CHEIBA Trust Employee Benefit Plan

2017 Plan Year

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

Sponsored by - Colorado Higher Education Insurance Benefits Alliance Trust (CHEIBA Trust)
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 51 and 52 for more details.
2017 Employee Benefit Insurance

Health Insurance
Anthem Blue Cross and Blue Shield
- BlueAdvantage Point of Service Plan (HMO/POS)
- PRIME Blue Priority Plan (PPO) and Custom Plus Health Plan
- Blue Priority HMO Plan
- Lumenos High Deductible Health Plan
  Phone: 1-800-542-9402
  Provider Directories for Health and Dental
  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
LiveHealth Online ……………………………………………………………………………………………………………1-855-603-7985

Prescription Drug Benefit
Express Scripts Mail Order …………………………………………………………………………………………………1-866-297-1011
Accredo (Specialty Drugs) …………………………………………………………………………………………………1-800-870-6419

Dental Insurance
Anthem Blue Cross and Blue Shield
- Anthem Blue Dental PPO Plus
- Anthem Blue Dental PPO
  Phone: 1-800-627-0004

Vision Insurance
Anthem Blue Cross and Blue Shield
  Phone: 1-866-723-0515
  Discount Information ………………………………………………………………………………………………………www.anthem.com/specialoffers

Basic Term Life Insurance & Voluntary Term Life
Anthem Life Insurance Company
  Phone: 1-866-594-0516

Voluntary Accidental Death & Dismemberment Insurance
Mutual of Omaha Insurance Company
  Phone: 1-800-524-2324

Flexible Benefit Plan
24HourFlex (Except Fort Lewis College – See Separate Insert)
  Phone: 1-800-651-4855
  Email: info@24hourflex.com
  Participant Website ………………………………………………………………………………………………………https://participant.24hourflex.com

Long Term Disability Insurance
Standard Insurance Company
  Phone: 1-800-368-1135

Colorado State Employee Assistance Program (C-SEAP)
  Phone: 303-866-4314 or Toll Free 1-800-821-8154

Travel Accident Insurance
Chubb
  Phone: 1-888-987-5920
  E-Mail: ops@europassistance-usa.com

Participant Advocate Link (P.A.L.)
Arthur J. Gallagher & Co.
  Phone: 303-889-2692 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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CHEIBA Trust
Employee Benefit Plan

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 2017. The information in this booklet provides a comprehensive overview of your benefits package to help you in making the choices that best meet your individual and family needs.

Please read the benefit summaries carefully before completing your Election Forms. There have been additions and changes to your benefits for the 2017 plan year. If you have questions or concerns, phone numbers and website addresses are included for your convenience.

As an additional resource to this booklet, please also visit the CHEIBA Trust member webpage (www.mybensite.com/cheiba) to find more detailed plan summaries, forms, contacts and much more. We encourage you to become familiar with and use the resources offered through the web portal.

Login: cheiba
Password: benefits

Authority of the CHEIBA Trust Committee

The CHEIBA Trust Committee has the sole and absolute discretion to interpret the terms of a Plan and determine the right of any Participant to receive benefits under a 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.

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.
Benefits under the CHEIBA Trust Plans 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” definition will be defined by each of the State colleges, universities and institutions who participate in the CHEIBA Trust. Please see the Eligibility document for your campus/institution. Eligible Employees on an authorized leave of absence not to exceed a 24-consecutive month period, including Employees on sabbatical and summer break, may be 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; (b) partner in a civil union pursuant to CRS §14-15-101, et seq.; and (c) an Employee’s married or unmarried child or children until the end of the month of their 26th birthday. 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 shall also include any dependent which 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 the purposes of paragraphs A above, the term “child” or “children” shall include a natural or biological child, child of a partner in a civil union, step-child, legally adopted child, child under legal guardianship, child or children of any age who are medically certified by a physician as disabled, and a child for whom the Employee is required to provide health benefits pursuant to a court order or qualified medical child support order, provided however, the term “child” or “children” shall not include the grandchild or grandchildren of the Employee.

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 partner in a civil union.

Civil Union Benefits

Pursuant to the Colorado Civil Union Act, CRS §14-15-101, et seq., the CHEIBA Trust modified the definition of "Dependent" to include partners in a civil union of covered Employees effective as of January 1, 2014. A Civil Union is a relationship established by two eligible persons pursuant to CRS §14-15-103(1) that entitles them to receive the benefits and protections and be subject to the responsibilities of spouses. This means that Civil Union Partners are eligible for group medical, dental, voluntary vision, voluntary life and voluntary accidental death and dismemberment benefits offered by the CHEIBA Trust Members.

• Eligibility for Coverage
  Civil Union Partners and their eligible dependents will be eligible for medical, dental, term life, 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 Civil Union 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 qualified 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 the issuance of a valid civil union certificate.

To enroll, the Employee must present the civil union certificate to your Human Resources/Benefits Office.
• **Benefit Eligibility**

- **Dissolution, Legal Separation and Invalidity of Civil Unions**
  In accordance with CRS §14-15-115(2), the dissolution, legal separation and invalidity of civil unions shall follow the same procedures as the dissolution, legal separation and invalidity of marriages.

- **Flex Plans**
  If the Civil Union Partner and his/her children are the Employee's tax dependents for medical 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. However, if the Civil Union Partner and his/her children are **not** the Employee's tax dependents, their expenses are not eligible for reimbursement from the Employee's flexible spending account.

  Benefits relating to the Civil Union Partner and his/her children under dependent care spending accounts will depend on how the Civil Union 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 Civil Union Partner and/or children of the Civil Union 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 Civil Union 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 Civil Union Partner or dependent of a Civil Union Partner are paid on an after-tax basis. There is an exception to this rule if the Civil Union Partner and his/her children are tax dependents for medical, dental and term life plan purposes. Please review the document titled, "Important Tax Information for Partners in a Civil Union – Medical, Dental and Term Life Benefits", and complete the Certification of Tax-Qualified Dependents, if appropriate.

### Required Dependent Eligibility Documentation

<table>
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<tr>
<th>Category</th>
<th>Documentation Requirements</th>
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| Legal Spouse   | • Registered copy of marriage certificate  
                        AND  
                        • A document dated within the last 60 days showing current relationship status, such as a monthly or quarterly household bill or statement of account. The document must list your spouse’s name, the date and your mailing address **OR** the first page and signature page of your most recent federal tax return. |
| Common-Law Spouse | • Common-law marriage affidavit  
                        AND  
                        • A document dated within the last 60 days showing current relationship status, such as a monthly or quarterly household bill or statement of account. The document must list your spouse’s name, the date and your mailing address. |
| Civil Union     | • Registered copy of civil union certificate.  
                        AND  
                        • A document dated within the last 60 days showing current relationship status, such as a monthly or quarterly household bill or statement of account. The document must list your partner’s name, the date and your mailing address. |
| Children        | • The child’s birth or adoption certificate, naming you or your spouse as the child’s parent, or appropriate custody or allocation of parental responsibility documents naming you or your spouse as the responsible party to provide insurance for the child.  
                        • Newborns – The registered birth certificate must be provided within 31 days of birth. Social Security number must be provided within 90 days of birth. |
The eligibility documentation must be provided within the following timeframes:

- Within 31 days of benefits eligibility, or
- During the annual Open Enrollment period as scheduled by the member institutions for benefit changes effective the following January 1st, or
- Within 31 days of all changes related to IRS-defined change of status

The employee must provide a certified and notarized translation of any documents presented which are in a foreign language.

**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 whose coverage under any Benefits Plan is continued or extended in accordance with the provisions of the Benefit Plan and Trust.

**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. For eligibility, please contact your Human Resources/Benefits Office. 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. Individual or family coverage through the Health Insurance Marketplace is not group health insurance and does not qualify for a waiver of medical and dental coverage.

**Premium Payments**

To assist in reducing your insurance premium costs, your share of medical, dental and vision insurance premiums can be paid with pre-tax dollars under the CHEIBA Section 125 Plan. For Premium Payments involving Civil Union Partners and the children of Civil Union Partners, please review the document titled, “Important Tax Information for Partners in a Civil Union – Medical, Dental and Term Life Benefits”.

**PERA Participants**

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.

**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 Blue Priority (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.
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. 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.
  
  **NOTE:** A newborn child born to the Subscriber or Subscriber’s Spouse is covered under the Subscriber’s coverage for the first 31 days after birth. To continue the newborn child’s participation in the coverage beyond the 31-day period after the newborn child’s birth, the Subscriber must complete and submit an Enrollment Application and Change Form within 31 days after the birth of the child to add the newborn child as a Dependent child to the Subscriber’s policy.

