2019 CSU Benefits Plans (Cost Share)

Summary Plan Description — Privileges and Benefits Summary

Academic Faculty, Administrative Professionals, Veterinary & Clinical Psychology Interns, Post Doctoral Fellows
The privileges and benefits approved through the Governing Board of Colorado State University are made available to eligible Academic Faculty, Administrative Professionals, Post Doctoral Fellows, Veterinary Interns and Clinical Psychology Interns through employment with Colorado State University are summarized in this booklet. The CSU Cost Share Benefits Plan describes the benefits available to, and the manner in which the University shares in the cost of those benefits for all benefits eligible employees.

This Summary Plan Description Privileges and Benefits (SPD) booklet contains, in the case of some of the more complex benefits plans such as medical coverage, only general and summary information and should not be considered as a replacement for the more detailed information set forth in the certificates of coverage or master plan documents of Benefit Providers, available online at http://www.hrs.colostate.edu/benefits/ or from Human Resources. Great care is taken to assure the accuracy of this SPD, but in the event of any discrepancies between the information in this SPD and in such other documents, the official documents will govern.

It is your responsibility to familiarize yourself with the guidelines of the CSU Benefits Plan (Cost Share) privileges and benefits available to you. Colorado State University assumes no responsibility for the loss to you of any benefit that might otherwise be due to you which occurs because of your failure to familiarize yourself with informational materials available to you. Questions you may have which are not addressed by the booklet or other written informational materials provided to you should be directed to Human Resources. If your spouse, domestic partner or civil union partner works at CSU and is also eligible for the CSU Benefits Plan (Cost Share), you may not choose duplicate coverage under any of the available options.

Any employee, covered individual of an employee, or other individual(s) who knowingly provides false, incomplete, or misleading facts or information using the CSU Online Benefits Enrollment System, benefit enrollment forms, affidavit, or other document for the purpose of defrauding or attempting to defraud the University’s benefits plans hereto commits a fraudulent act. Any such person will be subject to civil and/or criminal penalties, fines, denial of enrollment in any or all of the University’s benefits plans, or as provided in regulations, statutes, and applicable written directives.

Academic Faculty, Administrative Professionals, Post Doctoral Fellows, Veterinary Interns and Clinical Psychology Interns benefits and privileges are subject to change at any time for various reasons. With the exception of changes required by law, regulation, executive order or other external mandate, changes are normally the result of a collaborative and consultative process, having as its focus Academic Faculty and Administrative Professional input to the CSU Benefits Committee. Colorado State University, nonetheless, remains the final authority and expressly reserves to itself at all times the unilateral right to change, at its sole and final discretion, any or all aspects of the benefits and privileges it provides to the Academic Faculty and Non-Classified Staff.

The benefits described herein are provided or administered under contracts between Colorado State University and various insurers and vendors. A summary of the benefits provided under each Plan is set forth in this Summary Plan Description (SPD). In the event of a conflict between this SPD and any official plan document, the plan document of the appropriate contracted provider will govern.

Changes are announced by Human Resources, via benefits publications, memoranda, electronic mail, web access or other appropriate means at the time such changes are made, and are reflected in this Summary Plan Description Benefits and Privileges booklet as it is updated.

Colorado State University
Human Resources—Benefits
555 South Howes Street, Second Floor
6004 Campus Delivery
Fort Collins, Colorado 80523-6004
(970) 491-MyHR (6947)
# MEDICAL PLANS

<table>
<thead>
<tr>
<th>Plan</th>
<th>Green Plan or Ram Plan-HDHP</th>
<th>Gold Plan (frozen to new enrollment)</th>
<th>POS Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Employee Only</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Premium</td>
<td>$538</td>
<td>$650</td>
<td>$738</td>
</tr>
<tr>
<td>CSU’s Contribution</td>
<td>$538</td>
<td>$538</td>
<td>$538</td>
</tr>
<tr>
<td>You Pay</td>
<td>$0</td>
<td>$112</td>
<td>$200</td>
</tr>
<tr>
<td><strong>Employee + 1</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Total Premium</td>
<td>$959</td>
<td>$1,191</td>
<td>$1,352</td>
</tr>
<tr>
<td>CSU’s Contribution</td>
<td>$729</td>
<td>$729</td>
<td>$729</td>
</tr>
<tr>
<td>You Pay</td>
<td>$230</td>
<td>$462</td>
<td>$623</td>
</tr>
<tr>
<td><strong>Family</strong></td>
<td></td>
<td></td>
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<tr>
<td>Total Premium</td>
<td>$1,348</td>
<td>$1,683</td>
<td>$1,916</td>
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<tr>
<td>CSU’s Contribution</td>
<td>$1,024</td>
<td>$1,024</td>
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<tr>
<td>You Pay</td>
<td>$324</td>
<td>$659</td>
<td>$892</td>
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<tr>
<td><strong>Family Split - Both Spouses, Domestic Partners or Civil Union Partners Benefit Eligible</strong></td>
<td>$40.50/each</td>
<td>$208/each</td>
<td>$324.50/each</td>
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# DENTAL PLANS

