



2022 CHEIBA TRUST EMPLOYEE BENEFITS GUIDE



Your CHEIBA Trust Benefits

We're committed to you and your health

An annual Open Enrollment period is announced each fall, in which eligible employees can make certain coverage changes. The enrollment window start and end dates vary by institution. The information in this booklet provides an overview of your 2022 benefits package to help you in making the choices that best meet your individual and family's needs – but it is up to you to take action.

In the end, it's your coverage. You have the power – take your health into your own hands through the selections available to you. We encourage you to review the current benefit offerings on BeneCenter before you enroll.

Ensure you elect the best coverage for you and your family:

- + Carefully read the benefit summaries and utilize resources before completing your election forms.
- + Review the additions and changes to your benefits for the 2022 plan year.
- + Add or delete dependents from coverage under the plan.
- + If you have questions, phone numbers and website addresses are included throughout this guide for your convenience.

“
We know your health is important to you, and it is important to us, too. That's why the CHEIBA Trust is committed to providing you and your family a strong benefits package.
”

Who is CHEIBA?

CHEIBA stands for Colorado Higher Education Insurance Benefits Alliance. Your employer has joined together with seven other educational institutions to create more purchasing power in the insurance market.

By creating a purchasing group of over 9,000 lives, your employer is able to deliver better benefits at a lower cost. The Trust meets every other month to monitor your plans, and reevaluates them each year to determine the best benefit offerings.

CHEIBA Trust Member Institutions:

Adams State University, Auraria Higher Education Center, Colorado School of Mines, Colorado State University-Pueblo, Fort Lewis College, Metropolitan State University of Denver, University of Northern Colorado, and Western Colorado University.

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If you require this information in a different format, or have specific requirements under ADA accessibility, contact your institution's Human Resources/Benefits Office.

Go online to the BeneCenter

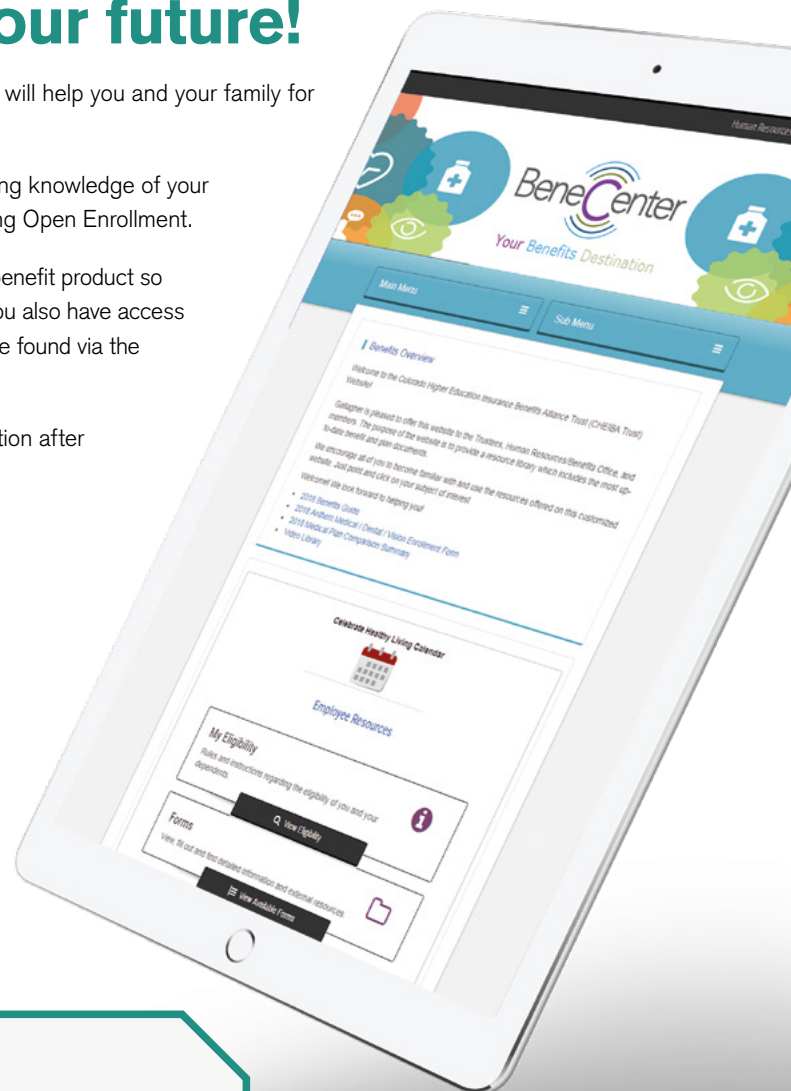
Open Enrollment 2022 – an opportunity to shape your future!

Understanding your benefits is the first step to making a decision that will help you and your family for the next calendar year.

We encourage you to become familiar with the benefits website; having knowledge of your benefit options will guide you to making more informed selections during Open Enrollment.

When you go online, you will find information regarding each employee benefit product so you can choose a benefit package that's right for you and your family. You also have access to various tools and resources loaded with helpful tips, all of which can be found via the BeneCenter home page.

This resource is available year-round should you need benefits information after Open Enrollment ends.



To learn more about the benefit offerings, levels of coverage, Out-of-Network coverage, and the costs associated, go online to the BeneCenter.

mybensite.com/cheiba

What can you find on BeneCenter?

- ✓ BeneBits: Benefits Education Information
- ✓ Plan summaries and comparisons
- ✓ Enrollment and claim forms
- ✓ Health and wellness resources
- ✓ Information on special programs
- ✓ Customer service numbers
- ✓ Direct links to the insurance carriers
- ✓ Premium Information

AND MUCH MORE!



Participant Advocate Liaison “P.A.L.”

Need assistance with your benefits?

There comes a time when you’ll have a question about your benefits. P.A.L. can assist you!

We’re here to assist you in resolving benefit issues that you can’t on your own. 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, you can call your P.A.L. directly.

Best of all – it’s totally free and confidential.

This service is provided by the CHEIBA Trust at no cost to you. Your P.A.L. is an independent consultant located at Gallagher, the full-service benefit consulting firm for the CHEIBA Trust.

When you call, have your Member ID number, name of your employer and other relevant information available (e.g. name of insurance company, group number, date of service, physician or hospital name, bills or letters from the insurance company).

Contact your P.A.L. directly

Monday through Friday from
8:00 a.m. to 5:00 p.m.

 **303-889-2692**

 **800-943-0650**

 **pal_gbi@ajg.com**





Key Information

You owe it to yourself to decide if the plans you choose fit how you use health care and insurance. Taking some time to analyze you and your family's situation could make a huge difference and save you money.

The following are your benefit offerings for 2022:

- + Medical Insurance and Prescription Drugs
- + Dental Insurance
- + Vision Insurance
- + Flexible Benefit Plan
- + Basic Term Life Insurance
- + Voluntary Term Life and AD&D Insurance
- + Long-Term Disability Insurance
- + Employee Assistance Program (EAP)
- + Travel Accident Insurance
- + Voluntary Critical Illness, Accident and Hospital Indemnity
- + Wellness Incentive Program

New hires

Eligible employees must enroll within 31 days of their first day of employment, and authorize payroll deductions. **If an eligible employee does not enroll or waive coverage within 31 days of the first day of employment, the employee will automatically be enrolled in the medical benefits Anthem Prime Blue Priority (PPO) and Anthem Dental Essential Choice PPO plans.**



Eligibility

Who is eligible to be a dependent?

- + Legal spouse, including civil union and common law.
- + Employee's or spouse's married or unmarried child(ren) until the end of the month in which their 26th birthday occurs or medically certified disabled child(ren) of any age. Children include your natural or legally adopted child, stepchild, or a child who is less than 26 and has been placed under your legal guardianship.

Timeframes

Documentation of dependency must be provided within the following timeframes:

- + Within 31 days of benefits eligibility;
- + During the annual Open Enrollment period; or
- + Within 31 days of all changes related qualifying events.

Documentation



Legal Spouse

Registered copy of marriage certificate, or common-law marriage affidavit, or registered copy of civil union certificate.



Child(ren)

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.

Qualifying events

Qualifying events are the only opportunities to make changes to your benefit elections outside of annual Open Enrollment, and include, but are not limited to:

A marriage, common-law marriage, civil union, divorce, or legal separation.

