both eyes or the loss of one limb and the sight of one eye when these losses are the result of the same accident. One-half payment is payable for the loss of one limb, one eye, speech or hearing. One-quarter benefit is payable for the loss of the thumb and index finger of the same hand. See the Mutual of Omaha AD&D brochure for a complete description of loss payment schedules.

For questions call Mutual of Omaha Customer Service:..... 1-800-524-2324
Website www.mutualofomaha.com

NOTE: This is only an overview of your Accidental Death & Dismemberment Plan. Review the Mutual of Omaha AD&D brochure for further details and explanations. If discrepancies are found, depend upon the policy itself for accuracy.

FLEXIBLE BENEFIT PLAN

PAYFLEX SYSTEMS USA, INC.



The colleges, universities and institutions of higher education participating in the CHEIBA Trust offer a Flexible Benefit Plan under Section 125 of the Internal Revenue Code. There are three separate and optional components under the Plan:

These options provide you with the opportunity to pay some of your insurance premiums and other eligible family expenses with pre-tax dollars. This Plan is offered on a voluntary basis and participation may require an administration fee. **NOTE:** Not all information in this Chapter will apply to Fort Lewis College (see your Human Resources/Benefits Office for details). When you choose to participate in the Flexible Benefit Plan your monthly taxable income is reduced. Dollars elected in the health care spending account are available to you at any time during the Plan Year. You can claim reimbursement for eligible expenses, incurred while you are active in the plan, up to your maximum elected amount.

- 1) Pre-Tax Insurance Premium Payments [eligible premiums include employer-sponsored Medical, Dental, Vision and Basic Term Life (to \$50,000 death benefits)]
- 2) Health Care Spending Account
- 3) Dependent Care Spending Account

NOTE: Once selected, the pre-tax election for insurance premium payments will continue until a waiver is signed during open enrollment or as the result of an eligible status change (see Status Change Rules in the Benefit Highlights Chapter).

For Premium Payments involving Domestic Partners and the children of Domestic Partners, please review the document entitled, "Important Tax Information for Domestic Partner Health and Dental Benefits".

HEALTH CARE SPENDING ACCOUNT

The maximum amount of reimbursement for health care expenses is \$5,000 per Employee, per calendar year. If you wish to continue to participate in this benefit you must re-enroll in the plan each year.

Through the Health Care Spending Account, eligible out-of-pocket expenses incurred by you, your spouse and Dependents during the Plan Year include the following items: deductibles, copayments, (non-cosmetic) dental work, crowns, bridges, orthodontics, prescriptions, eye care, glasses, LASIK and PRK procedures, contact lenses and more. Prescribed medications include medications that are also available over the counter as long as participants have prescriptions from their physicians. Generally, if a medical expense is considered eligible as a medical deduction on your federal tax return it may be eligible for pre-tax payments within your Flexible Benefit Plan. Health-related insurance premiums cannot be paid through a Health Care Spending Account. For a complete list of qualified medical expenses, see www.healthhub.com.

Expenses for your Eligible Dependents may be reimbursed through this account even if they are not enrolled in the CHEIBA Trust medical, dental or vision plans. Expenses paid by another insurance plan are not eligible for reimbursement through the Health Care Spending Account.

HEART Act (Heroes Earnings Assistance and Relief Tax Act of 2008)

As of January 1, 2011, if you are a member of a reserve unit and are ordered or called to active duty, then you may be able to request a Qualified Reservist Distribution (QRD) from your Health Flexible Spending Account (FSA). A QRD is a taxable cash distribution of amounts from your Health FSA that is not dependent on whether you have incurred medical expenses. You can only request this distribution if you are ordered or called to active duty for a period in excess of 180 days or for an indefinite period. You may only request this distribution during the period beginning on the date of the order or call and ending on the last date that reimbursements could otherwise be made under the Plan for the Plan Year which includes the date of the order or call.

COBRA Option for the Health Care Spending Account

In the event of a COBRA qualifying event you may be eligible to continue participation in your Health Care Spending Account through the end of your current Plan Year. This option only applies if you have a positive balance in your account at the time of your termination or other eligible event. If you elect COBRA you must continue to make contributions and can submit claims for reimbursement for expenses incurred while you are on COBRA.