<table>
<thead>
<tr>
<th>Plan</th>
<th>Delta Dental Basic</th>
<th>Delta Dental Plus</th>
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<tbody>
<tr>
<td><strong>Employee Only</strong></td>
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<tr>
<td>Total Premium</td>
<td>$23</td>
<td>$46</td>
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<tr>
<td>CSU’s Contribution</td>
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<td>$23</td>
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<tr>
<td>You Pay</td>
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<td>$23</td>
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<tr>
<td><strong>Employee + 1</strong></td>
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<tr>
<td>Total Premium</td>
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<td>CSU’s Contribution</td>
<td>$32</td>
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<td>You Pay</td>
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<td><strong>Family</strong></td>
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<tr>
<td>Total Premium</td>
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<td>CSU’s Contribution</td>
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<td>$45</td>
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<tr>
<td>You Pay</td>
<td>$15</td>
<td>$93</td>
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<td><strong>Family Split—Both Spouses, Domestic Partners or Civil Union Partners Benefit Eligible</strong></td>
<td>$2.50/each</td>
<td>$41.50/each</td>
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</tbody>
</table>

*Available only if both spouse, domestic partner or civil union partner are enrolled in Cost Share (provides a higher level of institutional support.)*
### VISION PLAN

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Coverage Level</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Employee Only</td>
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<tr>
<td>Vision Service Plan</td>
<td>$5.79</td>
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### DISABILITY INSURANCE

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short-Term Disability (STD)</td>
<td>Provided at no cost to the employee</td>
</tr>
<tr>
<td>Long-Term Disability (LTD)</td>
<td>Provided at no cost to the employee</td>
</tr>
</tbody>
</table>

### LIFE INSURANCE PLANS

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Group Term Life and AD&amp;D</td>
<td>$70,000 provided at no cost to the employee (subject to imputed income)</td>
</tr>
<tr>
<td>Voluntary Group Term Life</td>
<td>Cost based on coverage level and age</td>
</tr>
<tr>
<td>UNUM (PERA)</td>
<td>This plan is only available for active PERA members. Contact PERA at (800) 759-7372 for more information</td>
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### VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Accidental Death and Dismemberment Insurance (AD&amp;D)</td>
<td>Single or family coverage $0.38 - $19.00 per month, cost varies with amount of coverage</td>
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</tbody>
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### LONG TERM CARE (LTC) INSURANCE  (Rollout April 1, 2014)

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Long Term Care Insurance (LTC)</td>
<td>Rates are based upon the coverage level selected (Not available through payroll deduction.)</td>
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</tbody>
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### FLEXIBLE SPENDING REIMBURSEMENT ACCOUNTS

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Dependent Care Flexible Spending Accounts (FSA)</td>
<td>University funded annual administrative fee applies to enrollment in one or both accounts</td>
</tr>
</tbody>
</table>
Benefits Guidance Wherever You Are

ALEX® provides personalized, confidential benefits guidance on any computer, tablet, or smartphone. When you talk to ALEX, he will ask you a few questions about your healthcare needs, crunch some numbers, and point out which plans best fit your needs. Before you make your enrollment decisions, let ALEX help you find the plans that make the most sense for you and your family.

Discover your lowest-cost benefit options (and more) at myalex.com/csucsu/2019.

Talk to ALEX on Whatever You Like

After you visit ALEX, you can enroll online at aar.is.colostate.edu.
Administrative Provisions

Introduction

Under the CSU Benefits Plan, the University and the employee share in the cost of basic benefit coverage for Academic Faculty, Administrative Professionals, Post Doctoral Fellows, Veterinary Interns, Clinical Psychology Interns, and Federal employees (herein referred to as Faculty and Non-Classified staff).