The death of a spouse or other dependent.

The birth or adoption of a child.

You or your spouse experiencing a change in work hours that affects benefits eligibility.

Loss or gain of a spouse's coverage through their employer.

Changing your benefit elections related to these events must be completed within 31 days of the event.

Waiving coverage

- + If employees elect medical coverage, they will automatically be enrolled in dental coverage. However, if employees waive medical coverage, they are still able to enroll in dental and vision coverage.
- + If medical and dental coverage is waived, dependent coverage must also be waived.
- + If coverage is waived, eligible employees and their dependents may only enroll in coverage during the next open enrollment, or within 31 days of a qualifying event.
- + Medical coverage may only be waived with proof of other group medical coverage.

Section 125 pre-/post-tax elections

Complete the Section 125 election form to elect whether or not your insurance premiums will be taxed.

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 Section 125 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 Section 125 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.

If you joined PERA after July 1, 2019, please check with your benefits office.



What's New in 2022?

New Medical Plan Offering

Introducing the new Pathway EPO medical plan for 2022!

This new offering will be available for CHEIBA members living in the front-range. This plan matches or enhances the current PRIME Blue Priority PPO benefits, using a high-performing provider network called Pathway EPO.

What you need to know;

- Access to 63 hospitals, more than 2,580 Primary Care Physician (PCP) and 6,800+ specialists in Colorado.
- When out-of-state, your In-network benefits are available through the BlueCard PPO with over 90% of hospitals and doctors nationwide.
- In-network preventive care covered 100%.
- Primary Care Physician selection required.
- No referrals required for specialists.
- Out-of-network benefits - Not available (urgent/emergency care only).
- Everside is NOT a contracted provider on the Pathway Plan.
- The Pathway network includes Rocky Mountain Children's Hospital. Children's Hospital in Denver is NOT in the Pathway network.

See page 10 for additional information.

New Health Savings Account (HSA)

For employees enrolling in the 2500 HDHP PPO Medical plan, CHEIBA has partnered with WEX to provide you a convenient way to set aside funds in your HSA on a pre-tax basis through payroll deductions. HSA funds can be used for qualified medical, dental and vision expenses in the future.

See page 21 for additional information.

New Digital Behavioral Health Platform

You are eligible for a new therapy program through Meru Health*, available on your smart phone. Meru Health is here to help improve your mental health through a 12-week program proven to reduce anxiety, depression, and burnout. Over the course of three months, you will learn and practice the skills needed to create long-lasting healthy lifestyle habits—all with the daily support of your personal therapist and peer group.

See the Behavioral Resource Guide located in the BeneCenter for additional information.



Meru Health

Call us or go online to learn more and sign up.

1-833-940-1385

meruhealth.com

*Meru Health is presently only available to Colorado residents.

New Voluntary Hospital Indemnity Offering

If you have to stay in the hospital, Hospital Indemnity insurance provides cash payments directly to you, to help protect your finances from the costs you may incur from a hospital stay.

See page 31 for additional information.



Medical Insurance

Peace of mind when you need it most

Anthem Blue Cross and Blue Shield

We help you protect what's important to you, because it also matters to us. Having coverage when you need it most is as important to us as it is to your family. That's why the CHEIBA Trust offers you four medical insurance plans to choose from.

Ensure you carefully review the summaries regarding the various medical insurance plan options to see if it is right for you and your family, before you make your selection.



To learn more about the medical plans, levels of coverage, Out-of-Network coverage, and the costs associated, go online to the BeneCenter.

mybensite.com/cheiba

Recommended preventive care routine for adults

100% coverage on all medical plans

	18-29	30-49	50-59	65+
Women	Pap Smear (yearly)	Mammogram (every 2 years after age 40) Cholesterol Test (regularly after age 45)		Bone Density Scan (regularly from age 65)
Men		Cholesterol Test (regularly after age 35)		Abdominal Ultrasound (once between ages 65-75)
Both	Body Mass Index (yearly) Blood Pressure Test (yearly) STD Screening (yearly, depending on sexual activity)	Blood Sugar Test (regularly, after age 45)	Colonoscopy (every 10 years, after age 50)	

What are my options?

This is a brief benefit outline, for more detail, including Out-of-Network benefits, please see the plan documents in the BeneCenter at mybensite.com/cheiba.

	Blue Advantage HMO/POS	PRIME Blue Priority PPO	Pathway EPO*	Blue Priority HMO*	2500 HDHP PPO
Plan Network Name	HMO Network	Blue Priority PPO Network	Pathway EPO	Blue Priority HMO Network	Anthem PPO Network
Out-of-Network access?	✓	✓	Emergency services only	Emergency services only	✓
Deductible Individual/Family	None	\$500/\$1,000	\$500/\$1000	\$2,000/\$6,000	\$2,500/\$5,000
Coinsurance	0% (Copay-based)	15%	15%	20%	15%
Out-of-Pocket Max Individual/Family	\$2,000/\$4,000	\$3,000/\$6,000	\$3,000/\$6,000	\$4,000/\$10,000	\$3,500/\$7,000
Preventive Care	100% covered	100% covered	100% covered	100% covered	100% covered
Telemedicine Live Health Online	\$20 copayment per visit	\$10 copayment per visit	\$10 copayment per visit	\$20 copayment per visit	\$59 prior to deductible being met, then 15% after deductible
Primary Office Copay	\$20 per visit \$0 at an Everside facility**	\$10 per visit (designated provider) 15% after deductible (participating provider) \$0 at an Everside facility**	\$10 per visit	\$20 per visit \$0 at an Everside facility**	15% after deductible Significantly lower cost at an Everside facility**
Specialist Office Copay	\$40 per visit	\$10 per visit (designated provider) 15% after deductible (participating provider)	\$10 per visit	\$60 per visit	15% after deductible
Inpatient Hospital	\$600 per admission	15% after deductible	15% after deductible	\$250 per admission + 20% after deductible	15% after deductible
Outpatient Surgery	\$60 at a freestanding facility; \$125 at a hospital facility	10% at a freestanding facility; 15% after deductible at a hospital facility	10% at a freestanding facility; 15% after deductible at a hospital facility	\$250 at a freestanding facility; \$250 plus 20% after deductible at a hospital facility	15% after deductible
Advanced Imaging	\$60 at a freestanding facility; \$120 at a hospital facility	10% at a freestanding facility; 15% at a hospital facility	10% at a freestanding facility; 15% at a hospital facility	\$250 at a freestanding facility; \$250 plus 20% after deductible at a hospital facility	15% after deductible
Emergency Room	\$150 per visit	15% after deductible	15% after deductible	\$250 per visit	15% after deductible
Urgent Care	\$50 copayment per visit	15% after deductible	15% after deductible	\$60 copayment per visit	15% after deductible

*Pathway EPO and Blue Priority HMO have NO out-of-network benefits, except for urgent/emergent care

*Everside Health is NOT a contracted doctor with the Pathway plan

*You MUST designate a PCP if you enroll in the Pathway plan

*No referrals required for specialist

**Must be enrolled in the Everside Health program to visit an Everside provider. See page 12 for details.

How to Find an In-Network Doctor/Facility

To find an In-Network physician, please visit [anthem.com/find-doctor](https://www.anthem.com/find-doctor), then scroll down to Search by Selecting a Plan or Network, click continue. Fill out fields on the next page and enter the network name listed below for the plan you are enrolling in, and then click continue. Finally, add any filters on the physician type you're searching for and then click continue.

Prescription Drug Benefits

Save more on regular medications

Your prescription drug coverage has four copayment tiers, with generic medications having the lowest copayments. Plans use a drug list called a formulary to help determine your copayment for each prescription. Your Essential Formulary can be found on the BeneCenter or on Anthem's website at [anthem.com/pharmacyinformation/](https://www.anthem.com/pharmacyinformation/).

If you take regular medications for ongoing conditions such as asthma, diabetes, or high blood pressure, you can eliminate monthly trips to the pharmacy and receive a larger supply with fewer copayments with the home delivery service. Typical savings are at least one copayment for each prescription.