DEPENDENT CARE SPENDING ACCOUNT

You can pay up to \$5,000 per family, per calendar year, for child or dependent care necessary to your employment with pre-tax dollars. When using the Dependent Care Spending Account your expenses must be incurred during the Plan Year. You are limited to \$5,000 per year or to the income of the lesser earning spouse (whichever is less). If your spouse is disabled or is a full-time student five months or more each year, then the spouse's income is considered to be \$250 per month if you have one child or dependent or \$500 per month if you have two or more children or dependents.

The number of children or dependents does not impact the \$5,000 limit. If you are married and filing separate tax returns, you are limited to \$2,500 per spouse, per calendar year. If you wish to continue to participate in this benefit you must re-enroll in the plan each year.

Eligible expenses must be for children under the age of 13 or for older dependents with a physical or mental disability requiring supervision so you can work and the individual has gross income less than the exemption amount. All care expenses must be necessary to employment. Ineligible expenses include payments for referral services, parenting seminars, tuition expenses including kindergarten, child support payments, and payments to a spouse or other dependent for the care of the child or dependent. Overnight camp is not an eligible expense.

Tax Guidelines

Under current IRS regulations you must report the care provider's name, address and Tax ID or Social Security number on your federal tax return. This requirement is the same for both the pre-tax spending account and the federal tax credit. You cannot pay your spouse or other dependents to care for your children or dependents.

Eligible Expenses

The child or Dependent must live in your home on average eight hours per day. Eligible expenses include in-home care, a child care home, child care center, summer camp, before and after-school programs and adult day care.

NOTES:

- ▶ If you have a cost change for day care during the Plan Year you may be eligible to change your election. See your Human Resources/Benefits Office for details.
- ▶ You can also use a combination of the tax credit and the pre-tax program. However, when a combination is used you are limited to the tax credit limits for the total dollars allowed.
- ▶ Expenses paid through a dependent care spending account cannot be claimed as a tax credit on your income tax return or submitted to any other source for reimbursement.

ENROLLMENT GUIDELINES

Enrollment

You must enroll for the Health Care Spending Account and the Dependent Care Spending Account on an annual basis. You may change elections during the Plan Year only when a qualifying status change occurs as described earlier in this summary and in accordance with IRS rules governing tax qualified flexible benefit plans. Changes in a daycare provider would allow for a change in the election of the participant. They would be allowed to stop, increase or decrease their election for this reason. Changes must be requested within 31 days of the status change and must be approved by the Human Resources/Benefits Office.

"Use it or Lose it" - Health Care and Dependent Care Spending Accounts

You must incur eligible expenses during the Plan Year while you are an active Participant in the plan. **All claims must be received no later than April 15th of the year following the Plan Year.** Dollars not claimed by April 15th will be forfeited. Other rules apply upon termination of employment during the Plan Year (see your Human Resources/Benefits Office for details).

BASIC PLAN RULES

Health Care and Dependent Care Spending Accounts

All eligible expenses must be incurred after your effective date and during the Plan Year. The incurred date is considered the date you or your Eligible Dependent received the care, services, medicines, or purchased supplies.

Your contributions are elected specifically to one or two accounts. The funds are maintained separately and cannot be combined for reimbursement purposes. For example, you cannot be reimbursed from your Health Care Spending Account for dependent care expenses.

During the enrollment process, you must carefully consider your health and child/dependent care needs and estimate predictable expenses you will incur during the Plan Year. **Important** - any contributions to these accounts that are not used for eligible expenses incurred during the Plan Year will be forfeited. Set aside dollars only for those expenses you know you will incur. Plan carefully.

You may not change your contribution during the Plan Year except in the case of a qualifying status change (as described earlier in this summary). Requested election changes must be submitted in writing to the Human Resources/ Benefits Office within 31 days of the qualifying status change and all approved election changes must be *on account of or corresponding with* a change in status that affects eligibility for coverage under an employer's plan.

Retirement Concerns

The Defined Contribution Pension Plan retirement benefits are based on the dollars contributed to the plan over your total years of employment.

These contributions may be based on your taxable wages which are reduced by your participation in the Flexible Benefit Plan. However, you may be able to increase your voluntary retirement plan contributions to compensate for this reduction in contributions and reduction in future retirement benefits.