General information about your benefits is provided in this SPD. Additional information is available in certificates of coverage at: www.hrs.colostate.edu/benefits/fap-insplans.html

Under this “cost share” model the University pays:

- **Medical and Dental**
  - 100% of the premium cost of employee only coverage under the Green or Ram Plan-HDHP medical and/or the Delta Dental Basic plans for those eligible employees electing such coverage;
  - 76% of the premium cost of employee + 1 or family coverage under the Green medical.
  - 75% of the Delta Dental Basic plans for those eligible employees electing coverage.

If you choose to upgrade to the Gold or Point of Service medical plan and/or to the Delta Dental Plus self-funded dental plan you will bear the difference in cost of the selected plan(s) and the institutional support for the Green or Delta Dental Basic plan at the comparable coverage level (e.g., employee only, employee + 1, family).

In order to “opt-out” of medical coverage you must certify that you have comparable medical coverage elsewhere. If you fail to do so, you will be automatically enrolled in employee only coverage on the Green plan.

You MUST enroll in a dental plan if you want dental coverage. You will not be defaulted into a plan.

**Note:** Federal employees are not eligible to enroll in a CSU medical plan. Contact Cooperative Extension at (970) 491-6367 for information on available Federal medical plans.

- **Basic Group Term Life and AD&D**
  - The cost of $70,000 basic group term life and AD&D coverage. You will be asked to select a beneficiary(ies) during the enrollment process.

- **Long-Term and Short-Term Disability**
  - The cost of coverage for Long-Term and Short-Term Disability (LTD).
  - The cost of the disability premiums will be added as a supplemental amount to your monthly salary and listed on your pay advice as “LTD-STD Allowance”. $4 will automatically be deducted back out of your earnings on a post tax basis to cover the cost of the STD and LTD premium. Your STD and LTD premiums are deducted post-tax basis. Paying for your premiums on a post-tax basis allows the income replacement benefit to be tax exempt, should you need to utilize it.

Eligibility and Appointment Types

Enrollment in a retirement plan is required and is effective upon the date of employment for all employees.

**Academic Faculty—Regular, Special or Senior Teaching Appointments**

Faculty on Regular, Special or Senior Teaching appointments of half-time or greater are eligible for benefits as of the date of appointment unless otherwise noted.

**Faculty Transitional Appointments**

Faculty transitional appointees have the option of remaining on the active group insurance plans that are available to full-time academic faculty members.

**Administrative Professionals—Regular or Special Appointments**

Administrative Professionals on Regular or Special appointments of half-time or greater are eligible for benefits as of the date of appointment unless otherwise noted.

**Temporary Appointments (New eligibility effective 1/1/2014)**

Faculty and Administrative Professionals on Temporary appointments of half-time or greater are eligible for benefits. Retirement plan participation, in lieu of Social Security, is mandatory and begins as of the date of appointment. Employer contributions to the Defined Contribution Plan for Retirement (DCP) will not begin until a one year waiting period is satisfied. Refer to the Retirement section later in this summary booklet for additional information.

**Post Doctoral Fellows, Veterinary Interns and Clinical Psychology Interns**

Post Doctoral Fellows, Veterinary Interns and Clinical Psychology Interns on appointments of half-time or greater are eligible for benefits, except as required as a condition of appointment under Colorado law, to contribute to a retirement plan in lieu of Social Security.
benefits (excluding CSU medical and retirement plans) as of the date of appointment unless otherwise noted.

Contact Cooperative Extension, (970) 491-6367, for information on Federal medical and retirement option(s).

The Affordable Care Act (ACA)

Full time (30 or more hours) or Variable Hour Employees

Employees who, at the time of hire, are classified as full time employees who can reasonably be expected to work 30 hours per week or more1 for the entire academic year if 9-month, or the entire calendar year if 12-month, will be eligible to enroll in a medical plan as of their date of hire. These employees are not eligible for other benefits.

Employees whose hours cannot be determined to be 30 hours per week or more on an ongoing basis will be classified as a Variable Hour Employee2 and have their hours tracked during an “Initial Measurement Period”2. That period will be the first 12 months of employment beginning the 1st of the month following their date of hire. If the employee averages at least 30 hours per week during the 12 month Initial Measurement Period2, the Variable Hour Employee will be offered medical coverage for a 12 month period beginning the 1st of the month following 30 days after the end of the Initial Measurement Period. The employee must enroll in coverage according to CSU requirements for coverage to become effective.