Diabetic supplies/prescriptions and asthma inhalers/prescriptions are covered at no cost to you. **Prescription drugs purchased from Out-of-Network pharmacies are not covered.**

	Blue Advantage HMO/POS	PRIME Blue Priority PPO	Pathway EPO	Blue Priority HMO	2500 HDHP PPO
Retail Individual/Family (30-day supply)	Tier 1: \$10 copayment Tier 2: \$40 copayment Tier 3: \$60 copayment	Tier 1: \$10 copayment Tier 2: \$40 copayment Tier 3: \$60 copayment	Tier 1: \$10 copayment Tier 2: \$40 copayment Tier 3: \$60 copayment	\$200/\$400 Deductible* Tier 1: \$15 copayment Tier 2: \$40 copayment Tier 3: \$60 copayment	15% after deductible
Mail Order (90-day supply)	Tier 1: \$10 copayment Tier 2: \$80 copayment Tier 3: \$120 copayment	Tier 1: \$10 copayment Tier 2: \$80 copayment Tier 3: \$120 copayment	Tier 1: \$10 copayment Tier 2: \$80 copayment Tier 3: \$120 copayment	Tier 1: \$15 copayment Tier 2: \$80 copayment Tier 3: \$120 copayment	15% after deductible
Specialty Tier 4** (30-day supply)	30% coinsurance to a maximum of \$125	30% coinsurance to a maximum of \$125	30% coinsurance to a maximum of \$125	30% coinsurance to a maximum of \$250	15% after deductible

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

** 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. Specialty drugs by overnight mail or common carrier, up to a 30-day supply, must be ordered through Accredo at 800-870-6419.

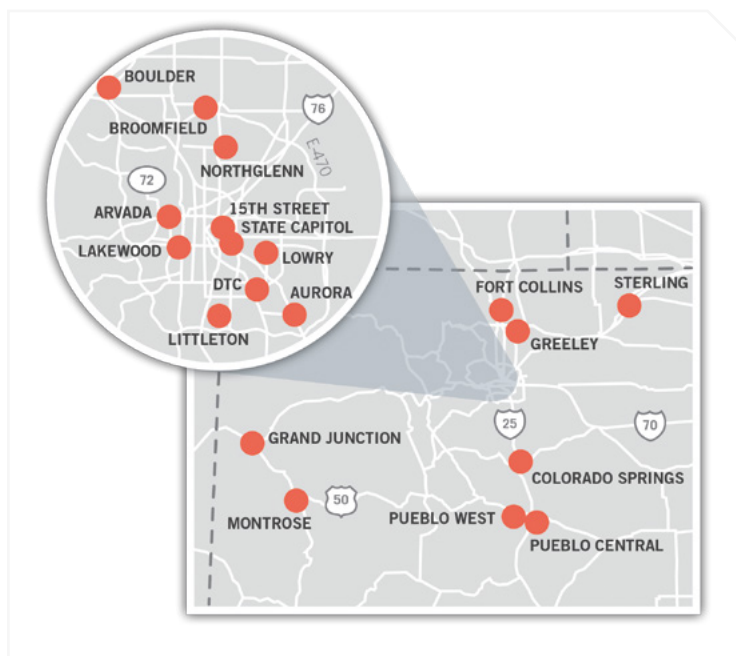
Everside Health - Paladina Health is now Everside Health

The healthcare you want and the convenience you need.

Employees and eligible family members who are enrolled in an Anthem plan have access to Everside Health at no additional cost. Partner with an experienced primary care doctor who delivers a broad scope of care, including primary and preventive care, chronic condition management, same-or next-day appointments for urgent care, and coordination with specialists and hospitals.

- Most services are little to no cost, with no copays or coinsurance,* with a wait time averaging less than 5 minutes.
- Access your doctor 24/7 via phone for urgent needs, email through the health portal or visit your doctor at a convenient location near work or home, including those who live in the Denver Metro area, Boulder, Colorado Springs, Fort Collins, and Pueblo.

Convenient locations:



Newest locations:

- Greeley
- Denver Lowry
- Littleton
- Montrose
- Northglenn

Enroll in Everside Health in minutes by visiting or calling Member Services to get started.

 866-808-6005

 eversidehealth.com/CHEIBA



* Members enrolled in the HDHP will pay a significantly lower cost than at a non-Everside Health facility until they meet their deductible, then will pay \$0. Everside Health is not available on the Pathway EPO plan.

DispatchHealth

Injured or feeling ill?

Get urgent care treatment at home with no membership required. DispatchHealth brings urgent care to you on-demand at your home or workplace.* A medical team arrives equipped with the latest technology and tools to treat common ailments to severe injuries and illnesses. These services will be covered the same as an urgent care visit.



How does it work?

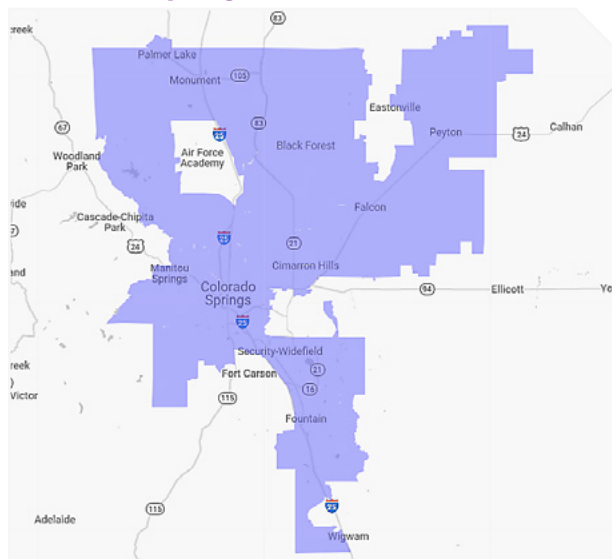
1	2	3	4
Call, go online or use the mobile app to request care.	Explain your symptoms to trained medical technicians to ensure correct care.	Stay put at home/work, ER-trained care teams usually arrive within an hour.	Rest up. The mobile team will handle any prescriptions, doctor updates, and billing.

DispatchHealth is available 7 days a week, 365 days a year (from 8 a.m.–10 p.m.) for those that live in the Denver Metro area, Boulder, and Colorado Springs.

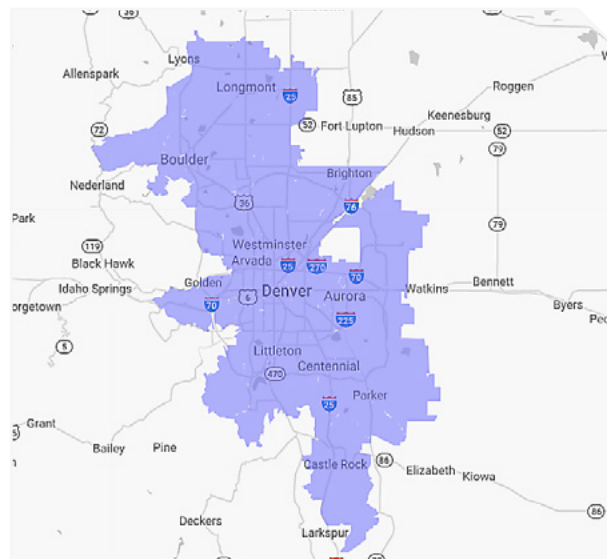
Where we serve:

DispatchHealth is available in the shaded areas as shown below. Check to see if your zip code is in the DispatchHealth service area at <https://www.dispatchhealth.com/locations/co/denver/map>.

Colorado Springs



Denver Metro



To get in contact with DispatchHealth, call, go online or download the mobile app.

303-500-1518
dispatchhealth.com

* Not currently available in Alamosa, Durango, Greeley, Gunnison, or Pueblo.



Sydney

Tired of paperwork and phone calls?

Anthem offers its members a useful website, **anthem.com**, and smartphone app "Sydney". MyAnthem™ takes the hassle out of your health care and allows you to get your information when you need it, help find a doctor, estimate your costs and manage prescription benefits. For a tutorial of the Sydney app, please visit **mybensite.com/cheiba**.

(Click through Medical & Prescription > Sydney Mobile App > Video: Sydney Health (anthem.com))

 **Register at anthem.com**

Helpful extras – included in your Anthem Plan at no additional cost

24/7 NurseLine – confidential, one-on-one conversations

Whether it is 3 p.m. or 3 a.m., speak with an experienced nurse about any of your health questions. Make more informed health care decisions with a registered nurse or a library of audio tapes, any time of the day or night.