Public Employee Retirement Association (PERA) contributions are not paid on any dollars re-directed through participation in the Flexible Benefit Plan. PERA retirement benefits are based on your highest average salary. If you are within your final three years of employment under PERA, you may want to elect after-tax payments for insurance premiums and decline participation in the spending accounts. Please contact your Human Resources/Benefits Office for additional information.

REIMBURSEMENT GUIDELINES

PayFlex Systems USA, Inc. is your Flexible Benefit Plan Administrator (except for Fort Lewis College). You will receive a reimbursement packet with instructions and claim forms prior to your first salary adjustment. Check with your Human Resources/Benefits Office regarding administration fees for participation in the Flexible Benefit Plan Spending Accounts.

For those Employers who offer the debit card, Employees participating in a Health Care Spending Account will receive a PayFlex MasterCard which will be credited with their plan year elected amount. This card can be used at most qualified health merchants; for example, pharmacies, doctor's offices, dental offices, vision centers, etc. When purchasing services or items with your PayFlex card, you may be required to submit receipts to show these purchases are qualified expenses. This is an IRS requirement.

Spending account reimbursement checks will be written to you personally and mailed to your home address.

Health Care Spending Account Required Documentation

You must submit a copy of your provider statement or Explanation of Benefits (EOB) from the insurance carrier along with your signed claim form when submitting for reimbursement. The following is a list of acceptable documentation:

- ▶ The provider statement or EOB must include the date of service, family member for whom the service was provided, and documentation that the expense was not paid by an insurance plan
- ▶ Eligible expenses cannot be paid by an insurance company or other company spending plan
- ▶ Expenses must be incurred during the Plan Year, while you are an active Participant in the plan
- ▶ Prescription tags or statement from pharmacy. Cash receipts are not acceptable.
- ▶ Itemized receipt from store showing over-the-counter qualified expense. Receipt must show name of item purchased, date, who from and amount.

To be reimbursed for mileage expenses, including driving Dependents to and from medical appointments, submit your vehicle odometer readings, with the starting and ending mileage and the points of travel (where you traveled to and from). Include the name of the family member requiring treatment, the reason and the date of the visit. Sign and date the claim form, then submit it with the proper documentation for reimbursement.

Expenses reimbursed in the Flexible Benefit Plan cannot be claimed as a deduction on your tax return.

Dependent Care Spending Account Required Documentation

Your signed claim form must be accompanied by an itemized statement from the provider. The statement must include the following information:

- ▶ name of the Dependent
- ▶ type of service rendered
- ▶ name of the provider
- ▶ amount charged
- ▶ date(s) of service
- ▶ Social Security number or Tax ID number of the provider

For questions, call PayFlex Systems USA:

Telephone: 1-800-284-4885

Claims Fax: 1-402-231-4310
or 1-800-450-0016

Address: PO Box 3039
Omaha, NE 68103

Website: www.healthhub.com

NOTE: This is only an overview of your Flexible Benefit Plan. Ask your Human Resources/Benefits Office for further details and explanations. If discrepancies are found, depend upon the plan document itself for accuracy.

LONG TERM DISABILITY INSURANCE

STANDARD INSURANCE

When a disability affects an Employee, benefit payments are available. With Long Term Disability (LTD) Insurance, a portion of your income is protected if you are unable to work because of a disability.



Schedule of Coverage

LTD Benefit is the lesser of the following:

- ◆ 66 2/3% of your pre-disability earnings to a maximum benefit of \$7,000 per month; or
- ◆ 70% of your pre-disability earnings, reduced by deductible income (i.e., Social Security or PERA disability).

The benefit waiting period is 90 days. The minimum monthly payment is \$100. If a disability began on or after January 1, 2001, a cost-of-living adjustment (COLA) may increase benefit payments.

Pre-disability earnings are based on the last full day worked prior to the disability. The Maximum Benefit Period is determined by your age when disability begins, as follows:

Age	Maximum Benefit Period
61 or younger	to age 65, or to SSNRA ¹ , or 3 years 6 months, whichever is longest
62	to SSNRA ¹ or 3 years 6 months, whichever is longer
63	to SSNRA ¹ or 3 years, whichever is longer
64	to SSNRA ¹ or 2 years 6 months, whichever is longer
65	2 years
66	1 year 9 months
67	1 year 6 months
68	1 year 3 months
69 or older	1 year

¹SSNRA = Social Security Normal Retirement Age

Exclusions

Preexisting Condition defined as treatment received during the 90-day period just before your coverage becomes effective.