- **Terminating Coverage**
  When you or a covered Dependent terminates coverage under the medical plan, you may request that the medical plan send you a certificate of coverage that identifies the length of coverage under the plan. The HIPAA Certificate of Coverage may be needed for you to enroll in another medical plan. 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 October 2016, 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.

- **Protected Health Information**
  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.
**Benefit Eligibility Changes**

- **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.

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<th>Eligible changes listed under IRS regulations include the following status changes:</th>
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<td>✓ change in Employee’s marital status; marriage, divorce, annulment, legal separation or death of a spouse;</td>
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<tr>
<td>✓ 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;</td>
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<tr>
<td>✓ 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;</td>
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<tr>
<td>✓ 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;</td>
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<tr>
<td>✓ commencement or termination of employment by an Employee, Employee’s spouse or Eligible Dependent;</td>
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<td>✓ attainment or loss of Dependent eligibility as defined by the Plan, i.e., exceeding the Plan’s established age limitations or eligibility for coverage under another health plan would all qualify as an eligible change in status events;</td>
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<tr>
<td>✓ entitlement to/or loss of Medicaid or Medicare coverage by an Employee, Employee’s spouse or Eligible Dependent;</td>
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<tr>
<td>✓ residence and/or worksite change: a required change in place of residence and/or worksite 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;</td>
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<tr>
<td>✓ 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</td>
</tr>
<tr>
<td>✓ 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. <strong>NOTE:</strong> This does not allow election changes in the Health Care Spending Account.</td>
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<td>✓ Other eligible changes include the establishment of a civil union and the termination or dissolution of the civil union.</td>
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**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.
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 in which an Employee terminates employment for any reason including death and retirement or 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”
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 terms 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 and Dependent 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.
**Benefit Highlights**

**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. Four (4) Options are available: BlueAdvantage Point of Service Plan (HMO/POS), PRIME Blue Priority PPO, Blue Priority HMO Plan and Lumenos High Deductible Health Plan (HSA Compatible).

**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 (2) options are available: Anthem Blue Dental PPO Plus or Anthem Blue Dental PPO

**Vision Insurance**
Anthem Blue View Vision

Your enrollment in any of the CHEIBA medical plans includes coverage for a routine eye exam (once every 12 months). You will need to elect coverage for eyewear materials and lens treatment option and this is a voluntary Employee-paid option. 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, Civil Union 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, or your Civil Union 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 Civil Union Partner will be 50% of yours and each eligible child’s benefit amount will be 10% of yours.

**FLEXIBLE BENEFIT PLAN**

24HourFlex (Except 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 24HourFlex (except Fort Lewis College).

**LONG-TERM DISABILITY INSURANCE**

Standard Insurance

Should you experience a long-term disability, the plan will replace a portion of your income. You are eligible for benefits after you have been disabled for 90 days.

**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.).

**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 Arthur J. Gallagher & Co., 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 303-889-2692 or 1-800-943-0650; Monday through Friday from 8:00 a.m. to 4:00 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).
The CHEIBA Trust and the CHEIBA Trust Members offer you four medical insurance plans from which to select. Please carefully review the Multi-Option Plan Summary 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 Plan Contacts Page at the beginning of this book.

**ANTHEM BLUE CROSS AND BLUE SHIELD/HMO COLORADO**

Your choices include:

- BlueAdvantage Point of Service Plan
- Prime Blue Priority PPO Plan
- Blue Priority HMO Plan
- Lumenos High Deductible Health Plan
<table>
<thead>
<tr>
<th>Description</th>
<th>BlueAdvantage In Network (HMO)</th>
<th>Out of Network (POS)</th>
<th>PPO In Network</th>
<th>Non-PPO Out of Network</th>
<th>Blue Priority HMO HMO In Network Only</th>
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<th>Non PPO Out of Network</th>
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<td>$400 Individual</td>
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<td>$1,000 Family</td>
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<td>Out-of-Pocket Annual Maximum</td>
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<td>$4,000 Individual</td>
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<td>Deductible, Coinsurance</td>
<td>All copayments (including Rx copayments), Deductible and Coinsurance</td>
<td>Deductible &amp; Coinsurance</td>
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<td>Physician Selection</td>
<td>PCP required</td>
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<td>Medical Office Visits</td>
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<tr>
<td>• Specialist</td>
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<tr>
<td>LiveHealth Online (Telemedicine)</td>
<td>$20 copayment per visit</td>
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<tr>
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<td>$40 copayment per visit</td>
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<td>$60 copayment per visit</td>
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<tr>
<td>Urgent Care</td>
<td>$50 copayment per visit</td>
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<td>15% after deductible</td>
<td>35% after deductible</td>
<td>$20 copayment per visit</td>
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<tr>
<td>Emergency Room</td>
<td>$150 copayment per visit</td>
<td>$150 copayment per visit</td>
<td>15% after deductible</td>
<td>35% after deductible</td>
<td>$20 copayment per visit</td>
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<td>Inpatient Hospital</td>
<td>$600 copayment per admission</td>
<td>30% after deductible</td>
<td>15% after deductible</td>
<td>35% after deductible</td>
<td>$250 copayment per visit</td>
<td>$250 copayment per visit</td>
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<td>Outpatient Surgery</td>
<td></td>
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<tr>
<td>• Hospital Based Facility</td>
<td>$125 copayment per visit</td>
<td>30% after deductible</td>
<td>15% after deductible</td>
<td>35% after deductible</td>
<td>$250 copayment + 20% after deductible (Hospital)</td>
<td>$250 copayment + 20% after deductible (Hospital)</td>
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<tr>
<td>• Freestanding Facility</td>
<td>$60 copayment per visit</td>
<td></td>
<td>10% after deductible</td>
<td></td>
<td>$250 copayment + 20% after deductible (Hospital)</td>
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<td>Outpatient Lab &amp; X-Ray</td>
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<td>30% after deductible</td>
<td>10% after deductible</td>
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<td>Labs covered 100% X-Ray $60 copayment (Freestanding)</td>
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<tr>
<td>Advanced Imaging (MRI/MRA/PET/CT Scans)</td>
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<td>• Hospital Based Facility</td>
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<tr>
<td>• Freestanding Facility</td>
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<tr>
<td>Prescriptions Retail (30-day supply)</td>
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<td>Tier 1-$10 copayment</td>
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<td>Not Covered</td>
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<td>Not covered</td>
<td>Tier 1-$15 copayment</td>
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<tr>
<td>Tier 2-$40 copayment</td>
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<td>Tier 2-$40 copayment</td>
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<td>Tier 2-$40 copayment</td>
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<td>Tier 3-$50 copayment</td>
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<tr>
<td>Prescriptions Mail Order (90-day supply)</td>
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<td>Tier 1-$10 copayment</td>
<td>Not Covered</td>
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<td>Not Covered</td>
<td>Tier 1-$15 copayment</td>
<td>Not covered</td>
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<tr>
<td>Tier 2-$80 copayment</td>
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<td>Tier 3-$120 copayment</td>
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<td>Tier 3-$120 copayment</td>
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<tr>
<td>Specialty Drugs¹ (Tier 4) (30-day supply)</td>
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<tr>
<td>30% coinsurance to max $125</td>
<td>Not Covered</td>
<td>30% coinsurance to max $250</td>
<td>Not Covered</td>
<td>30% coinsurance to max $250</td>
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</tbody>
</table>

Not all specialty drugs on Tier 4 are subject to the Tier 4 coinsurance. Certain specialty drugs may be subject to the Tier 1, 2 or 3 copayment.

¹ Tier 2 and Tier 3 retail pharmacy, specialty pharmacy and/or home delivery drugs are first subject to a deductible. Once satisfied, then services are subject to the applicable copayment per prescription.

² Tier 2 and Tier 3 retail pharmacy, specialty pharmacy and/or home delivery drugs are first subject to a deductible. Once satisfied, then services are subject to the applicable copayment per prescription.

³ Tier 2 and Tier 3 retail pharmacy, specialty pharmacy and/or home delivery drugs are first subject to a deductible. Once satisfied, then services are subject to the applicable copayment per prescription.
PRESCRIPTION DRUG BENEFIT

Prescription drug coverage is included with all medical plans. Your prescription drug coverage has three copayment tiers, with generic medications having the lowest copayments. You can save more on medications you take regularly, sometimes called maintenance medications, by using the mail order program.