With 24/7 NurseLine, you can talk to a nurse about hundreds of health issues from colds, coughs, and headaches to food and diet, smoking, and women's health.

 **800-337-4770**

ConditionCare – make a real difference

ConditionCare offers 24-hour, toll-free access to registered nurses to answer questions and provide support as well as educational tools to manage conditions, through specially designed diaries, monitoring charts, and self-care.

Gain access to resources for conditions such as diabetes, coronary artery disease, heart failure, chronic obstructive pulmonary disease, or asthma as you strive for better health.

 **866-962-0953**

Future Moms – nurses available around the clock

At such an important time in your life, you'll have access to extra pre- and post-natal, confidential support and education at any time. Even with regular care from your doctor, you may have questions between visits.

Benefit from useful maternity care materials and tools to help you. Your doctor and your Future Moms nurse track your pregnancy, and identify possible risks.

 **800-828-5891**

Colorado QuitLine – if you would like to quit smoking, join the QuitLine

Join QuitLine today and receive your personally tailored quit program, nicotine replacement therapy, support network, telephone coaching, and tools and tips based on the latest research.

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

 **800-784-8669**



Dental Insurance

Smile, you're covered

Anthem Blue Cross and Blue Shield

Strong teeth and healthy gums are a big part of your overall health. We give you coverage when it comes to your teeth and gums for a reason. Aside from routine check-ups and cleanings, knowing that you're covered should you need to see a dentist or a specialist for a big-ticket procedure, such as fillings, root canals, and crowns, is added peace of mind.

The Anthem Dental Essential Choice PPO network offers you a broad provider network and comprehensive dental benefits.

The Anthem Dental Essential Choice PPO also allows access to powerful member tools, including Ask a Hygienist, risk assessments, cost estimators, as well as network information and on-the-go claims info via Anthem Anywhere. **Look for a provider listing in the Anthem "Dental Complete" Network on anthem.com.**



To learn more about your dental plan, Out-of-Network coverage, and the costs associated, go online to the BeneCenter.

mybensite.com/cheiba

Anthem Dental Essential Choice PPO Prices

Benefit	Description	In-Network	Out-of-Network
Deductible	Individual/Family	\$0/\$0	\$50/\$150
Preventive/Diagnostic	<ul style="list-style-type: none"> • Oral Exam • X-rays • Cleanings (3x annual for adults) 	100% Deductible waived	80%
Basic	<ul style="list-style-type: none"> • General anesthesia • Endodontics • Periodontal • Oral surgery • Tooth extractions • Root canals • Specified space maintainers 	80%	60%
Prosthodontic	<ul style="list-style-type: none"> • Crowns/onlays • Removable/fixed partials or dentures • Implants 	50%	40%
Orthodontics	Realignment of teeth (adults and children)	50%	40%
Orthodontics Maximum	Per eligible person	\$1,500	\$1,500
Annual Maximum per person	Per insured person. Preventive/diagnostic costs do not apply.	\$2,000	\$2,000



Vision Insurance

Your vision, our coverage

Anthem Blue View Vision

We understand how important vision is in everyday life, and how expensive it can be if you aren't insured. That's why we give you coverage that will help your eye health and your wallet at the same time. For 2022, employees can elect the voluntary full-service vision coverage, comprising of a yearly vision exam, eyewear materials, and lens treatments (LASIK discounts are also included in this plan) all through the Blue View Vision network.



To learn more about your vision benefit, levels of coverage, Out-of-Network coverage, and the costs associated, go online to the BeneCenter.

mybensite.com/cheiba

Plan Prices

Benefit	Description	Copay	Frequency
Vision Exam		\$15 copay, then 100% covered	12 months (from last day of service)
Materials		\$15 copay	12 months (from last day of service)
Frames		\$130 allowance, then 20% off remaining balance	12 months (from last day of service)
Lenses	<ul style="list-style-type: none"> Plastic Single Vision Plastic lined Bifocals Plastic lined Trifocals 	\$15 copay, then 100% covered	12 months (from last day of service)
Lens Enhancements materials copay applies	<ul style="list-style-type: none"> Transitions Lenses (Adult) Polycarbonate (Adult) UV Coating Progressive Lenses <ul style="list-style-type: none"> Standard Premium Tier 1 Premium Tier 2 Premium Tier 3 Anti-Reflective Coating <ul style="list-style-type: none"> Standard Premium Tier 1 Premium Tier 2 Other Add-ons and Services 	\$75 \$40 \$15 \$65 \$85 \$95 \$110 \$45 \$57 \$68 20% off retail price	Included as part of the Lenses Benefits
Contacts	<ul style="list-style-type: none"> Medical Necessary Elective Conventional Elective Disposable Exam & Fitting 	Covered in full \$130 allowance, 15% off balance \$130 allowance Up to \$55	12 months (from last day of service)
Low Vision Benefit Those with severe visual problems that are not correctable with regular lenses	Maximum Supplementary Testing Supplementary Care Aids	\$1,000 Covered in full 25% copay	24 months
Additional Glasses Benefit	Additional sets of glasses can be obtained on the same day as an exam by the same provider	40% discount	

Lasik VisionCare Program

Anthem BVV partners with TruVision & Premier Lasik to offer multiple discount options for Lasik surgery candidates. Log in at anthem.com, select discounts, then Vision, Hearing & Dental.



Remote Health Options

Virtual healthcare where and when you need it.

Often virtual healthcare visits are a safe and efficient way to receive care from a provider, wherever you are. By using online video, you can access consultations, get answers to medical questions, diagnose illnesses, evaluate injuries and access at home dentistry. Anthem's virtual care offering helps redirect unnecessary emergency room visits and is often the same cost or less than a regular office visit.

What are the benefits of virtual healthcare?

- ✓ **Affordable** - Typically costs the same or less than a regular office visit.
- ✓ **Convenient** - Available at home or on the go, 7 days a week.
- ✓ **No waiting** - Be seen in minutes or schedule a time to suit you.

LiveHealth Online

Administered through Anthem, LiveHealth Online offers at home or on the go private video visits with board-certified doctors, mental health professionals, psychiatrists or licensed therapists from your smartphone, tablet or computer.

To sign up for LiveHealth Online or for more information, visit livehealthonline.com or download the app and register on your phone or tablet.

 **855-603-7985**
 livehealthonline.com

Ortho@Home

At home orthodontia is now covered as part of select Anthem Dental plans. By partnering with several popular providers, such as Byte and Candid, Anthem is now able to offer clear orthodontic aligners at home, overseen remotely by licensed dentists.

On average, at home orthodontia costs up to 60% less than traditional orthodontics.

To find a participating provider please visit anthem.com or contact your Anthem representative.

TheTeleDentists

TheTeleDentists® is an in-network provider with Anthem, offering virtual dental consults via laptop, tablet or smart phone – all from board-licensed dentists.

Providing a valuable solution if primary care dental offices are closed, lack teledentistry capabilities, or for those members who do not have a primary care dentist, Anthem covers all teledentistry care the same as if provided in a dentist office.

For more information visit www.anthem.com/find-care or contact your Anthem representative or the number on the back of your ID card.

Online vision tools

If you're a Blue View Vision member, you can use in-network benefits when ordering glasses and contacts online, saving you money, time and effort.

Glasses.com – offering a wide range of styles and 24/7 phone and online access, Glasses.com works with your eye doctor to make sure you get the right lenses for your vision.

ContactsDirect – Use your contact lens allowance to order lenses from the convenience of your home.

1-800 CONTACTS – get access to the largest variety of brand-name specialty lenses in stock and ready to ship.



Flexible Spending Accounts

Making your money go further

You have the option to take advantage of tax-efficient accounts if you so choose

When you choose to participate in a Flexible Spending Account, your monthly taxable income is reduced. Dollars elected in the Healthcare 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 account, up to your maximum elected amount. This plan is offered on a voluntary basis and participation may require an administration fee. See your institution's rate sheet for fee information.

Use the comparisons and descriptions below to carefully consider you and your family's health and child/dependent care needs, and estimate predictable expenses you will incur during the plan year. Any contributions to these accounts that are not used for eligible expenses incurred during the plan year will be forfeited unless your employer offers a roll-over option.

What is a Flexible Spending Account?

Pay some of your out-of-pocket medical, dental, vision expenses, and other eligible family expenses with pre-tax dollars. Alerus tax-efficient accounts make your money go further. All you have to do is sign up to reap the reward.