Exclusion Period 12 months

Limitations

Chronic Fatigue Conditions..... Yes

Limitation Period 24 Months

Chemical and Environmental Sensitivities Yes

Limitation Period 24 months

Mental Disorders Yes
 Limitation Period 24 months

Musculoskeletal and Connective
 Tissue Disorders Yes
 Limitation Period 24 months

Alcohol Use, Alcoholism or Drug Use Yes
 Limitation Period: 24 months

Benefit Offsets

Social Security/Deductible Income
 Social Security Offset: Full Offset

Salary Continuation Offset: Sick Pay or other salary continuation payable to you by your employer, but not including vacation pay.

Survivor Benefit

In the event of your death while receiving long term disability benefits, a Survivor Benefit may be payable to your eligible survivor. Contact the Human Resources/Benefits Office for further details.

Filing a Claim

If you have a claim, notify the Human Resources/Benefits Office immediately. You will be required to show written proof of your disability. Claims should be filed on the appropriate forms. If you do not receive the appropriate forms within 15 days after you request them, you may submit your claim in a letter to the Human Resources/Benefits Office. The letter should include the date disability began and the cause and nature of the disability.

You have 90 days after the end of the benefit waiting period to file a claim. If you cannot do so, you must give it to us as soon as reasonably possible, but not later than one year after the end of the 90-day benefit waiting period. If a claim is filed outside these time limits, your claim will be denied. These limits will not apply while you lack legal capacity.

For questions, call Standard Insurance Customer Service: 1-800-368-1135
 Website www.standard.com

NOTE: This summary is designed to answer some common questions about LTD coverage. It is not intended to provide a detailed description of the coverage. When you become covered, a more detailed description of the coverage will be available in a certificate provided to you. The controlling provisions of coverage are in the Plan Document. This summary and the certificate do not modify the Plan Document or coverage in any way.

PERA DISABILITY BENEFITS

PUBLIC EMPLOYEES RETIREMENT ASSOCIATION (PERA)

PERA Disability Program

(Requires five years of earned service credit to be vested in PERA)



If you believe you may have a potentially disabling condition, you should discuss all of your options with your human resources or benefits office. One of those options is the PERA Disability Program.

PERA members with five or more years of earned service credit are covered by the PERA Disability Program. The Program provides both short term disability protection and disability retirement benefits. Coverage is automatic upon earning five years of service credit and members pay no premium for this Program.

Once you have discussed your options with your employer, contact PERA's Customer Service Center to discuss the PERA Disability Program and to request a Disability Program booklet which includes the Program's application form. You can also obtain this information on PERA's Website.

Eligible members apply for the Disability Program – not the specific type of benefit. Once PERA staff has confirmed your eligibility, your application is then forwarded to PERA's Disability Program Administrator, which is an outside firm, for medical determination. Based upon this determination, you may be found eligible for short term disability payments or disability retirement.

Short Term Disability

STD's goal is to help you to return to work as soon as practical either at your previous job or another job. In order to receive STD payments, you must meet the following standards:

- ◆ Your medical condition prevents you from performing the essential functions of your job with reasonable accommodation as required by federal law;
- ◆ You are medically unable to earn 75% of your pre-disability earnings in any job given your existing education, training and experience regardless of whether you do so: and
- ◆ You are not totally and permanently medically incapacitated from all regular and substantial gainful employment.

Individuals approved for STD may receive payments for up to 22 months once a 60-day waiting period is satisfied. The maximum monthly payment is 60% of the applicant's pre-disability income and is paid by PERA's Disability Program Administrator. Payments are coordinated with certain other forms of income. Vocational rehabilitation and workplace accommodation may also be available.

The Program does not require your employer to hold a position open for you while you receive STD payments. However, you should discuss any options available to you from your employer. If your employer does terminate your employment, STD payments may continue so long as you do not refund your PERA account.

Disability Retirement

Disability retirement provides benefits when you are totally and permanently disabled from any regular and substantial gainful employment. In order to receive disability retirement benefits, you must meet the following standards:

- ◆ Your medical condition is being treated to the extent appropriate by a physician with the appropriate specialty;
- ◆ Your medical condition prevents you from engaging in any regular gainful employment;
- ◆ You are medically unable to earn 75% of your pre-disability earnings in any job for which you are or could be educated or trained;
- ◆ You are totally and permanently incapacitated and are not reasonably expected to recover from your disabling medical condition; and
- ◆ Your medical condition existed as of the date of your termination of employment.