Your plans use a drug list called a formulary to help determine your copayment for each prescription. The drugs on your formulary were selected to give you the highest level of coverage under your prescription drug benefit.

What is the Essential Drug List?

The Essential Drug List is a list of brand-name and generic prescription medications that have been selected and are periodically reviewed through Anthem’s Pharmacy & Therapeutics process for proven effectiveness, high quality, and affordability. The Essential Drug List includes all of the essentials, but is a focused list that offers pharmacy cost savings while ensuring there are no gaps in care.

What can a member do if their medication isn’t on the Essential Drug List?

If your medication is not on the Essential Drug List, there may be a brand alternative, a generic equivalent or OTC option. When you search the Essential Drug List, you will see the generic equivalent if available; however, OTC options will not be displayed. If an alternative isn’t listed, members should talk with their doctor or pharmacist about whether another medication that is included on the Essential Drug List or an OTC may be right for them.

Non-formulary medications can be requested through the formulary exception process. If a medication a member takes isn’t covered on the Essential Drug List, the member or doctor can ask us to keep covering it by asking for a formulary exception. The process is the same as any Prior Authorization request. The member or doctor can call Member Services at the number on the ID card. Members can also go online to find the preapproval fax form to ask for a formulary exception. In most cases, the prescribing doctor is first asked whether the member has tried two formulary alternatives. If not appropriate or available, Anthem will review the clinical requirements and concerns presented by the doctor. For some classes and most specialty medications, drug-specific prior authorization criteria may be used. This is done to ensure specific alternatives are tried or the medication is used for the correct indication.

How can I search the Essential Drug List?

At www.anthem.com/pharmacyinformation select the Essential 4-tier Drug List. You can search for medications, and see which drugs are covered and at what tier level. You can enter the name of the drug or you can browse through the categories shown on the screen. Once you are on the drug details page, you’ll see the tier level listed. If you see “NF” that means the drug is non-formulary and not covered.
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:

- **Tier 1 Generics** - these drugs are simply copies of brand-name drugs. Brand-name and generic drugs have the same active ingredients, strength and dose. The FDA requires that generic drugs meet the same high standards for purity, quality, safety and strength. With generics, you get the same quality for less money.
- **Tier 2 Preferred Brand** - these are drugs for which generic equivalents are not available. They have been in the market for a time and are widely accepted. They cost more than generics, but less than non-preferred brand-name drugs.
- **Tier 3 Non-Preferred Brand** - these drugs are generally higher-cost medications that have recently come on the market. In most cases, an alternative preferred or generic medication is available.
- **Tier 4 Specialty Drugs** - these are prescription medications used to treat complex, chronic conditions that may require special handling and/or management. It is important to note the following:
  - Not all specialty drugs on Tier 4 are subject to the Tier 4 coinsurance. For example, capecitabine, a drug used to treat cancer, is generic so a member could obtain this prescription for the Tier 1 copayment.
  - Some specialty drugs are considered Retail Pharmacy Drugs and are not on the Exclusive Specialty List. These drugs are not required to be obtained through the specialty pharmacy. An example of this would be Arixtra, a drug used to prevent blood clots.

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.

**NOTE:** Prescription drugs will always be dispensed as ordered by your provider and by applicable State Pharmacy Regulations, however, you may have higher out-of-pocket expenses. You may request, or your provider may order, the brand-name drug. However, if a generic drug is available, you will be responsible for the cost difference between the generic and brand-name drug, in addition to your Tier copayment. The cost difference between the generic and brand-name drug does not contribute to the out-of-pocket annual maximum. *(Tier 1 generic copayment is not applicable if you are enrolled in the Lumenos HDHP)*

**Diabetic supplies/prescriptions and asthma inhalers/prescriptions will be covered at no cost to you.**

**Members taking specialty drugs must order them through Accredo 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.

**Mail Order/Home Delivery:** If you need maintenance medications for ongoing conditions such as asthma, diabetes, high blood pressure, etc., you may want to use home delivery service. This service offers you the convenience of having prescriptions delivered directly to the home, office or anywhere in the United States. Ordering your maintenance medications through home delivery eliminates monthly trips to the pharmacy and allows you to receive more days’ supply with fewer copayments. Typical savings are at least one copayment for each prescription.

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

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**If you have questions**

Call Customer Service at: .................. 1-800-542-9402

or

Go to the website: ...................... www.anthem.com
The Point-of-Service (HMO/POS) Plan includes both in-network and out-of-network benefits. 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**
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. 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.

To search for primary care providers and participating health care professionals online, please visit [www.anthem.com](http://www.anthem.com):

- Select Find A Doctor
- Select Search by selecting plan or network
- Select a state: (choose from drop down menu)
- Select a plan/network (Medical Network): HMO
- Choose Select and Continue
- Complete fields for provider type, specialty and location
- Select: Search

**Prime Blue Priority PPO**
This choice provides a flexible plan option that allows you access to three different levels of providers, each with different out-of-pocket costs:

- **Level 1**: Blue Priority Designated providers are either PCP’s or specialists. A Designated PCP or Designated specialist has the lowest out-of-pocket costs with a simple co-pay. **Blue Priority Designated providers are located in the following counties**: Adams, Arapahoe, Boulder (including Longmont), Broomfield, Denver, Douglas, Elbert, El Paso, Fremont, Jefferson, La Plata, Montezuma, Pueblo, Summit and Teller.
- **Level 2**: Providers in Anthem’s large, traditional PPO network may serve as PCP’s and specialists.
- **Level 3**: Nonparticipating providers have the highest out-of-pocket costs.

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.

**Note**: If you live in a rural area and there are no PPO providers within a reasonable distance from you, you may request an authorization to see an out-of-network provider. If approved, benefits will be applied at the in-network level. Please contact Anthem Blue Cross Blue Shield at 1-800-542-9402 for assistance.

**Physician Selection**
You must select a Blue Priority Designated primary care physician (PCP) for yourself and each covered Dependent. However, you may receive care from any provider that participates in the network. You will pay less if you receive care from a Designated provider.

Members are not required to obtain referrals from their PCP to see an in-network specialist. However, Anthem does encourage you to ask your PCP for an in-network referral recommendation.

To search for primary care providers and participating health care professionals online, please visit [www.anthem.com](http://www.anthem.com):

- Select Find A Doctor
- Select Search by selecting plan or network
- Select a state: (choose from drop down menu)
- Select a plan/network (Medical Network): PPO (Level 2 & 3 providers) / For Designated Blue Priority (Level 1) providers, please select the Blue Priority PPO
- Choose Select and Continue
- Complete fields for provider type, specialty and location
- Select: Search
The Blue Priority HMO Plan includes **in-network benefits only**.

Members must choose a primary care physician from the Blue Priority network. Providers are located in the Denver metro area, which includes Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas and Jefferson counties, as well as Elbert, El Paso, Teller, Fremont, La Plata, Montezuma, Pueblo, Summit counties and the city of Longmont.

**PHYSICIAN SELECTION**
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.

Your primary care physician is your personal provider who coordinates your care within the Blue Priority HMO network. **Referrals to see a specialist are required.**

To search for primary care providers and participating health care professionals online, please visit [www.anthem.com](http://www.anthem.com):

- Select Find A Doctor
- Select Search by selecting plan or network
- Select a state: (choose from drop down menu)
- Select a plan/network (Medical Network): Blue Priority HMO
- Choose Select and Continue
- Complete fields for **provider type, specialty and location**
- Select: Search

**LUMENOS HIGH DEDUCTIBLE HEALTH PLAN**
This choice is a High Deductible Preferred Provider (PPO) plan option which includes in and out-of-network coverage.

Members must pay their annual deductible¹ during the plan year before the plan helps pay for costs. This includes costs for medical and prescription drug expenses. All in-network preventive care services are 100% covered.

In-network doctors have a pre-negotiated rate with Anthem Lumenos, so your expenses will be less if you use in-network doctors.

**Example**: If you go to a doctor for a sore throat before you meet the deductible, you pay the full (negotiated) cost of the office visit and any tests your physician orders and prescription drugs prescribed.

This plan can be combined with a health savings account (HSA) to allow you to pay for qualified, out-of-pocket medical expenses on a pre-tax basis. An HSA account is a personal, portable account and remains in your control regardless of your employment. An HSA can be established through any qualifying financial institution. **Please contact your financial advisor or banking institution for additional information.**

¹ The annual deductible under the Lumenos HDHP is non-embedded. For employees with dependents, this means that **all family members’ out-of-pocket expenses count toward the family deductible until it is met. It does not matter if one person incurs all the expenses that meet the deductible or if two or more family members contribute toward meeting the family deductible.**

**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, or you may 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.