Making changes to elections

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. You would be allowed to stop, increase or decrease your election for this reason. **Changes must be requested within 31 days of the status change and must be approved by your Human Resources/Benefits Office.**



You must enroll for the Healthcare Spending Account and the Dependent Care Spending Account on an annual basis. Please contact your Human Resources/Benefits Office.

“Use it or Lose it”

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 15 of the year following the plan year.

Dollars not claimed by April 15 will be forfeited. The ‘Use it or Lose it’ provisions may have some exceptions. Please check with your Human Resources/Benefits Office for more information.

What do these accounts mean to me?

Healthcare Spending Account

Through the Healthcare 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.

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. 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. If you wish to continue to participate in this benefit you must re-enroll in the plan each year.

Dependent Care Spending Account

If you are single, married filing jointly, or filing head of household, you may contribute up to \$5,000. 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.

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 and your spouse can work or attend college full-time. All care expenses must be necessary to employment or the pursuit of a college education on a full-time basis. 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.

Note: You cannot take advantage of both the Dependent Care FSA and the ChildCare tax credit; however, you may be able to use a combination of the tax credit and the pre-tax program. 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. Be sure to consult a tax professional for information as to which tactic is best for your specific situation.

For a complete list of qualified medical expenses, see IRS Publication 502 at <https://www.irs.gov/forms-pubs/about-publication-502>.

Alerus – account types

	Healthcare Spending Account	Dependent Care Spending Account
	Re-enroll during open enrollment each year, or enroll as a new benefit-eligible employee.	Re-enroll during open enrollment each year, or enroll as a new benefit-eligible employee.
Maximum amount of reimbursement	Up to the IRS annual maximum limit. The 2021 limit is \$2,750; the IRS has not yet released the 2022 maximum limit.	\$5,000 if you are married filing jointly, or filing as single or head of household. \$2,500 if you are married filing separately.
Minimum contribution	Check with your institution.	N/A
Payments not covered	Health-related insurance premiums.	N/A
Funds availability	Full election is available as of January 1.	Funds are available once they are deposited in the account (on a per period basis).



Health Savings Account

Why should I choose a health savings account (HSA)?

An HSA is a benefit that allows you to choose how much of your paycheck you'd like to set aside, before taxes are taken out, for healthcare expenses or use as a retirement savings tool. This plan offers tax savings that a 401(k) and IRA don't, making it a powerful option for diversifying your retirement portfolio.

It's yours

Think of your HSA as a personal savings account. Any unspent money in your HSA remains yours, allowing you to grow your balance over time. When you reach age 65, you can withdraw money (without penalty) and use it for anything, including non-healthcare expenses.

Flexibility

Save for a rainy day. Invest for your future retirement. Or spend your funds on qualified expenses, penalty free.

Easy to use

Swipe your HSA benefits debit card at the point of purchase. There is no requirement to verify any of your purchases. We recommend keeping any receipts in case of an IRS audit.

Smart savings

The HSA's unique, triple-tax savings means the money you contribute, earnings from investments and withdrawals for eligible expenses are all tax-free, making it a savvy savings and retirement tool.

Investment options

You can invest your HSA funds in an interest-bearing account or our standard mutual fund lineup. Savvy investors may opt for a Health Savings Brokerage Account powered by Charles Schwab, giving you access to more than 8,500 mutual funds, stocks and bonds.

What does it cover?

There are thousands of eligible items. The list includes but is not limited to:

- ✓ Copays, coinsurance, insurance premiums
- ✓ Doctor visits and surgeries
- ✓ Over-the-counter medications (first aid, allergy, asthma, cold/flu, heartburn, etc.)
- ✓ Prescription drugs
- ✓ Birthing and lamaze classes
- ✓ Dental and orthodontia
- ✓ Vision expenses, such as frames, contacts, prescription sunglasses, etc.

View our searchable list of eligible expenses at www.wexinc.com/insights/benefits-toolkit/eligible-expenses/

Can I enroll?

You must be enrolled in a high-deductible health plan (HDHP) in order to enroll in the HSA.

You're not eligible for an HSA if:

- You're claimed as a dependent on someone else's taxes.
- You're covered by another plan that conflicts with the HDHP, such as Medicare, a medical flexible spending account (FSA) or select health reimbursement arrangements (HRAs).
- You or your spouse are contributing to a medical FSA.



Wellness Program

Anthem's Wellness Reward Program

Get rewarded for reaching your goals

Anthem

We want you to be as healthy as you can because we care about you and your family. To encourage you to live a healthier life, we are offering Anthem's incentive wellness program again this year.

Because your health is so important, we want to reward you for it. Anthem's wellness program offers many types of wellness activities you can earn incentives through. Below is a list of activities available to you:

Incentives	
Online WebMD Health Assessment	\$25
Future Moms (post partum)	\$100
Well-being Coach (Tobacco Cessation or Weight Management)	\$125
ConditionCare (Asthma, Diabetes, COPD, CAD or CHF)	\$125
Claims Based Annual Wellness Exam	\$50
Dental exam benefit - see flyer for details	\$25
Maximum Incentive Amount	\$450



To learn more about Anthem's Wellness Reward Program and levels of coverage, go online to the BeneCenter.

mybensite.com/cheiba

How it works

In 2022, as you complete your healthy activities, you will begin earning dollars towards a digital gift card. As you complete activities throughout the year and earn additional rewards, your rewards account is automatically updated with the funds.

Once you have completed your first Health Reward activity, you will have an online balance in your anthem.com account. You will be able to redeem those dollars at any point, or save them up through the course of the year. When you are ready, you can redeem your dollars by selecting a digital gift card on anthem.com or the Sydney mobile app.

How to access Anthem Health Rewards

To access Anthem Health Rewards through the member portal:

- + Register at anthem.com.
- + Go to the My Health Dashboard. Select Program.
- + Select Anthem Health Rewards.

To access it through the Sydney app:

- + Launch the Sydney App.
- + Go to the More Menu.
- + Select My Health Dashboard.
- + Scroll down and select My Rewards to view or Redeem Rewards to select a gift card.



Basic Term Life Insurance

A helping hand when you need it most

Anthem Life Insurance Company

It's unpleasant to think about, but you can take comfort in knowing your family is covered in the event of death or accident with Basic Term Life Insurance, which includes Term Life and Accidental Death and Dismemberment (AD&D). There's also dependent coverage, so you know you've got your entire family covered.

Maximum Benefits

The amount of life insurance benefit for active employees is calculated on your annual base salary. This plan provides the following coverage:



To learn more about your Basic Term Life Insurance and levels of coverage, go online to the BeneCenter.

mybensite.com/cheiba

Age 66 and under	Age 67-69	Age 70 and over
Two times annual base salary to a maximum of \$500,000	Two times annual base salary to a maximum of \$50,000	\$10,000
Coverage is rounded up to the nearest \$1,000. 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	Beneficiary Changes	AD&D Benefits
Eligible dependents have a maximum benefit of \$2,000 per person. Eligible dependent children aged 14 days to six months are insured for \$200. Coverage excludes any person who is an employee and any person residing outside the United States or Canada.	You must submit any changes to your beneficiary designation through the Human Resources/Benefits Office.	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 the Anthem Life brochure.



Voluntary Term Life & AD&D Insurance

Need more coverage?

Sun Life Financial

Voluntary Term Life & AD&D provides added security if you need more than the Basic Life Insurance included in your benefits. We understand you may want to provide more coverage for your family – the voluntary employee-paid term life insurance and AD&D insurance plans add protection beyond the basic plan. You'll have high-limit protection in case the unthinkable happens. Our voluntary employee-paid term life insurance plan can be designed to meet the needs of each individual or family.