Individuals approved for disability retirement must terminate all PERA covered employment before receipt of benefits may begin.

The benefit will be calculated by multiplying 2.5% of your highest average salary by your years of earned and purchased service credit plus projected service to either 20 years or to age 65, whichever is earlier. If you have more than 20 years of earned and purchased service credit, your benefit will include an additional 2.5% of your highest average salary for each year over 20 based upon your earned and purchased service only. The benefit is paid by PERA and continues so long as the disability continues. Because eligibility is based upon being totally and permanently disabled from any regular and substantial gainful employment, any post-retirement return to work will call into question the continued existence of the disabling condition.

For questions, call PERA Customer Service: 303-832-9550
1-800-759-7372
Website www.copera.org

NOTE: This summary is only an overview of the PERA Disability program. Read the PERA brochure for specific details and provisions. If discrepancies are found, depend upon the PERA brochure for accuracy.

TRAVEL ACCIDENT INSURANCE

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If you are actively employed by a CHEIBA Trust Member employer and have an accident while traveling for college-approved business, this Travel Accident Insurance Plan protects you with benefit payments to you or your beneficiary.

Coverage

- 24-Hour Business Travel
- Hijacking or Skyjacking
- Extraordinary Commutation

Benefits

The maximum benefit (Principal Sum) is \$100,000 of Accidental Death and Dismemberment (Age Discrimination Employment Act Schedule is applicable). If the accidental injuries to the insured person result in death or dismemberment within 365 days of the date of the accident, the policy will pay as follows:

Payment Schedule	
Injury or Dismemberment	Policy Pays
Loss of Life	The Principal Sum
Loss of Speech & Hearing Loss of Speech & Loss of: One Hand, One Foot, Sight of One Eye Loss of Hearing & Loss of: One Hand, One Foot, Sight of One Eye Loss of Both Hands, Both Feet, Sight Loss of combination of any two: Hand, Foot, Sight of One Eye Quadriplegia	The Principal Sum
Paraplegia	75% of Principal Sum
Hemiplegia Loss of: Hand, Foot or Sight of One Eye (any one of each) Loss of Speech or Hearing	50% of Principal Sum
Uniplegia Loss of Thumb & Index Finger of the Same Hand	25% of Principal Sum

Additional Coverages Included:

- ◆ Medical Evacuation/Repatriation – Unlimited
- ◆ Carjacking – 10% of Principal Sum
- ◆ Home Alteration or Vehicle Modification – 10% of Principal Sum each
- ◆ Coma – 1% of Principal Sum per month to a maximum of \$100,000
- ◆ Psychological Therapy – 5% of Principal Sum
- ◆ Rehabilitation/Retraining – 5% of Principal Sum
- ◆ Seatbelt & Occupant Protection Device Coverage – 10% of Principal Sum each
- ◆ Travel Assistance Services & ID Theft Services
- ◆ Exposure & Disappearance
- ◆ Personal Excursion – Up to seven days

Aggregate Limit of Insurance: \$1,000,000 per Accident

NOTE: The insurance coverage described above is in summary form only and is subject to the terms and conditions of the Policy. In the event of a discrepancy, the Policy will govern. Please read the Policy wording for complete terms and conditions, exclusions and complete coverage explanation.

RETIREMENT PLANS

In order to assist you in planning for the future, you have the opportunity to choose from several voluntary tax-deferred retirement plan investment options, as well as having benefits provided on your behalf by your CHEIBA Trust Member employer.



Employer Provided Plans

All CHEIBA Trust Member employers offer a Defined Contribution Pension Plan (DCPP) with the exception of Colorado School of Mines and Auraria Higher Education Center. This is a non-PERA retirement program. Contributions are made to the DCPP on your behalf and are based on your annual taxable income. The contribution rates of both the Employee and the employer are set by the individual institutions; this contribution is not subject to federal or state taxation.

The DCPP is for non-classified Employees working half-time or more, and is required unless you are eligible for and choose to participate in PERA.