To search for primary care providers and participating health care professionals online, please visit [www.anthem.com](http://www.anthem.com):

- Select Find A Doctor
- Select Search by selecting plan or network
- Select a state: (choose from drop down menu)
- Select a plan/network (Medical Network): Lumenos PPO
- Choose Select and Continue
- Complete fields for **provider type, specialty and location**
- Select: Search
CUSTOM PLUS HEALTH PLAN

Closed to new enrollment effective January 1, 2010.
This 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.

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](http://www.anthem.com). Claim forms are provided through Anthem Blue Cross and Blue Shield of Colorado or through your Human Resources/Benefits Office.

### Medical Benefits

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<thead>
<tr>
<th>Description</th>
<th>Custom Plus No Defined Network</th>
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<tbody>
<tr>
<td>Annual Deductible</td>
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</tr>
<tr>
<td>Annual Maximum Out-of-Pocket</td>
<td>$3,800 Individual $7,600 Family</td>
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<tr>
<td>Physician Selection</td>
<td>Unrestricted; greater benefits with Traditional Participating Network provider</td>
</tr>
<tr>
<td>Physician Services</td>
<td>80% after deductible (based on the maximum benefit allowance)</td>
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<tr>
<td>Hospital</td>
<td>80% after deductible (based on the maximum benefit allowance)</td>
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<tr>
<td>Outpatient Surgery</td>
<td>80% after deductible (based on the maximum benefit allowance)</td>
</tr>
<tr>
<td>Outpatient Lab</td>
<td>80% after deductible (based on the maximum benefit allowance)</td>
</tr>
<tr>
<td>Prescriptions Retail &amp; Mail Order</td>
<td>80% after deductible</td>
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</tbody>
</table>

If you want to complete your enrollment forms, review the Multi-Option Plan Summary or review this Benefit Booklet, reference this plan name: Custom Plus

If you want to search for information (like searching for a doctor) on the anthem.com website, reference this plan name: Major Medical/Traditional Provider Network

If you have questions
Call Customer Service at: .......................... 1-800-542-9402 or
Go to the website: .............................. [www.anthem.com](http://www.anthem.com)
MyAnthem™
Tired of paperwork and phone calls? Anthem offers its members a useful website. Register with anthem.com to get online access to your benefits. MyAnthem™ takes the hassle out of your health care and allows you to get your information when you need it. Use MyAnthem™ to:

- **Find a doctor**
  Search for a doctor, specialist, urgent care or hospital close by.

- **Get your ID card**
  Share, fax, or email your ID card.

- **Check your claims**
  Find out what your doctor billed, how much was paid and if you owe anything.

- **Estimate your costs**
  See what nearby doctors and facilities charge for a procedure. You can compare providers on cost and quality.

- **View your medical benefits**
  See your copays, deductibles, your percentage of the costs, and other important plan benefit information.

- **Manage prescription benefits**
  Check the cost of drugs, get refills or switch to our home delivery program.

- **Access your Health Record**
  View your Health Record and share with your doctors whenever you go.

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**DO YOU HAVE A SMARTPHONE?**

Using Anthem’s free mobile app can make it easier than ever to manage your health care.

1. Go to the app store on your smartphone or mobile device.
2. Search for Anthem Anywhere
3. Select the app and start the free download.

To use the mobile application, you must be registered on Anthem’s secure member site and have a username and password.
Register with anthem.com to get online access to your benefits

From any computer with Internet access, type anthem.com in the Web browser address field and click Register Now.* This can be found on the top right-hand side of your screen in the Member Log In area.

Step 1: Personal information

Enter your personal information, including member identification number, first and last name, date of birth (mm/dd/yyyy). For security, you’ll also be asked to put in the security code that’s shown. Click Save & Continue.

Step 2: Username and password

Create your username and password. Then select a security question from the drop-down menu and give the answer. You’ll be asked to answer your security question if you ever forget your password. Please keep this information secure. Once you’re done with your username, password and security question, check the box to agree to the terms and conditions of Anthem and click Save & Continue.

Step 3: Email setup

You’ll be able to choose how you’d like to get future legal notifications, special offers and other health plan notifications. Enter your email address to set up your online profile. You can also choose to receive information about new products and services, benefit updates, and required notices. Click Save & Continue.

Step 4: Confirm registration

Here you’ll make sure all your personal information, username and password and your notification choices are right. Click Confirm.

Having problems signing up? Call the eBusiness Help Desk at 866-755-2680 for help.

Now you can log in to start taking advantage of online access to your benefits. It’s all the information you need to make an informed decision - coverage, quality, cost, and patient experience information - all in one place.

*If you are 35 years of age or older, you must register your own account.
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 their 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.

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.

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.

To reach 24/7 NurseLine, call toll-free 1-800-337-4770 or go to www.anthem.com and select Health & Wellness.

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: ............................................................................................................................................. 1-855-891-9988
**LiveHealth Online**

**What is LiveHealth Online®?**
Use LiveHealth Online for common health concerns like colds, the flu, fevers, rashes, infections, allergies and more! It’s faster, easier and more convenient than a visit to an urgent care center.

LiveHealth Online is part of your health plan benefits. The cost of a LiveHealth Online visit is the same or less than a primary care office visit. With LiveHealth Online, you have a doctor by your side 24/7. LiveHealth Online lets you talk face-to-face with a doctor through your mobile device or a computer with a webcam. No appointments, no driving and no waiting at an urgent care center.

**How does LiveHealth Online work?**
When you need to see a doctor, simply go to livehealthonline.com or access the LiveHealth Online mobile app. Select the state you are located in and answer a few questions. Best of all, LiveHealth Online is a part of your health plan. So, the cost of a LiveHealth Online visit is the same or less than a primary care office visit. Establishing an account allows you to securely store your personal and health information. Plus, you can easily connect with doctors in the future, share your health history and schedule online visits at times that fit your schedule. Once connected, you can talk and interact with the doctor as if you were in a private exam room.

**How do I access LiveHealth Online?**
Sign up at [www.LiveHealthOnline.com](http://www.LiveHealthOnline.com) or Download the LiveHealth Online mobile app for free on your mobile device by visiting the App StoreSM or Google PlayTM.

**How do I pay for a LiveHealth Online session?**
LiveHealth Online accepts Visa, MasterCard and Discover cards as payment for an online visit with a doctor. Please keep in mind that charges for prescriptions aren’t included in the cost of your doctor’s visit.

**Do doctors have access to my health information?**
LiveHealth Online doctors can only access your health information and review previous treatment recommendations and information from prior LiveHealth Online visits.

If you are using LiveHealth Online for the first time, you will be asked to answer a brief questionnaire about your health before you speak with a doctor. Then the information from your first online visit will be available for future LiveHealth Online visits.

**Who do I get in touch with if I still have questions?**
You can email, customersupport@livehealthonline.com or call toll free at 1-855-603-7985.

If you send us an email, please be sure to include:
- Your name
- Your email
- A phone number where you can be reached

LiveHealth Online should not be used for emergency care. If you experience a medical emergency, call 911 immediately.
**LiveHealth Online Psychology**

If you’re feeling stressed, worried or having a tough time, you may need someone to speak with. Now you can see a licensed therapist using LiveHealth Online Psychology. Talk with a therapist from your home or wherever you have internet access. It’s quick, easy and private. Just download the free LiveHealth Online app to your mobile device or visit [www.livehealthonline.com](http://www.livehealthonline.com) on a computer with a webcam.

**How do I schedule my first appointment with a psychologist or therapist using LiveHealth Online?**

For your first visit, set up a time by going online, using the mobile app or calling LiveHealth Online:

- **Online**: Visit [www.livehealthonline.com](http://www.livehealthonline.com) and sign up or log in. Once you have logged in, select LiveHealth Online Psychology. Next choose from available therapists after seeing their backgrounds and set up a visit.
- **Mobile App**: Download the free LiveHealth Online mobile app and then sign up or log in. Once you have logged in, select LiveHealth Online Psychology and choose an available therapist after checking out their qualifications.
- **Phone**: Call 1-844-784-8409 from 7 a.m. to 11 p.m.

In most cases, you can make an appointment to see a therapist within four days or less. LiveHealth Online will send you an email confirming your appointment. You must be at least 18 years or older to visit with a therapist online. Psychologists and therapists using LiveHealth Online Psychology do not prescribe medications.

**How do I set up a follow up appointment?**

At the end of your first visit, you can set up a future visit with the therapist if both of you feel it is needed. You always have the choice of the therapist you would like to see.