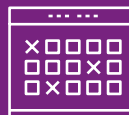


To learn more about your Voluntary Term Life & AD&D Insurance, levels of coverage, and the costs associated, go online to the BeneCenter.

mybensite.com/cheiba

	Voluntary Term Life Sun Life Financial	AD&D Sun Life Financial
Employee	Choose from \$10,000 to \$500,000 (without exceeding 5x annual salary) in \$10,000 increments. You may elect up to \$200,000 with no health questions asked during this open enrollment period only. This is your guaranteed coverage amount.	Choose from \$10,000 to \$500,000 (without exceeding 5x annual salary) in \$10,000 increments.
Spousal	Additional coverage for your spouse is available from \$10,000 to \$300,000 in \$10,000 increments. Starting with new plans issued in 2021, employees must have coverage for themselves in order to elect spouse coverage. You may elect up to \$30,000 with no health questions during this open enrollment period only. This is your guaranteed coverage amount.	Choose from \$5,000 to \$250,000 (without exceeding 100% of employees elected amount) in \$5,000 increments.
Dependent Children	Coverage for children age 14 days to 6 months is \$500, in 6 months to age 26 choose from \$5,000 to \$25,000 in increments of \$5,000 with no health questions asked. You must be accepted for coverage in order to elect child coverage.	Choose from \$1,000 to \$10,000 (without exceeding 100% of employees elected amount) in \$1,000 increments.
Notes	This is a general summary of your Voluntary Term Life Insurance Plan. Final interpretations and a complete listing and description of any and all benefits, limitations and exclusions are found in, and governed by the Sun Life Master Contracts.	This is only an overview of your AD&D Plan, for more information, explanations and for a complete description of loss payment schedules, see the Sun Life Financial brochure.

Employees may elect up to \$200,000 of coverage upon benefits eligibility without providing Evidence of Insurability. Any employee who wishes to add or increase coverage after their initial eligibility may do so, but must be approved through medical underwriting.



Long-Term Disability Insurance

Let your benefits do the work

Sun Life Financial

If you're sick or hurt and can't work, you are covered with Long-Term Disability (LTD) Insurance. You are eligible to receive two-thirds of your salary, up to \$7,000 a month, after you have been disabled for 90 days, so even during one of the hardest times of your life, you'll be able to support those you love.

Schedule of Coverage

LTD Benefit is the lesser of the following:

- + 66.66% 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.

Some limitations may apply.

Any questions?

Contact Sun Life Financial Customer Service.

 **800-247-6875**

 **[sunlife.com/us](https://www.sunlife.com/us)**





Employee Assistance Program

Everybody needs support sometimes

We provide counseling and referrals through the Colorado State Employee Assistance Program (C-SEAP).

It's completely confidential, cost-free, and there are offices state-wide, or phone counseling, so you can talk to someone in your time of need.

C-SEAP is offered to State employees with work-related or personal concerns, and is 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 such as:

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

C-SEAP offices are located in Downtown Denver, Loveland, Sterling, Grand Junction, Colorado Springs, Pueblo, Canon City, Alamosa, Golden and Durango. Phone counseling is available in all areas.

“
Sometimes balancing work and personal responsibilities creates stress that is hard to handle on your own. We'll help you find the answers.
”

Want to schedule an appointment?

Call C-SEAP anytime Monday through Friday between 8 a.m. and 5 p.m.

 **303-866-4314**

 **800-821-8154**

 **colorado.gov/c-seap**





Travel Accident Insurance

The coverage you're used to, anywhere on the planet

Unexpected medical emergency while you're traveling? No worries. That's already "packed" into your group life insurance. We want to make sure you can get the help you need — whenever you need it and no matter where you are in the world.

CHEIBA offers two options for travel insurance depending on which benefits meet your needs.



To learn more about your Travel Accident Insurance go to:

mybensite.com/cheiba

Chubb –all employees

CHUBB provides all employees free access to Europ Assistance to give you 24/7 access to medical and travel assistance services around the world, while on business. That way, you never have to worry where you're covered and just have to worry about the situation at hand.

If the accidental injuries to the insured person result in death or dismemberment within 365 days of the date of the accident, a percentage of the maximum benefit "Principal Sum" (\$100,000) of Accidental Death and Dismemberment will be paid depending on the injury sustained.

Traveling for work?

Go to the web link below for more information. Once registered follow the link in the automated email to complete your registration.

acetravelassistance.com

Group ID: aceah

Activation Code: security

For medical referrals, evacuation, repatriation or other services please call:



Chubb Travel Assistance Program
800-243-6124 (Inside the USA)
202-659-7803 (Outside the USA Call Collect)
OPS@europassistance-usa.com

Visit **www.acetravelassistance.com** for access to global threat assessments and location based intelligence.

Register to access the site using the Group ID and Activation Code:



Group ID: aceah
Activation Code: security

Travel Assistance Program

Plan Number: 01AH585
Organization: COLORADO HIGHER EDUCATION INSURANCE BENEFITS ALLIANCE TRUST
Policy Number: 9906-91-71
Assistance Provider: Europ Assistance USA

Europ Assistance provides emergency medical and travel services and pre-trip information services. Please call when:

- You require a referral to a hospital or doctor
- You are hospitalized
- You need to be evacuated or repatriated
- You need to guarantee payment for medical expenses
- You experience local communication problems
- Your safety is threatened by the sudden occurrence of a political or military event.



Anthem Life –benefits eligible employees

Anthem Life provides all benefits-eligible employees free access to Generali Global Assistance, Inc. (GGA) to give you 24/7 access to medical and travel assistance services around the world, while traveling for business or pleasure. Anthem Life has teamed up with GGA to help provide a safety net so you and your dependents have peace of mind knowing you'll be able to get help should you need it.

Whether you are traveling for personal or business, you can get medical travel assistance when you're more than 100 miles away from home for 90 days or less. All services, including medical transport, must be arranged in advance by GGA. You may have to pay fees for certain other services GGA provides, such as cash advances.

Retirees are not eligible for travel assistance services. Some other exclusions also apply - for more details, go to anthemlife.com.

Traveling for pleasure?

For travel emergency assistance services, first call the appropriate number below, depending on your location:

U.S. and Canada:

1-866-295-4890

Other locations (call collect):

+1-202-296-7482, Opt 2

Travel Assistance

Provided by General Global Assistance, Inc. (GGA) for Anthem Life

Valid only for eligible members with group life insurance coverage. Retirees are not eligible for travel assistance services.

For travel emergency assistance services, first call the appropriate number, depending on your location:

For more details, go to anthemlife.com.

Life and Disability products underwritten by Anthem Life Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

U.S. and Canada: **1-866-295-4890**

Other locations (call collect): **+1-202-296-7482**

When you call, you will hear the following prompts. Select Option 2:

1. For information regarding Beneficiary Companion Assistance.
2. If you have questions about Travel assistance or need assistance due to a medical emergency.
3. Unsure or have additional questions.

AnthemLife 

Travel Assistance Plans

	CHUBB - BTA	Anthem – Basic Life
Covered Population	All employees covered by the BTA policy	All employees covered by the Basic Life policy
Services Provided	Pre-Travel Risk Intelligence; Medical Assistance; Medical Evacuation and Repatriation	Pre-Trip Travel Tips; Emergency Travel Support; Medical Assistance; ID Theft Recovery & Monitoring, Legal Services (through Resource Advisor Benefits)
Covered Travel	Business travel, and personal excursions while on business travel – away from residence or regular place of employment. Limited to any consecutive 7 day period surrounding business or relocation travel	Any business or personal travel 100+ miles from home for 90 days or less
Covered Dependents	Employee only	Employee, spouse, and dependent children
Contracted Carrier and Contact Info	Europ Assistance 800-243-6124	General Global Assistance, Inc. US/Canada: 866-295-4890
International Coverage	Yes; call collect 202-659-7803	Yes; call collect 202-296-7482



Voluntary Accident Insurance

Accident Insurance

Sun Life Financial

Accidents can happen to anyone, and, if tragedy strikes, the costs associated with treatment can add up quickly.

Sun Life's Accident Insurance helps you manage such costs by paying a cash benefit if you or a covered family member require medical care as a result of a covered accident. You can spend it any way you choose and it is payable regardless of other coverage you may have.

Examples of covered injuries and services include:

- Broken bones
- Burns
- Cuts
- Hospital admission
- Stitches
- Physical therapy

An example of how this benefit can help you:

Covered event: Inpatient – compound leg fracture	Benefit payment
Fracture (open)	\$1,000
Ground ambulance	\$100
Hospital admission	\$500
Hospital confinement (15 days per accident) – 3 days	\$450
Physical therapy – 8 times	\$200
Physician follow-up visits – 2 times	\$50
Total benefits	\$2,300



To learn more about Sun Life's Accident and Critical Illness Insurance, go online to the BeneCenter.

mybensite.com/cheiba



Voluntary Critical Illness Insurance

Critical Illness Insurance

Sun Life Financial

Critical illnesses can have devastating physical and financial consequences. Health plans cover many of the direct costs associated with a critical illness, but related expenses like child care, travel, high deductibles and copays can also be worrying.