Colorado PERA (Public Employees Retirement Association) is the defined benefit retirement plan for all State Classified Employees and is also the plan option available to non-classified Employees at the Colorado School of Mines and Auraria Higher Education Center. It is also available to other Employees who have had at least one year of PERA service credit and a current balance with PERA. If you have ever made a previous selection between the DCPP and PERA, that selection is irrevocable, and you will be placed into the plan that you have previously chosen. The contribution rates of both the Employee and the employer are established annually by the state legislature; this contribution is not subject to federal or state taxation. Pre-tax dollars elected within the CHEIBA Trust Flexible Benefit Plan are excluded from these contributions.

For additional information and a list of your fund sponsors contact your Human Resources/Benefits Office.

Voluntary Tax Deferred Retirement Plan Options

You have a number of tax-deferred retirement plans available to you. You can direct part of your taxable wages into the tax-deferred retirement plan of your choice. When participating in a retirement plan option, you defer taxes on these account dollars until the money is withdrawn. This way your retirement savings can grow tax-deferred until you are ready to use them in retirement.

If you are eligible to access these dollars prior to retirement, you will generally pay an IRS penalty tax of 10% (above the normal taxes) for early withdrawal of these funds. Exceptions may apply such as: death, separation from service during or after the year you reach age 55, reaching age 59½, and, in some cases, hardship. In some cases you may also be allowed to roll these funds to another tax-deferred qualified plan.

NOTE: Participants in an IRC Section 457 Plan are not assessed a penalty at withdrawal.

Maximum Contributions

You can set aside from your salary up to the maximum amounts specified under Federal law.

You have several choices when deciding where to place your tax-deferred retirement contributions. Contact your Human Resources/Benefits Office for a list of the fund choices available to you. Funds available and plan design options vary by location. However, all tax-deferred dollars contributed to your Employee-paid voluntary retirement plan are funded through the payroll deduction process. Plans available may include 403(b), 457, 401(k) and Roth 403(b) plans. See the Plan Comparison Chart (that follows) for basic plan rules.

NOTE: Participation in a pre-tax voluntary tax-deferred retirement plan option will not lower your highest average salary as calculated by PERA.

NOTE: These retirement plans are not provided by the CHEIBA Trust. This summary is only an overview of the retirement plans. Read the plan documents for specific details and provisions. If discrepancies are found, depend upon the plan documents for accuracy.

The Plan Comparison Chart

This chart summarizes participation in each category of retirement plan options.

	Colorado PERA 457 Plan	Colorado PERA 401(k) Plan	403(b) Tax-Deferred Annuity Program
Who can participate	Government Employees & Higher Education employed by an employer affiliated with the plan	Government Employees & Higher Education	Employees of education institutions
Contributions:			
Employee	Via payroll deductions	Via payroll deductions	Via payroll deductions
Employer	None	None	None
Contribution amounts			
Minimum	\$25 per month	None	Depends on plan document
Maximum	100% of annual gross salary, or annual IRS limit of: \$16,500 in 2011 then may be indexed in future years (IRS releases new annual limits in October or November of each year).	100% of annual gross salary, or annual IRS limit of: \$16,500 in 2011 then may be indexed in future years (IRS releases new annual limits in October or November of each year).	100% of annual gross salary, or annual IRS limit of: \$16,500 in 2011 then may be indexed in future years (IRS releases new annual limits in October or November of each year).
Loans to Participants	Permitted for any reason (one loan at a time). May borrow up to 50% of balance. Maximum loan amount of \$50,000. Repayment period: Up to five years for a general loan; up to 15 years for principal residence loans.	Permitted for any reason (two loans at a time). May borrow up to 50% of balance. Repayment period: Up to five years for general loans; up to 15 years for principal residence loans.	Available if plan permits. May borrow up to 50% of balance; not to exceed \$50,000. Repayment period five years; 15 years for principal residence
Withdraws while working	Permitted only for extreme unforeseeable emergency hardship as determined under IRS guidelines	Permitted only for: - Employee, age 59 ½ or older - Financial hardship	Permitted only for contributions made before 1/1/1989, for hardships and if over 59 ½ if Plan Document allows.
Catch-Up Provisions	For the three consecutive years prior to retirement you may be able to contribute up to twice the available limit. Participants age 50 and over may make additional contributions of \$5,500 in 2011. The amount of catch up may be indexed in future years based on IRS limits.	Participant age 50 or over may make an additional \$5,500 in 2011. The amount of catch up may be indexed in future years based on IRS limits.	Participants age 50 or over may make an additional contribution of \$5,500 in 2011. Participants who have at least 15 years of service and who did not max out in the first 15 years of service, may contribute up to \$3,000 for a max catch up of \$15,000 (if plan document allows).
When Distributions can be Paid	Retirement, termination (regardless of age), unforeseeable emergency, death (beneficiary). (see Plan Document)	Retirement, termination, hardship, death (beneficiary)	Retirement, termination, hardship (if qualified and if plan document allows), disability, age 59 ½ and death (beneficiary)
To Enroll	PERA: 1-800-759-7372 or 303-832-9550 www.copera.org	PERA: 1-800-759-7372 or 303-832-9550 www.copera.org	Contact your Human Resources/Benefits Office to get your vendor representative's name and phone number.
Penalty on early withdrawal before age 59½	No	Yes, unless directly rolled over to another tax-deferred account or you terminate employment during or after the year you reach age 55.	Yes, unless directly rolled over to another tax-deferred account or transferred to a DB plan to purchase service credit time.