**How long does a visit usually last?**

A typical visit with a psychologist or therapist using LiveHealth Online Psychology is about 45 minutes.

**How do I pay for a LiveHealth Online session?**

Depending on your coverage, the cost may be similar to what you would pay for an office visit, considering your benefits, copay or coinsurance. You can pay your share of the visit using a Visa, Mastercard, Discover or American Express credit or debit card. You will see what you owe before you start a visit and the cost is charged to your credit card. The cost is the same no matter when you have the visit - whether it’s a weekday, the weekend, evening or holiday.

**What conditions can LiveHealth Online Psychology help with?**

Therapists using LiveHealth Online can help you with stress, anxiety, depression, relationship or family issues, grief, panic attacks and stress from coping with a sickness.

**How do I know if a psychologist or therapist is in-network?**

When you log in to [www.livehealthonline.com](http://www.livehealthonline.com), the providers you see on the website are part of the Anthem Blue Cross and Blue Shield provider network. Make sure you select the state where you are currently located to view the most up-to-date list of providers.
Dental Insurance

Strong teeth and gums are an important part of good health, which is why the CHEIBA Trust offers you and your eligible dependents the choice of two comprehensive dental plans through Anthem.

<table>
<thead>
<tr>
<th>PLAN HIGHLIGHTS</th>
<th>Anthem Blue Dental PPO Plus</th>
<th>Anthem Blue Dental PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Maximum (per member)</td>
<td>In Network: $2,000</td>
<td>In Network: $2,000</td>
</tr>
<tr>
<td></td>
<td>Out of Network: $2,000</td>
<td>Out of Network: $2,000</td>
</tr>
<tr>
<td>Annual Deductible (individual/family)</td>
<td>In Network: $25 / $75</td>
<td>In Network: $0</td>
</tr>
<tr>
<td></td>
<td>Out of Network: $25 / $75</td>
<td>Out of Network: $50 / $150</td>
</tr>
</tbody>
</table>

### PLAN HIGHLIGHTS

#### Diagnostic & Preventive Services (deductible does not apply)

*Diagnostic & Preventive services do not accumulate towards annual maximum*

**Services include:**

- Oral evaluations
- X-Rays
- Cleanings *(Benefit includes (3) three annual cleansings for adults only)*
- Specified space maintainers

<table>
<thead>
<tr>
<th>Services</th>
<th>Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Network</td>
<td>100%</td>
</tr>
<tr>
<td>Out of Network</td>
<td>80%</td>
</tr>
</tbody>
</table>

#### Restorative/General Services (deductible applies)

**Services include:**

- Emergency palliative treatment
- General anesthesia
- Amalgam and anterior composite restorations

<table>
<thead>
<tr>
<th>Services</th>
<th>Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Network</td>
<td>80%</td>
</tr>
<tr>
<td>Out of Network</td>
<td>60%</td>
</tr>
</tbody>
</table>

#### Endodontic Services (deductible applies)

**Services include:**

- Root canal therapy

<table>
<thead>
<tr>
<th>Services</th>
<th>Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Network</td>
<td>80%</td>
</tr>
<tr>
<td>Out of Network</td>
<td>60%</td>
</tr>
</tbody>
</table>

#### Oral Surgery Services (deductible applies)

**Services include:**

- Simple and surgical tooth extractions

<table>
<thead>
<tr>
<th>Services</th>
<th>Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Network</td>
<td>80%</td>
</tr>
<tr>
<td>Out of Network</td>
<td>60%</td>
</tr>
</tbody>
</table>

#### Periodontal Services (deductible applies)

**Services include:**

- Gingivectomy
- Osseous surgery

<table>
<thead>
<tr>
<th>Services</th>
<th>Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Network</td>
<td>80%</td>
</tr>
<tr>
<td>Out of Network</td>
<td>60%</td>
</tr>
</tbody>
</table>

#### Prosthodontic Services (deductible applies)

**Services include:**

- Crowns/onlays
- Removable or fixed partials or dentures
- Implants

<table>
<thead>
<tr>
<th>Services</th>
<th>Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Network</td>
<td>50%</td>
</tr>
<tr>
<td>Out of Network</td>
<td>40%</td>
</tr>
</tbody>
</table>

#### Orthodontic Services

- **Adults**
  - 50% up to $1,500
  - 50% up to $1,000
- **Children**
  - 50% up to $1,500
  - 50% up to $1,000

*¹Lifetime Maximum – the cumulative dollar amount the plan will pay for orthodontic treatment incurred by an individual enrollee for the life of the plan. For family coverage, each individual covered under the plan is subject to the lifetime maximum.*

*Note: This is only an overview of your dental plan choices. Review the specific dental brochures pertaining to each plan for further details and explanations. If discrepancies are found, depend upon the certificate of coverage itself for accuracy.*
Helpful Information to Help You Decide Which Plan/Network to Choose

Dental Insurance

<table>
<thead>
<tr>
<th>Number of In-Network Providers</th>
<th>Dental PPO</th>
<th>Dental PPO+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access Points: over 4,300</td>
<td>Access Points: over 5,000</td>
<td></td>
</tr>
<tr>
<td>Unique Providers: over 1,700</td>
<td>Unique Providers: over 2,100</td>
<td></td>
</tr>
</tbody>
</table>

Access Points = the number of locations when Anthem has In-Network Providers.
Unique Providers = the number of individual providers in the network.

Both of your dental plan options are Preferred Provider Organizations (PPO) and offer you flexibility to select the dentist of your choice or a dentist within the extensive Anthem dental network throughout Colorado. While your dental plan lets you choose any dentist, you may end up paying more for a service if you visit an out-of-network dentist. Here’s why:

In-network dentists have agreed to payment rates for various services and cannot charge you more. On the other hand, out-of-network dentists do not have a contract with Anthem and are able to bill you for the difference between the total amount Anthem allows to be paid for a service - the “maximum allowed cost” - and the amount they usually charge for a service. When they bill you for this difference, it is called “balance billing.”

EXAMPLE: (this is an example only. Your experience may be different, depending on your insurance plan, the services you receive and the dentist who provides the services.)

Ted needs to get a crown and his plan allows him 50% coinsurance for either in or out-of-network services. The cost for this service is $1,200.

Here’s the Math:

<table>
<thead>
<tr>
<th>Out-Of-Network Provider</th>
<th>In-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentist Charge: $1,200</td>
<td>Dentist Charge: $1,200</td>
</tr>
<tr>
<td>Anthem’s Maximum Allowed Cost: $800</td>
<td>Anthem’s Maximum Allowed Cost: $800</td>
</tr>
<tr>
<td>Anthem Pays 50%: $400</td>
<td>Anthem Pays 50%: $400</td>
</tr>
<tr>
<td>Ted Pays 50% coinsurance: $400</td>
<td>Ted Pays 50% coinsurance: $400</td>
</tr>
<tr>
<td>Balance Ted Owes the Provider: $400 (difference between charge and allowed amount)</td>
<td>Provider Write Off: $400</td>
</tr>
<tr>
<td>Ted’s Total Cost: $400 provider balance + $400 coinsurance = $800</td>
<td>Ted’s Total Cost: $400 coinsurance</td>
</tr>
</tbody>
</table>

Minimize your out-of-pocket expense for dental care by asking your dentist for a pre-treatment estimate before you agree to receive services for costly procedures such as crowns, periodontal surgery and wisdom tooth extractions. A pre-treatment estimate will not only allow you to confirm if the treatment is covered, it will also help you to know what your cost of the treatment will be, if you will exceed your maximum and how to best plan your payment portion. In-network providers are responsible for obtaining a pre-treatment estimate, if requested. If you use an out-of-network provider, you are responsible for making sure the provider submits a written treatment plan, with the required documentation for services to Anthem.

After receiving treatment from a dentist, you will receive a summary of services that shows how much Anthem paid and what your cost share is. This Explanation of Benefits (EOB) should always be read thoroughly and Anthem should be contacted if there are any questions. The EOB will also indicate how much of your deductible you have met as well as how close you are to reaching your plan’s annual maximum.

To search for participating dental providers online, please visit www.anthem.com:

- Select Find A Doctor
- Select a state: (choose from drop down menu)
- Select a plan/network: Dental PPO or Dental PPO Plus
- Choose Select and Continue
- Complete fields for provider type, specialty and location

Routine preventive care such as regular exams and cleanings can help prevent the incidence of higher cost treatments and medical related issues. Dental coverage will provide you and your family affordable options for overall health.