Employees who have gone through an Initial Measurement Period will also have their hours averaged during the Standard Measurement Period2. Hours will be calculated following the Standard Measurement Period and if a employee is determined to have worked 30 or more hours per week on average, they will be offered Medical coverage. Human Resources will notify these employees of their eligibility. Coverage will begin on January 1st following the Standard Measurement Period, providing the employee enrolls in coverage according to CSU requirements. This 12-month period of coverage is referred to as the Standard Stability Period2.

Coverage will remain in effect for the entire 12-month Stability Period, providing the employee pays their portion of the premium, regardless of the number of hours the employee works during the subsequent Standard Measurement Period. Coverage will remain in effect for each Standard Stability Period providing the employee works a minimum of 30 hours per week on average during each Standard Measurement Period, and pays the appropriate contribution.

1Hours worked on a Federal or State work study program do not count towards the 30 hours per week

2 Healthcare Reform Variable Hour Employee Terms are Defined as follows:

Administrative Period: An Administrative Period is a period of time between a Measurement Period and a Stability Period, during which CSU will determine which employees classified as Variable Hour Employees are eligible for coverage, as well as notify and offer medical coverage to those employees. For newly hired employees who are not determined to be Full-Time Employees on the date of hire, the Administrative Period also includes the period between date of hire until the end of the month after the date of hire, unless the date of hire is on the first of the month, and then the Administrative Period will start on the date of hire.

Initial Administrative Period: An Initial Administrative Period is a period of time between an Initial Measurement Period and an Initial Stability Period, during which CSU will determine which employees classified as Variable Hour Employees are eligible for coverage, as well as notify and offer medical coverage to those employees. The Initial Administrative Period also includes the time period between the date of hire and the beginning of the Initial Measurement Period.

Initial Measurement Period: An Initial Measurement Period is a period of time that begins the first of the month following your date of hire and is twelve months in length. During an Initial Measurement Period, CSU will calculate an employee’s Hours of Service. If that employee averages 30 or more hours of service per week or 130 hours of service per month during that 12-month period, the employee will be considered a Full-Time Employee for purposes of health benefits during an Initial Stability Period.

Initial Stability Period: An Initial Stability Period is a period of time during which an employee will either be considered to be a Full-Time Employee or Non-Full-Time Employee for purposes of eligibility for health benefits.

Measurement Period: A Measurement Period is a period of time during which CSU will “look back” to see how many hours of service per week Variable Hour Employees were credited on average. CSU will use that average to determine the initial eligibility or continued eligibility for health benefits for those employees.

Stability Period: A Stability Period is a period of time during which an employee will either be considered to be a Full-Time Employee or Non-Full-Time Employee for purposes of eligibility for health benefits. If an employee is determined to be Full-Time Employee during the immediately prior Measurement Period, that employee will be considered a Full-Time Employee
eligible for health benefits for the immediately subsequent Stability Period. However, if the employee is determined not to be a Full-Time Employee during the immediately prior Measurement Period, then that employee will be considered a Non-Full-Time Employee who is not eligible for health benefits for the immediately subsequent Stability Period, unless you have a Change in Employment Status that causes you to become eligible for health benefits.

Standard Administrative Period:
The Standard Administrative Period is a period of time between a Standard Measurement Period and a Standard Stability Period, during which CSU will determine which employees classified as Variable Hour Employees or Seasonal Employees are eligible for coverage, as well as notify and enroll those employees. The Standard Administrative Period will occur annually from October 15 through December 31 of each year.

Standard Measurement Period:
The Standard Measurement Period is a period of time that begins on October 15 each year and is twelve months in length. During a Standard Measurement Period, the employer will calculate an employee’s Hours of Service. If that employee averages 30 or more hours of service per week or 130 hours of service per month during that 12-month period, the employee will be considered as a Full-Time Employee for purposes of health benefits during the Standard Stability Period. Hours will be credited for breaks longer than 4 weeks providing the break is not longer than 26 weeks. A maximum of 501 hours can be credited during a calendar year.