Sun Life's Critical Illness Insurance offers the financial help to pay the costs associated with life-altering illnesses. The plan pays a fixed benefit if you are diagnosed with a critical illness such as a heart attack, stroke, kidney failure, cancer, advanced Alzheimer's or Parkinson's, or if you require treatment like coronary artery bypass surgery or a major organ transplant. Benefits are paid directly to you so you decide how to spend the money.

Premiums for Critical Illness Insurance are age-based and correlate to your tobacco status. As part of the plan you can choose from \$5,000 to \$30,000 of coverage for yourself, \$2,500 to \$15,000 of coverage for a spouse, and \$2,500 or \$5,000 of coverage for children.



To learn more about Sun Life's Accident and Critical Illness Insurance, go online to the BeneCenter.

mybensite.com/cheiba

An example of how this benefit can help you:

Covered condition	Benefit payment
Wellness benefit: blood test for cholesterol	\$50
Heart attack (100%)	\$30,000
Recurrent heart attack (100%)	\$30,000
Coronary artery bypass graft (25%)	\$7,500
Total benefits	\$67,550



Hospital Indemnity

Hospital Indemnity Insurance

Sun Life Financial

If you have to stay in the hospital, Hospital Indemnity insurance provides cash payments directly to you, to help protect your finances from the costs you may incur from a hospital stay.

- + Supplement your health insurance with a lump sum benefit for hospital stays due to a covered accident or sickness.
- + Pays benefits for each day that you're in the hospital.
 - \$1,000 is payable the first day
 - \$100 each day for up to 30 days while in the hospital
 - \$100 per day for up to 10 days if you are in ICU
- + Receive \$50 for your annual wellness screening.
- + Use the benefit however you see fit – to help pay for out-of-pocket medical costs like, co-pays or deductibles, or for everyday expenses like childcare or groceries.
- + For more information on the benefits you could receive, refer to your plan details.



To learn more about Sun Life's Hospital Indemnity Insurance, go online to the BeneCenter.

mybensite.com/cheiba

An example of how this benefit can help you:

Hospitalization for Heart Attack – 5 days/2 days ICU	Benefit payment
Wellness benefit: blood test for cholesterol	\$50
First Day Hospital benefit	\$1,000
Hospital Confinement	\$500
ICU Confinement	\$200
Total benefits	\$1,750

FAQs
—
Key Contacts
—
Legal Notices

Frequently Asked Questions

What is the CHEIBA Trust?

The Colorado Higher Education Insurance Benefits Alliance Trust is a benefit purchasing consortium and trust. Each participating college shall designate one of its Employees to serve as a Trustee and member of the Trust Committee.

What is a copayment?

A copayment is a charge that must be paid at the time of service e.g. a visit to your doctor's office.

What is a coinsurance?

The portion of covered health care costs for which the covered person has a financial responsibility (usually a fixed percentage). Often coinsurance applies after first meeting a deductible requirement.

What is a 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.

What is an Out-of-Pocket cost?

The portion of payments for health services required to be paid by the enrollee (includes copayments, coinsurance and deductibles).

What is an Out-of-Pocket limit?

This is the pre-determined amount of medical expenses you are responsible for before a plan pays 100% of remaining "reasonable and customary" charges. Certain charges like penalties for non-pre-certification and balance billing are not eligible for out-of-pocket limits.

What is a drug formulary?

This is 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. 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.

What is '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 may be required to pay the excess amount as out-of-pocket expenses.

What is a Point-of-Service (POS) Plan?

A POS health plan allows 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. POS 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.

What is a Health Maintenance Organization (HMO)?

An HMO is an entity that provides, offers or arranges coverage of health services needed by Plan members for a fixed, prepaid premium.

What is a High Deductible Health Plan (HDHP)?

An HDHP 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. Compared to other plans, the HDHP has lower monthly premiums and you pay a portion of the expenses when you use the services.

What is a Health Savings Account (HSA)?

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. An HSA can be established through WEX. You will be responsible for monthly fees associated with the account.

What is a Flexible Spending Account (FSA)?

An FSA is a tax-free account which allows 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.

If I terminate employment, when do my benefits end?

Eligibility will terminate at the end of the month of the termination of employment for any reason including death and retirement. Contact Human Resources/Benefits Office for other situations.

If I have a leave of absence, is my coverage affected?

Coverage under the Plan may continue for certain Employees on an Approved Leave of Absence, including but not limited to: Short/Long Term Disability, Workers Compensation Leave, Family and Medical Leave Act, Sabbatical or Military Leave under the "Uniformed Services Employment and Reemployment Rights Act". Contact your HR Department for information related to your specific leave.

What is the Section 125 Premium Only Plan?

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.

Key Contacts

Here are some frequently used telephone numbers and websites if you need more information about any of the benefits we offer.

Health Insurance

Anthem Blue Cross and Blue Shield

- Blue Advantage Point of Service Plan (HMO/POS)
- PRIME Blue Priority Plan (PPO)
- Blue Priority HMO Plan
- High Deductible Health Plan
- Pathway EPO

Phone: 1-800-542-9402

Web: www.anthem.com

Future Moms

Phone: 1-800-828-5891

24/7 NurseLine

Phone: 1-800-337-4770

LiveHealth Online

Phone: 1-888-548-3432

Web: www.livehealthonline.com

Meru Health

Phone: 1-833-940-1385

Web: www.meruhealth.com/cheiba

Prescription Drug Benefit

Home Delivery Pharmacy

Phone: 1-833-203-1739

Everside Health

Phone: 866-808-6005

Web: www.eversidehealth.com/CHEIBA

DispatchHealth

Phone: 1-888-908-0553

Web: www.dispatchhealth.com

Health Savings Account (HSA)

WEX

Phone: 1-866-451-3399

Web: benefitslogin.wexhealth.com

Dental Insurance

Anthem Blue Cross and Blue Shield

- Anthem Dental Essential Choice PPO
- Phone: 1-844-729-1565
Web: www.anthem.com

Vision Insurance

Anthem Blue Cross and Blue Shield

Phone: 1-866-723-0515

Web: www.anthem.com

Basic Term Life Insurance

Anthem Life Insurance Company

Phone: 1-800-552-2137

Web: www.anthem.com

Voluntary Accidental Death and Dismemberment Insurance

Sun Life Financial

Phone: 1-800-247-6875

Web: www.sunlife.com/us

Flexible Spending Accounts

Alerus

Phone: 1-877-661-4727

Web: www.alerusrb.com/Contact

Email: info@alerus.com

Participant Web: alerusrb.com

Voluntary Critical Illness and Accident Insurance

Sun Life Financial

Phone: 1-800-247-6875

Web: www.sunlife.com/us

Hospital Indemnity

Sun Life Financial

Phone: 1-800-247-6875

Web: www.sunlife.com/us

Long-Term Disability Insurance

Sun Life Financial

Phone: 1-800-247-6875

Web: www.sunlife.com/us

Colorado State Employee Assistance Program

C-SEAP

Phone: 303-866-4314

Toll Free: 1-800-821-8154

Web: www.colorado.gov/c-seap

Travel Accident Insurance

Sun Life Financial

Phone: 1-800-247-6875

Email: medservices@assistamerica.com

Web: www.assistamerica.com

Participant Advocate Liaison (P.A.L.)

Gallagher

Phone: 303-889-2692 or

1-800-943-0650

Fax: 303-889-2693

Email: PAL_GBI@ajg.com

COBRA Coverage

Alerus

Phone: 1-800-761-1934

Email: cobra2@alerus.com

Participant Web: cobra.alerus.com

Legal Notices

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.

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020.