Under your dental plans, Diagnostic & Preventive services such as exams, cleanings, x-rays and more do not count towards your annual maximum – leaving you with more benefit dollars to use for other covered dental procedures.

The PPO+ plan is a good choice for members who live in rural locations and need a larger network to find an in-network provider.

Or, if no in-network provider is within close proximity, the higher coinsurance level should help offset the member’s out-of-pocket costs on the balance billing.
The CHEIBA Trust and the CHEIBA Trust Members are pleased to offer you a comprehensive managed vision care program. Anthem Blue View Vision offers a market-leading network with over 30,000 doctors across the nation, as well as the Anthem Whole Health Connection. This program clinically integrates vision with our health plan to allow the most comprehensive care for our members.

**Anthem Blue View Vision Program**

Your vision benefit option is separated into three components:

1. **Vision Exam Only Benefit** - your enrollment in any of the CHEIBA medical plans will include coverage for a routine eye exam (once every 12 months) through the Blue View Vision Network of providers. Your health plan rates include the premium for this benefit, and the cost may be shared between you and your employer.

2. **Vision Materials Only Benefit** - if you are enrolled in a CHEIBA medical plan, you can complement your vision coverage by electing this Voluntary eyewear materials and lens treatment option.

3. **Full Service Vision Benefit** - employees who are not enrolled in a CHEIBA medical plan, but would like vision coverage can elect the Voluntary full-service (exam and materials) vision coverage.

**How Anthem Blue View Vision Works:**

**STEP ONE:** To obtain vision care services, call your Anthem Blue View Vision provider to make an appointment. To locate an Anthem Blue View Vision network provider, call Customer Service at 1-866-723-0515, visit www.anthem.com/ or contact your Human Resources/Benefit Office.

**STEP TWO:** When making an appointment:
- **Identify yourself as an Anthem Blue View Vision member**
**VISION INSURANCE**

**STEP THREE:** When you arrive at your appointment, present your ID card to the office. The Anthem Blue View Vision provider will verify eligibility and benefits via their internal system. Once your eye exam is completed and a determination is made whether eyewear is necessary, you can select eyeglasses or contacts at the office. Keep in mind you have the option to purchase your materials (eyeglasses/contacts) at any in-network providers office, including retail locations such as Sears Optical, Pearle Vision, JC Penney Optical, Target Optical and LensCrafters. The Anthem Blue View network provider will calculate applicable discounts and itemize any out-of-pocket expenses including copays, non-covered lens enhancements, additional materials and/or overages. The balance must be paid in full at the time of service.

**How To Find a Provider:**

With over 32,000 doctors at more than 26,000 locations nationwide, with independent doctors, convenient retail stores and 1-800 CONTACTS - all in network - the Blue View Vision provider network makes it easy for you and your family to take care of your vision needs.

To search for a network provider, visit [www.anthem.com](http://www.anthem.com) and:

Select: **Find a Doctor**
Select: **Search by Selecting Plan or Network**
Select: **State**
Select a plan/network: **Blue View Vision**

Members can search for providers by name or location. Once you have entered the standard search procedures, you can search for a provider offering materials by clicking on the show more options link and selecting “materials (frames, lenses, contacts)”.

![Find a Doctor](image-url)
<table>
<thead>
<tr>
<th>Description</th>
<th>Level of Coverage from an Anthem doctor</th>
<th>Non-Anthem Doctor or Provider Level of Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue View Vision - Exam Only</td>
<td>Frequency: Once every 12 months (included with your medical plan election)</td>
<td>$15 copay, then covered in full</td>
</tr>
<tr>
<td>Blue View Vision - Materials Only (Voluntary)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyeglass Frames</td>
<td>Frequency: Once every 12 months</td>
<td>$130 allowance, then 20% off any remaining balance</td>
</tr>
<tr>
<td>Standard Plastic Lenses</td>
<td>Frequency: Once every 12 months (from last date of service)</td>
<td>One time materials copay of $15</td>
</tr>
<tr>
<td>Standard plastic single vision lenses</td>
<td></td>
<td>$15 copay, then covered in full</td>
</tr>
<tr>
<td>Standard plastic lined bifocal lenses</td>
<td></td>
<td>$15 copay, then covered in full</td>
</tr>
<tr>
<td>Standard plastic lined trifocal lenses</td>
<td></td>
<td>$15 copay, then covered in full</td>
</tr>
<tr>
<td>Lenses include factory scratch coating at no additional cost. Polycarbonate and photochromic lenses are covered for dependent children under age 19 with no additional cost.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact Lenses *</td>
<td>Frequency: Once every 12 months (from last date of service)</td>
<td>$130 allowance, then 15% off any remaining balance</td>
</tr>
<tr>
<td>Elective conventional lenses</td>
<td></td>
<td>$130 allowance</td>
</tr>
<tr>
<td>Elective disposable lenses</td>
<td></td>
<td>Covered in full</td>
</tr>
<tr>
<td>Non-elective contact lenses</td>
<td></td>
<td>Copayment up to $55</td>
</tr>
<tr>
<td>Contact lens exam (Fitting &amp; Evaluation)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Contact lenses are in lieu of lenses and/or frame.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyeglass lens upgrades</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When obtaining eyewear from a Blue View Vision Provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass lens copayment applies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Transitions lenses (Adults)</td>
<td></td>
<td>$75</td>
</tr>
<tr>
<td>• Standard Polycarbonate (Adults)</td>
<td></td>
<td>$40</td>
</tr>
<tr>
<td>• UV Coating</td>
<td></td>
<td>$15</td>
</tr>
<tr>
<td>• Progressive Lenses ¹</td>
<td></td>
<td>$65</td>
</tr>
<tr>
<td>o Standard</td>
<td></td>
<td>$85</td>
</tr>
<tr>
<td>o Premium Tier 1</td>
<td></td>
<td>$95</td>
</tr>
<tr>
<td>o Premium Tier 2</td>
<td></td>
<td>$110</td>
</tr>
<tr>
<td>• Anti-Reflective Coating ²</td>
<td></td>
<td>$45</td>
</tr>
<tr>
<td>o Standard</td>
<td></td>
<td>$57</td>
</tr>
<tr>
<td>o Premium Tier 1</td>
<td></td>
<td>$68</td>
</tr>
<tr>
<td>o Premium Tier 2</td>
<td></td>
<td>20% off retail price</td>
</tr>
<tr>
<td>• Other Add-ons and Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>¹ Please ask your provider for his/her recommendation as well as the progressive brands by tier.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>² Please ask your provider for his/her recommendation as well as the coating brands by tier.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laser vision correction surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LASIK Refractive Surgery</td>
<td>Discount per eye</td>
<td></td>
</tr>
<tr>
<td>If you see an out-of-network provider, you must pay the cost in full and submit an out-of-network claim form for reimbursement up to the allowed amount.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Eyeglasses

- Lenses - Anthem Blue View Vision covers single vision, lined bifocal and lined trifocal lenses in full less the applicable copay.
- Covered Lens enhancements - Covered lens enhancements for all members include factory-scratch resistant coating. Participants receive discounts on non-covered lens enhancements such as anti-reflective coating, tinting, UV protection and progressive lenses.
- Frames – Frames are covered up to $130 allowance. Participants receive a 20% discount on any amount over the frame allowance.

Contact Lenses

- Contacts are available in lieu of frames and/or lenses. If you elect to purchase contacts, the plan pays $130 towards the purchase of the contacts. The contact benefit allowance must be used at one time. You cannot carry over any unused balance within the year. The contact lens exam (fitting and evaluation) copay is up to $55.

Laser VisionCare Program

- Potential candidates for laser vision correction surgery can learn about this procedure by visiting www.anthem.com/specialoffers. Anthem BVV partners with Tru Vision & Premier Lasik to offer multiple discount options for Lasik surgery.

**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 as an exam by the same provider at a 40% discount.

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 from Anthem’s Optometric Consultants.

<table>
<thead>
<tr>
<th></th>
<th>Anthem Network Provider Benefit</th>
<th>Non-Anthem Provider Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Supplementary Testing</strong></td>
<td>Covered in Full</td>
<td>Up to $125.00</td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td><strong>Supplementary Care Aids</strong></td>
<td>25% copay</td>
<td>Up to 75% of Cost</td>
</tr>
<tr>
<td></td>
<td>Subsequent low vision therapy as Visually Necessary or appropriate.</td>
<td></td>
</tr>
<tr>
<td><strong>Copayment</strong></td>
<td>75% of the authorized benefits payable by the Company and 25% payable by Covered Person.</td>
<td></td>
</tr>
</tbody>
</table>

The maximum low vision benefit available is $1,000 (excluding copayments) every two years.