Standard Stability Period: The Standard Stability Period is a period of time during which an employee will either be considered to be a Full-Time Employee or Non-Full-Time Employee for purposes of eligibility for health benefits. The Standard Stability Period begins on January 1 and ends on December 31 each year.

Variable Hour Employee: A Variable Hour Employee is an employee whose Hours of Service an employer cannot determine at the time of hire will average at least 30 hours per week or 130 hours per month.

“Actively at Work” Provisions
Some insurance plans include an “actively at work” provision that delays the effective date of coverage when the employee is absent from work on the normal effective date.

University plans incorporating this provision include the Short-Term disability, Long-Term Disability, Basic Group Term Life and AD&D, Voluntary Group Term Life, Voluntary AD&D, and Long Term Care programs.

Additionally, the Voluntary Group Term Life and the Voluntary AD&D insurance programs delay effective dates for spouses, domestic partners or civil union partners and children under certain circumstances. Consult the Certificates of Insurance for plan details.

Monthly insurance premium payments for benefits selections will be deducted from monthly pay whenever possible. If the monthly salary is insufficient to cover premiums, arrangements must be made with Human Resources (970) 491-MyHR (6947), to make payments by check. Payments must be made no later than the 1st of each month, for the current month’s coverage.

Individuals Eligible for University Benefits
You may enroll eligible individuals in certain University benefits plans as outlined in this SPD. Although individuals may be eligible to participate in a University plan as a “dependent” they may not meet the definition of a “qualified” dependent for federal income tax purposes (see Federal Tax Dependent (Qualified vs. Non-qualified) section). If your dependent(s) meet the IRS test as a federal tax dependent he/she is considered a “qualified” dependent.

If your dependent(s) does not meet the IRS test, he/she is considered a “non-qualified” dependent. There are tax consequences (imputed income) associated with providing coverage to individuals (domestic partners, civil union partners, children of domestic partners and civil union partners) not meeting the criteria of Section 152 of the Internal Revenue Code which defines a federal tax dependent.

Examples of non-qualified federal tax dependents may be domestic partners, civil union partners, children of domestic partners or children of civil union partners not defined under the Patient Protection and Affordable Care Act (PPACA). You are strongly encouraged to consult a tax advisor to determine the status of your dependent(s), as this is a complex area of the law.

When enrolling your eligible individuals you must first determine if they meet the eligibility criteria for CSU plans. Eligible individuals include only the following:

- Your spouse (includes same gender spouse) or common-law spouse1 (“qualified” federal tax dependent).
- Your same or opposite gender domestic partner2 (may or may not be your “qualified” federal tax dependent).
- Your same or opposite gender civil union partner3 (may or may not be your “qualified” federal tax dependent).
- You, your spouse’s, common-law spouse’s, domestic partner’s or civil union partner’s unmarried or married child(ren) including natural children, legally adopted children, foster children placed with you for adoption, stepchildren, children in which legal guardianship has been designated and children defined under a Qualified Medical Child Support Order (QMCSO)4 (may
Automatic and Default Enrollment Process
(New Hires / Newly Eligible)

You will be automatically enrolled in the following benefits effective on your date of eligibility:

- $70,000 of basic group term life and AD&D insurance
- STD and LTD on an post-tax basis

If you do not complete the enrollment process timely, enroll or “opt-out” of medical coverage within the 30 day enrollment period, you will be defaulted (enrolled) in:

- Employee-only coverage in the Green medical plan on an post-tax basis.
  (Note: Federal employees are not eligible)

You will not be allowed to make changes until the next annual Open Enrollment period unless you have a qualifying event as defined by the IRS for pre-tax benefit plans.

or may not be your “qualified” federal tax dependent).

Each child must be either a:

Eligible individual defined by the Patient Protection and Affordable Care Act (PPACA) which allows medical coverage through the end of the month in which the child attains the age of 26; or until the end of the month in which the child attains the age of 26 for the insured vision plan underwritten by VSP; or until the end of the month in which the child attains the age of 26 for dental plan coverage regardless of tax dependency status.

- Eligible individuals of any age who is dependent on you because of a permanent physical or mental disability to the end of the month in which they turn age 26.
  Once the disabled dependent reaches age 26, the University requires the dependent to be certified as disabled prior to age 23, a “qualified” federal tax dependent and currently enrolled in the plan to maintain coverage.

1. You must complete an Affidavit of Common Law Marriage available on the Benefit’s website to enroll your same or opposite gender domestic partner.