NOTE:

- Employee can contribute:
- 1) The maximum to the 457 and a 401(k) or
 - 2) The maximum to the 457 and a 403(b)
 - 3) Cannot combine maximums to both the 401(k) and the 403(b)

GLOSSARY OF TERMS

Balance Billing – Out-of-network reimbursements are based on a maximum allowable fee schedule. If the provider's charge exceeds the maximum allowable fee schedule amount, you pay the excess amount as out-of-pocket expenses.



Beneficiary – means the person or entity designated by the participant to receive any death benefits payable under the terms of any benefit plan.

CHEIBA Trust – The Colorado Higher Education Insurance Benefits Alliance Trust (CHEIBA Trust) is a benefit purchasing consortium and trust made up of Adams State College, Auraria Higher Education Center, Colorado School of Mines, Colorado State University - Pueblo, Colorado State University System, Colorado State University - Global Campus, Fort Lewis College, Metropolitan State College of Denver, University of Northern Colorado and Western State College.

CHEIBA Trust Committee – The Trust Committee was formed pursuant to Article III of the Colorado Higher Education Insurance Benefits Alliance Trust (CHEIBA Trust) Agreement. Each participating college shall designate one of its Employees to serve as a Trustee and member of the Trust Committee.

Copayment – a cost-sharing arrangement in which a covered person pays a specified charge for a specified service, such as \$15 for an office visit. The covered person is usually responsible for the charge at the time the health care is rendered. Typical copayments are fixed or variable flat amounts for physician office visits, prescriptions or hospital services. Some copayments are referred to as coinsurance, with the distinguishing characteristics that copayments are flat or variable dollar amounts and coinsurance is a defined percentage of the charges rendered.

Coinsurance – the portion of covered health care costs for which the covered person has a financial responsibility, usually according to a fixed percentage. Often coinsurance applies after first meeting a deductible requirement.

Consolidated Omnibus Budget Reconciliation Act (COBRA) – is a federal law that, among other things, requires employers to offer continued health insurance coverage to certain Employees and their beneficiaries whose health insurance coverage has terminated.

Creditable Coverage – under the simplified method, a prescription drug plan is deemed to be creditable if it:

- 1) Provides coverage for brand and generic prescriptions;
- 2) Provides reasonable access to retail providers and, optionally, for mail order coverage;
- 3) It is designed to pay on average at least 60% of participants' prescription drug expenses; and
- 4) Satisfies at least one of the following:

For plans that are not integrated (a plan that provides Rx benefits that are separate from the medical plan, i.e., does not share a common deductible):

- a) The prescription drug coverage has no annual benefit maximum or a maximum benefit payable by the plan of at least \$25,000, or
- b) The prescription drug coverage has an actuarial expectation that the amount payable by the plan will be at least \$2,000 per Medicare eligible individual in 2008.

For integrated plans (a plan where medical and Rx expenses are subject to the same deductible):

- a) For entities that have integrated health coverage, the integrated health plan has no more than a \$250 deductible per year, has no annual benefit maximum or has a maximum annual benefit payable by the plan of at least \$25,000 and has no less than a \$1,000,000 lifetime combined benefit maximum.

Deductible - the amount of eligible expenses a covered person must pay each year from his/her own pocket before the plan will make payment for eligible benefits.