Non-Anthem Providers

If patients choose a Non-Anthem provider, they should pay the entire bill and submit a copy of the itemized receipt to Anthem along with a claim form that can be downloaded from www.anthem.com. If the patient prefers, they can contact Customer Service at 1-866-723-0515 to have a form sent directly to them. Claims must be submitted to Anthem within 180 days of the date of service. The address for submitting the claims is located directly on the form.

Anthem 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 covered by Anthem.
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 eye care professional. Exceptions must be granted through prior authorization of Anthem and will only be considered when the exception is deemed necessary to the patient’s visual welfare.

**NOTE:** This is only an overview of your vision plan choices. Review the specific vision brochures pertaining to each plan for further details and explanations. If discrepancies are found, depend upon the certificate of coverage itself for accuracy.
Anthem Life Insurance Company

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 the lower salary level.

Dependent Coverage
Under this plan, your spouse, your partner in civil union and your Eligible Dependent children have a maximum benefit of $2,000 per person. The term Dependent means:
• an Employee’s legal spouse or partner in civil union 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,

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.
**Basic Term Life Insurance**

**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.

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 your Human Resources/Benefit Office if this benefit applies to you.

**Retiree Coverage**
When an Employee retires on or after January 1, 1997, the 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, your spouse or partner in civil union 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.

**Portability**
Upon termination of employment, you can keep your coverage at the same group rates, provided you or your covered spouse or your Civil Union 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 1-866-594-0516.

**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.
**Voluntary Term Life & AD&D Insurance**

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.

**Anthem Life Insurance Company Voluntary Term Life**

**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 Civil Union Partner Coverage**
You can enroll in additional coverage for your spouse or your Civil Union Partner (under age 70) even if you do not enroll yourself. Spousal or Civil Union 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 Civil Union Partner is under age 60, during the Employee’s initial eligibility period only. Amounts in excess of the guaranteed amount, spouses or Civil Union Partners over age 60, and if the spouse or Civil Union 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, partner in civil union are accepted for insurance coverage. Children are covered at $5,000 per child.

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

**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 or your spouse or Civil Union 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 Civil Union 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.

**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.
Voluntary Term Life & AD&D Insurance

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 may choose to purchase coverage from $10,000 to $500,000
  - You may include coverage on your spouse, Civil Union Partner and dependent children
  - The amount of coverage purchased cannot exceed ten times your annual salary
  - Under the family plan coverage spouse and Civil Union Partner coverage is 50% or the employee elected amount and dependent child coverage is 10% of the employee elected amount
  - If no dependent children are covered the spouse or Civil Union Partner benefit increase to 60%
  - If no spouse of Civil Union Partner is covered, 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.

NOTE: This is only an overview of your Accidental Death & Dismemberment Plan. Please review the Mutual of Omaha AD&D brochure for further details and explanations. If discrepancies are found, depend upon the policy itself for accuracy.
This Plan is offered on a voluntary basis and participation may require an administration fee.

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.

**Health Care Spending Account**

Please contact your Human Resources/Benefits Office for information on your institution’s maximum amount of reimbursement for health care expenses. 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, 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.24hourflex.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)**

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 unless your employer offers the Roll-Over Option.

For those employers who offer a Roll-Over Option, employees participating in the Health Care Spending Account may carryover up to $500 in unused funds into the next Plan Year. These funds will automatically carryover to the next Plan Year if you are still in the plan as of the last day of the current Plan Year. Please contact your Human Resources/Benefits Office for details on the rollover option.

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 unless your employer offers the Roll-Over Option. Plan carefully and set aside dollars only for those expenses you know you will incur.

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
24HourFlex is your Flexible Benefit Plan Administrator (except for Fort Lewis College). 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 may request a Benny Card 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 Benny 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. You may also set up direct deposit by logging into your individual 24HourFlex account and entering your banking information.

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 itemized statement or EOB must include the date of service, service provided, family member for whom the service was provided, amount paid 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.

Reminder: The definition of qualified medication expenses for purposes of Flexible Spending Accounts is 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.

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
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.
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. Cost-of-living adjustment (COLA) is included.

The maximum 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:

<table>
<thead>
<tr>
<th>Age</th>
<th>Maximum Benefit Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>61 or younger</td>
<td>to age 65, or to SSNRA(^1), or 3 years 6 months, whichever is longest</td>
</tr>
<tr>
<td>62</td>
<td>to SSNRA(^1) or 3 years 6 months, whichever is longer</td>
</tr>
<tr>
<td>63</td>
<td>to SSNRA(^1) or 3 years, whichever is longer</td>
</tr>
<tr>
<td>64</td>
<td>to SSNRA(^1) or 2 years 6 months, whichever is longer</td>
</tr>
<tr>
<td>65</td>
<td>2 years</td>
</tr>
<tr>
<td>66</td>
<td>1 year 9 months</td>
</tr>
<tr>
<td>67</td>
<td>1 year 6 months</td>
</tr>
<tr>
<td>68</td>
<td>1 year 3 months</td>
</tr>
<tr>
<td>69 or older</td>
<td>1 year</td>
</tr>
</tbody>
</table>

\(^1\)SSNRA = 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

* The Definition of Disability is 24-months of your own occupation and after 24 months, it is any occupation until age 65 or SSNRA.
LONG TERM DISABILITY INSURANCE

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 provide it to Standard 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 may 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. Ask your Human Resources/Benefits Office for further details and explanations. 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.
Sometimes balancing work and personal responsibilities creates stress that is hard to handle on your own. To help you through those times, you can receive counseling and referrals through the Colorado State Employee Assistance Program (C-SEAP).

**What is C-SEAP?**

C-SEAP is a professional assessment, referral, and short-term counseling service offered to State employees with work-related or personal concerns, as well as a resource for supervisors and managers seeking individual managerial consultation, work-group organizational development, assistance with conflict resolution, or help with resolution of work-place traumatic events.

C-SEAP has confidential, cost-free counseling and coaching available for active State employees with concerns such as:

- Grief
- Anger
- Depression
- Anxiety
- Stress
- Health Concerns
- Domestic Violence
- Job Performance Concerns
- Workplace Conflict
- Substance Abuse
- Couples/Family Problems
- Personal/Professional Growth

**How do you use C-SEAP?**

In order to schedule an appointment, call C-SEAP anytime Monday through Friday between the hours of 8 a.m. and 5 p.m. When you contact C-SEAP, a staff specialist will ask you for some general information and set up an appointment for you to meet with a counseling professional. Additional after hours resources are available on the C-SEAP voice mail as well as on the website. You can reach C-SEAP by calling the main office 303-866-4314 or 1-800-821-8154 to schedule your initial appointment.

**Where are my counseling sessions?**

C-SEAP offices are located in Downtown Denver, Loveland, Sterling, Grand Junction, Colorado Springs, Pueblo, Canon City, Alamosa and Durango.

**Will anybody know I'm coming to C-SEAP for counseling?**

C-SEAP does not disclose that you are coming to their office for counseling. Counseling services are strictly confidential. The only exceptions are when you give written permission for others to be informed, or in rare situations in which the law requires others to be informed for reasons of physical safety.
When traveling for business or pleasure, you can now feel confident that you are in safe hands if an emergency arises. CHUBB partners with Europ Assistance, a leading global medical assistance provider, to give you 24/7 access to medical and travel assistance services around the world.