Contact your State for more information on eligibility:

Alabama – Medicaid

Website: <http://myalhipp.com/>
Phone: 1-855-692-5447

Alaska – Medicaid

The AK Health Insurance Premium Payment Program
Website: <http://myakhipp.com/>
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: <http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx>

Arkansas – Medicaid

Website: <http://myarhipp.com/>
Phone: 1-855-MyARHIPP (855-692-7447)

California

Website: Health Insurance Premium Payment (HIPP) Program
<http://dhcs.ca.gov/hipp>
Phone: 916-445-8322
Email: hipp@dhcs.ca.gov

Colorado – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: <https://www.healthfirstcolorado.com/>
First Colorado Member Contact Center: 1-800-221-3943 /State Relay 711
CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): <https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program>
Phone: 1-877-357-3268

Florida – Medicaid

Website: <https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html>
Phone: 1-877-357-3268

Georgia – Medicaid

Website: <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>
Phone: 678-564-1162, ext 2131

Iowa – Medicaid

Medicaid Website: <https://dhs.iowa.gov/ime/members>
Medicaid Phone: 1-800-338-8366
Hawki Website: <http://dhs.iowa.gov/Hawki>
Hawki Phone: 1-800-257-8563
HIPP Website: <https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp>
HIPP Phone: 1-888-346-9562

Indiana – Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: <http://www.in.gov/fssa/hip/>
Phone: 1-877-438-4479
All other Medicaid
Website: <https://www.in.gov/medicaid/>
Phone 1-800-457-4584

Kansas – Medicaid

Website: <https://www.kancare.ks.gov/>
Phone: 1-800-792-4884

Kentucky – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: <https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>
Phone: 1-855-459-6328
Email: KIHIPPPROGRAM@ky.gov
KCHIP Website: <https://kidshealth.ky.gov/Pages/index.aspx>
Phone: 1-877-524-4718
Kentucky Medicaid Website: <https://chfs.ky.gov>

Louisiana – Medicaid

Website: www.medicaid.la.gov or www.lahipp.la.gov
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Maine – Medicaid

Enrollment Website: <https://www.maine.gov/dhhs/ofi/applications-forms>
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage: <https://www.maine.gov/dhhs/ofi/applications-forms>
Phone: 1-800-977-6740.
TTY: Maine relay 711

Massachusetts – Medicaid & CHIP

Website: <http://www.mass.gov/eohhs/gov/departments/masshealth/>
Phone: 1-800-862-4840

Minnesota – Medicaid

Website: <https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp>
Phone: 1-800-657-3739

Missouri – Medicaid

Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>
Phone: 573-751-2005

Montana – Medicaid

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>
Phone: 1-800-694-3084

Nebraska – Medicaid

Website: www.ACCESSNebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

Nevada – Medicaid

Website: <https://dhcnp.nv.gov>
Phone: 1-800-992-0900

New Hampshire – Medicaid

Website: <https://www.dhhs.nh.gov/oi/hipp.htm>
Phone: 603-271-5218
Toll free: 1-800-852-3345, ext 5218

New Jersey – Medicaid & CHIP

Website: <http://www.state.nj.us/humanservices/mahs/clients/Medicaid/>
Phone: 609-631-2392
CHIP: <http://www.njfamilycare.org/index.html>
CHIP: 1-800-701-0710

New York – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/index.html
Phone: 1-800-541-2831

North Carolina – Medicaid

Website: <https://medicaid.ncdhhs.gov/>
Phone: 919-855-4100

North Dakota – Medicaid

Website: <http://www.nd.gov/dhs/services/medicalserv/medicaid/>
Phone: 1-844-854-4825

Oklahoma – Medicaid & CHIP

Website: <http://www.insureoklahoma.org>
Phone: 1-888-365-3742

Oregon – Medicaid

Website (EN): <http://healthcare.oregon.gov/Pages/index.aspx>
Website (ES): <http://oregonhealthcare.gov/index-es.html>
Phone: 1-800-699-9075

Pennsylvania – Medicaid

Website: <http://www.dhs.pa.gov/provider/medicalassistance/hinsurancepremiumpaymenthippprogram/index.htm>
Phone: 1-800-692-7462

Rhode Island – Medicaid

Website: <http://www.eohhs.ri.gov/>
Phone: 855-697-4347, or 401-462-0311 (Direct Rlte Share Line)

Utah – Medicaid & CHIP

Medicaid: <https://medicaid.utah.gov/>
CHIP: <http://health.utah.gov/chip>
Phone: 1-877-543-7669

Vermont – Medicaid

Website: <http://www.greenmountaincare.org/>
Phone: 1-800-250-8427

Virginia – Medicaid & CHIP

Website: <https://www.coverva.org/en/famis-select>
<https://www.coverva.org/en/hipp>
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-800-432-5924

Washington – Medicaid

Website: <http://www.hca.wa.gov/>
Phone: 1-800-562-3022, ext.15473

West Virginia – Medicaid

Website: <http://mywvhipp.com/>
Phone: 1-855-MyWVHIPP (1-855-699-8447)

Wisconsin – Medicaid & CHIP

Website: <https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf>
Phone: 1-800-362-3002

Wyoming – Medicaid

Website: <https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility>
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security
Administration

www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and
Human Services

Centers for Medicare & Medicaid
Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4,
Ext. 61565

Paperwork Reduction Act Statement

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

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

Women's Health And Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCA). The Women's Health and Cancer Rights Act requires group health plans and their insurance companies and HMOs to provide certain benefits for mastectomy patients who elect breast reconstruction. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

Breast reconstruction benefits are subject to deductibles and co-insurance limitations that are consistent with those established for other benefits under the CHEIBA Trust plans.

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, the Summary of Benefits of Coverage, or the COBRA General Notice. If you have any questions on your right to COBRA continuation coverage you may contact your Human Resources department or 24HourFlex (your COBRA administrator) at the contact information below:

24HourFlex

Phone: 1-800-651-4855
Email: cobra@24hourflex.com
Mail: PO Box 3789, Littleton, CO 80161

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.

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,
- 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 entitled 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 (this event may not result in eligibility for COBRA continuation coverage).

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 entitled in Medicare (Part A, Part B, or both);
- 5) The parents become divorced or legally separated;
- 6) The child stops being eligible for coverage under the plan as a "dependent child"; or
- 7) The civil union is dissolved (this event may not result in eligibility for COBRA continuation coverage).

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 entitlement 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 24HourFlex.

Disability 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 an additional 18 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 COBRA Administrator, 24HourFlex.

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 was 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 was terminated.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact 24HourFlex at 1-800-651-4855 or send an email to cobra@24hourflex.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, except in certain circumstances.

The required payment guidelines will be provided at the time of COBRA enrollment. There are certain disability circumstances with COBRA where the CHEIBA Trust reserves the right to charge up to 150% of the cost to the group health plan (including both employer and employee contributions) for COBRA coverage.

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 24HourFlex to confirm the correct amount of your first payment. Your COBRA coverage will not be reinstated until both the election and the full payment are sent to 24HourFlex.

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 24HourFlex by calling 1-800-651-4855 or send an email to cobra@24hourflex.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, HDHP 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 located in the BeneCenter or contact your Human Resources/Benefits Office for further information.

NOTE: You will receive this notice annually and at other times in the future such as before the next

period you can join a Medicare drug plan, and if this coverage through the CHEIBA Trust changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage:

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

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

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) on the web at www.socialsecurity.gov, or you can call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Human Resources & Benefits Office contact information

Name of Entity/Sender	Contact Position/Office	Address	Phone Number
Adams State University	Human Resources/ Benefits Office	208 Edgemont Blvd. Alamosa, CO 81101	719-587-7990
Auraria Higher Education Center	Human Resources/ Benefits Office	Campus Box C, PO Box 173361 1201-5th Street, #370 Denver, CO 80217-3361	303-556-3384
Colorado School of Mines	Human Resources/ Benefits Office	1500 Illinois Street Golden, CO 80401	303-273-3052
Colorado State University-Pueblo	Human Resources/ Benefits Office	2200 Bonforte Boulevard Pueblo, CO 81001	719-549-2441
Fort Lewis College	Human Resources/ Benefits Office	1000 Rim Drive Durango, CO 81301-3999	970-247-7428
Metropolitan State University of Denver	Human Resources/ Benefits Office	Campus Box 47, PO Box 173362 Student Success Building 890 Auraria Parkway, Suite 310 Denver, CO 80217-3362	303-615-0999
University of Northern Colorado	Human Resources/ Benefits Office	Carter Hall, Rm. 2002 Campus Box 54 Greeley, CO 80639	970-351-2718
Western Colorado University	Human Resources/ Benefits Office	600 N. Adams Street Taylor Hall, Room 321 Gunnison, CO 81231	970-943-3140

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.