Drug Formulary – a listing of prescription medications which are preferred for use by the health plan and which will be dispensed through participating pharmacies to covered persons. This list is subject to periodic review and modification by the health plan. A plan that has adopted an “open or voluntary” formulary allows coverage for both formulary and nonformulary medications. A plan that has adopted a “closed, select or mandatory” formulary limits coverage to those drugs in the formulary.

Federal Family and Medical Leave Act (FMLA) – This Act requires an employer which employs 50 or more employees (within a 75-mile radius) to allow an employee who has been employed for at least 12 months by the employer and for at least 1,250 hours of service with such employer during the previous 12-month period, to take a total of 12 weeks of leave during any 12-month period, as defined by the employer for:

- 1) the birth of a child;
- 2) the placement of a child with the employee for adoption or foster care;
- 3) the care for a spouse, child or parent of the employee if the individual has a serious health condition; or
- 4) a serious health condition which prevents the employee from performing the function of his/her regular position.

Flexible Spending Accounts – tax-free accounts which allow Employees to set aside pre-tax dollars from their gross wages to later be reimbursed tax free for eligible expenses incurred during the Plan Year. Unclaimed dollars are forfeited to the employer. Accounts include a Health Care Spending Account for out-of-pocket health care expenses for the family and a Dependent Care Spending Account for dependent care expenses necessary to employment. There is also a pre-tax insurance payments process which allows Employees to use their pre-tax dollars to pay their share of all the CHEIBA Trust sponsored health-related insurance premiums.

Generic Drug – a chemically equivalent copy designed from a brand name drug whose patent has expired. A generic is typically less expensive and sold under a common or “generic” name for that drug (e.g., the brand name for one tranquilizer is Valium, but it is also under the generic name diazepam). *Also called generic equivalent.*

Health Maintenance Organization (HMO) - an entity that provides, offers or arranges for coverage of designated health services needed by Plan members for a fixed, prepaid premium. There are four basic models of HMOs: group model, individual practice association, network model and staff model. Under the federal HMO Act, an entity must have three characteristics to call itself an HMO: an organized system for providing health care or otherwise assuring health care delivery in a geographic area, an agreed upon set of basic and supplemental health maintenance and treatment services and a voluntary enrolled group of people.

HIPAA - HIPAA is the “Health Insurance Portability and Accountability Act of 1996”. HIPAA is federal legislation designed to improve the portability of health coverage, to make system administrative simplification changes and to protect privacy rights.

In-Network Services – health care delivered by a participating provider who has contracted with the health plan to deliver medical services to covered persons.

Medicare Part “D” – prescription drug benefit provisions (Medicare Part D) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Part D prescription drug program is available to Medicare beneficiaries.

Out-of-Network Services – health care delivered by a non-participating provider who has not contracted with the health plan.

Out-of-Pocket Costs / Expenses – the portion of payments for health services required to be paid by the enrollee, including copayments, coinsurance and deductibles.

Out-of-Pocket Limit – the total payments toward eligible expenses that a covered person funds for himself/herself and/or Dependents: i.e., deductibles, copays, and coinsurance, as defined per the contract. Once this limit is reached, benefits will increase to 100% for health services received during the rest of that calendar year. Some out-of-pocket costs (e.g., mental health, penalties for non-pre-certification, etc.) are not eligible for out-of-pocket limits.

Plan Year – the CHEIBA Trust Plan year is a calendar year.

Point-of-Service (POS) Plan – a health plan allowing the covered person to choose to receive a service from a participating or non-participating provider, with different benefit levels associated with the use of participating providers. Point-of-Service can be provided in several ways:

- ▶ an HMO may allow members to obtain limited services from non-participating providers;
- ▶ an HMO may provide non-participating benefits through a supplemental major medical policy;
- ▶ a PPO may be used to provide both participating and non-participating levels of coverage and access; or
- ▶ various combinations of the previous options may be used.

Preferred Provider Organization (PPO) – is a network of physicians and hospitals who have agreed to a set fee schedule, thereby saving money for the covered person.

Primary Care Physician (PCP) – a physician the majority of whose practice is devoted to internal medicine, family/general practice and pediatrics. A primary care physician is accountable for the total health services of enrollees, arranges referrals and supervises other care, such as specialist services and hospitalization.

Trust or Trust Agreement – refers to the CHEIBA Trust, as defined above.