**Medical Assistance Services:**
- Medical provider search and referrals to help find hospitals and doctors in a given locale
- Medical monitoring of treatment
- Facilitation of medical payment
- Coordination of medication

**Medical Evacuation & Repatriation Services:**
- Emergency medical evacuations and medically-necessary repatriation
- Coordinate transportation to join a hospitalized family member
- Dependent children/traveling companion assistance

**Benefits**

The maximum benefit (Principal Sum) is $100,000 of Accidental Death and Dismemberment. 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:

<table>
<thead>
<tr>
<th>Injury or Dismemberment</th>
<th>Policy Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of Life</td>
<td>The Principal Sum</td>
</tr>
<tr>
<td>Loss of Speech &amp; Hearing</td>
<td></td>
</tr>
<tr>
<td>Loss of Speech &amp; Loss of: One Hand, One Foot, Sight of One Eye</td>
<td>The Principal Sum</td>
</tr>
<tr>
<td>Loss of Hearing &amp; Loss of: One Hand, One Foot, Sight of One Eye</td>
<td></td>
</tr>
<tr>
<td>Loss of Both Hands, Both Feet, Sight</td>
<td></td>
</tr>
<tr>
<td>Loss of combination of any two: Hand, Foot, Sight of One Eye Quadriplegia</td>
<td></td>
</tr>
<tr>
<td>Paraplegia</td>
<td>75% of Principal Sum</td>
</tr>
<tr>
<td>Hemiplegia</td>
<td></td>
</tr>
<tr>
<td>Loss of: Hand, Foot or Sight of One Eye (any one of each)</td>
<td>50% of Principal Sum</td>
</tr>
<tr>
<td>Loss of Speech or Hearing</td>
<td></td>
</tr>
<tr>
<td>Uniplegia</td>
<td>25% of Principal Sum</td>
</tr>
<tr>
<td>Loss of Thumb &amp; Index Finger of the Same Hand</td>
<td></td>
</tr>
</tbody>
</table>

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

Access the portal:

Go to [www.chubb.com/travelhelp/eb](http://www.chubb.com/travelhelp/eb) to access Europ Assistance’s portal and click on the “Sign Up Now” link in the gray Log In box. Use your Group ID and activation Code to fill out the registration information. Once registered, an automated email will be sent to confirm your registration. Follow the link in the email to complete your registration.
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.
**Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)**

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit [www.healthcare.gov](http://www.healthcare.gov).

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or [www.insurekidsnow.gov](http://www.insurekidsnow.gov) to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at [www.askebsa.dol.gov](http://www.askebsa.dol.gov) or call 1-866-444-EBSA (3272).

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<tr>
<th>State</th>
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<td>ALASKA – Medicaid</td>
<td><a href="http://dhss.alaska.gov/dpa/Pages/medicaid">http://dhss.alaska.gov/dpa/Pages/medicaid</a></td>
<td>1-866-251-4861</td>
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<td>COLORADO – Medicaid</td>
<td><a href="http://www.colorado.gov/hcpf">http://www.colorado.gov/hcpf</a></td>
<td>1-800-221-3943</td>
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<td>GEORGIA – Medicaid</td>
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<td>404-656-4507</td>
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<td><a href="http://www.hip.in.gov">http://www.hip.in.gov</a></td>
<td>1-877-436-4479</td>
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<td>IDAHO – Medicaid</td>
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<td>1-888-346-9562</td>
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<td>IOWA – Medicaid</td>
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<td>1-800-403-0864</td>
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<td><a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a></td>
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<td>NEW JERSEY – Medicaid</td>
<td><a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a></td>
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<td><a href="http://www.health.ny.gov/health_bulletins/medicaid">http://www.health.ny.gov/health_bulletins/medicaid</a></td>
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<td>OREGON – Medicaid</td>
<td><a href="http://www.oregonhealthplan.org/hipp">http://www.oregonhealthplan.org/hipp</a></td>
<td>1-888-222-2222</td>
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<td>RHODE ISLAND – Medicaid</td>
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<td>SOUTH DAKOTA – Medicaid</td>
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<td>TEXAS – Medicaid</td>
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<td>WYOMING – Medicaid</td>
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<td>1-888-695-2447</td>
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<td>LEGAL NOTICES</td>
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<td>Phone: 1-800-442-6003</td>
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<td>Phone: 1-844-854-4825</td>
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<td><strong>MASSACHUSETTS – Medicaid and CHIP</strong></td>
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<td>Phone: 1-800-462-1120</td>
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<td>Phone: 1-800-657-3739</td>
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<td>Phone: 1-888-365-3742</td>
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<td><strong>WASHINGTON – Medicaid</strong></td>
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<td>Medicaid Website: <a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a> Medicaid Phone: 1-800-432-5924</td>
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**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 lymphedemas

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

**Newborns’ and Mothers’ Health Protection Act**

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

**HIPAA Special Enrollment Notice**

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

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

**HIPAA Privacy and Security**

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for health care benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. The Notice of Privacy Practices has recently been updated. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact your Human Resources department.
CONTINUATION COVERAGE RIGHTS UNDER COBRA

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

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

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, Civil Union Partners, and dependent children 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 Civil Union 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 civil union is dissolved.

Your dependent children and the dependent children of a Civil Union 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; or
6) The child stops being eligible for coverage under the plan as a “dependent child”; or
7) The civil union is dissolved.

You are receiving this notice because you are covered under the CHEIBA Trust (the Plan). This notice contains important information about your right to continue your health care coverage in the CHEIBA Trust Employee Benefit Plan as well as other health coverage alternatives that may be available to you through the Health Insurance Marketplace. 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.
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, CIVIL UNION 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 Civil Union 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,
- 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).

**Domestic Partners**

All eligibility and coverage for domestic partners and the children of domestic partners was closed effective January 1, 2016, provided however that coverage for any domestic partner and the children of the domestic partnership is effective through December 31, 2016, if such coverage was in effect on December 31, 2015. After December 31, 2016, all coverage for domestic partners and the children of domestic partners is terminated.

The CHEIBA Trust and the CHEIBA Trust Members approved 18 months of COBRA coverage to domestic partners and the children of domestic partners whose coverage is in effect on December 31, 2016. Domestic partners and children of domestic partners who are covered under a CHEIBA medical, dental or vision plan will receive a Cobra Election Notice with the information that is necessary to maintain coverage for up to 18 months.

**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**

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment guidelines will be provided at the time of COBRA enrollment.

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is postmarked, if mailed) If you do not make your first payment for continuation coverage in full no later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the HealthSmart COBRA Administrator to confirm the correct amount of your first payment.

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The periodic payments may be made on a monthly basis. After the first payment, the periodic payments are due on the first of the month.
Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

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.

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)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage through 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 through the CHEIBA Trust for the HMO/POS, PRIME Blue Priority PPO, Blue Priority HMO, Lumenos 2500 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.

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 Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage, please reference the Multi-Option Plan Summary 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](http://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](http://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).

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<td>Name of Entity/Sender: Adams State University</td>
<td>Name of Entity/Sender: Fort Lewis College</td>
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<td>Address: 208 Edgemont Blvd. Alamosa, CO 81101</td>
<td>Address: 1000 Rim Drive Durango, CO 81301-3999</td>
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<tr>
<td>Phone Number: 719-587-7990</td>
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<td>Name of Entity/Sender: Metropolitan State University of Denver</td>
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<tr>
<td>Address: Campus Box C, PO Box 173361 1201-5th Street, #370 Denver, CO 80217-3361</td>
<td>Address: Campus Box 47, PO Box 173362 Student Success Building 890 Auraria Parkway, Suite 310 Denver, CO 80217-3362</td>
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<td>Name of Entity/Sender: University of Northern Colorado</td>
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<tr>
<td>Address: 1500 Illinois Street Golden, CO 80401</td>
<td>Address: Carter Hall, RM. 2002 Campus Box 54 Greeley, CO 80639</td>
</tr>
<tr>
<td>Phone Number: 303-273-3052</td>
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<td>Name of Entity/Sender: Western State Colorado University</td>
</tr>
<tr>
<td>Address: 2200 Bonforte Boulevard Pueblo, CO 81001</td>
<td>Address: 600 N. Adams Street Taylor Hall, Room 321 Gunnison, CO 81231</td>
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<td>Phone Number: 719-549-2441</td>
<td>Phone Number: 970-943-3140</td>
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<tr>
<td>Contact–Position/Office: Human Resources/ Benefits Office</td>
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<tr>
<td>Address: 7800 East Orchard Road, #200 Greenwood Village, CO 80111</td>
<td></td>
</tr>
<tr>
<td>Phone Number: 720-279-0168</td>
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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 University, Auraria Higher Education Center, Colorado School of Mines, Colorado State University - Pueblo, and Colorado State University - Global Campus, Fort Lewis College, Metropolitan State University of Denver, University of Northern Colorado and Western State Colorado University.

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:
   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 non-formulary 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.

Health Savings Account – An HSA is a tax-favored savings account that, when paired with a qualified High Deductible Health Plan (HDHP), allows you to pay for qualified medical expenses, or leave funds invested in the account for future medical expenses tax-free. An HSA account is a personal, portable account and remains in your control regardless of your employment. A Health Savings Account can be established through any qualifying financial institution. Please contact your financial advisor or banking institution for more information.

High Deductible Health Plan – A High Deductible Health Plan is a health insurance plan that has a high minimum deductible which does not cover the initial costs or all of the costs of medical expenses. The deductible must be met by the insurance holder before the insurance coverage kicks in.

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.


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, copayments, 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.