2. You must provide a Certificate of Civil Union Partnership to enroll your same or opposite gender civil union partner.

3. If the subscriber, subscriber’s spouse, domestic partner or civil union partner is subject to a Qualified Medical Child Support Order (QMCSO) for an eligible dependent child of the subscriber, subscriber’s spouse, domestic partner or civil union partner, the child is eligible for benefits, whether the child lives with the subscriber, subscriber’s spouse, domestic partner or civil union partner.

4. Must be certified by a physician and approved by the appropriate Plan. Please refer to the appropriate Certificate of Insurance for instructions or contact Human Resources at (970) 491-MyHR (6947)

Note: No spouse, domestic partner, civil union partner or child can be covered as an eligible individual on a plan if covered as an employee on this plan or a state classified plan.

Federal Tax Dependent
(Qualified vs. Non-qualified)

When you have confirmed your same or opposite gender domestic partner, domestic partner’s unmarried or married child(ren), civil union partner or civil union partner’s unmarried or married child(ren)’s eligibility and are ready to enroll them in a University plan, you must indicate whether each individual qualifies as YOUR federal tax dependent. If you fail to do so, they will be identified as non-federal tax dependents (“non-qualified”).

Note: Medical, dental or vision (pre-tax) enrollment of your eligible domestic partner, domestic partner’s child(ren), your eligible civil union partner or civil union partner’s child(ren) who are not also YOUR “qualified” dependents for federal income tax purposes, will result in tax consequences (imputed income).

Consult with your personal tax advisor prior to making your determination.

Individual Eligibility Date

Each dependent is eligible on the later of:

1. The date on which the employee’s coverage begins.
2. The date an eligible individual is added to your coverage (see the Qualifying Event section).
Individual coverage terminates at the end of the month in which the individual loses eligibility (i.e., divorce, termination of a domestic partnership or civil union partnership, attainment of age 26 for a child enrolled in medical, dental, vision and voluntary group term child life or on the last day of the calendar month when your employee insurance terminates, whichever occurs first.)

See the COBRA section regarding your individual’s right for continuation of medical and dental coverage.

Enrollment and Changes

New Hire/Newly Eligible

You have 30 days from your date of eligibility (refer to “Eligibility and Appointment Types”) to enroll and/or waive coverage under the CSU Benefits Plan (Cost Share). Enrollment requests after the 30 day enrollment period cannot be accepted. Unless you have a mid-year qualifying event, you may not enroll or make changes to coverage until the next Open Enrollment period, which generally occurs in November of each year. Plan choices selected during Open Enrollment begin at the beginning of the next plan year.

Enrollment Process

Human Resources will provide you with enrollment instructions electronically when you are initially eligible. You must indicate your benefit choice(s) or plans you are waiving coverage(s) (“opt-out”) by completing your enrollment in the CSU Online Benefits Enrollment System and you must return the Retirement Election Form and any other vendor required forms within this 30 day deadline. If you do not enroll by the 30 day deadline, you will automatically be enrolled in the default coverage options.

Refer to the default enrollment information for more important enrollment guidelines.

Eligible Individuals

You may enroll eligible individuals including your spouse, domestic partner or civil union partner and child(ren), in addition to yourself, in benefit plans that offer individual coverage during your 30 day eligibility period. Official documentation is required to validate dependent eligibility.

Effective Date of Coverage / Payroll Information

Premiums for insurances are deducted from your monthly pay for the current month’s coverage. Enrollment completed after the University monthly payroll deadline will not delay your coverage effective date, but may result in multiple premium deductions in your next paycheck based upon the date you complete the enrollment process.

Basic Group Term Life and AD&D, STD and LTD:

Coverage for basic group term life and AD&D insurance, STD and LTD is effective on the date you become eligible for benefits as long as you meet any applicable actively at work provisions.

Medical, Dental, Vision, Voluntary Group Term Life, Voluntary AD&D Insurance and Flexible Spending Accounts:

Benefit elections are generally effective the first of the month following your hire/change date providing you meet any actively at work provisions, if applicable.

Insurance premiums and Flexible Spending Account (FSA) contributions are deducted in the month of coverage.

Note: You may elect to have your insurance become effective on your date of eligibility. If you choose this option, you must pay a full month’s premium/contribution regardless of the number of days being covered; amounts cannot be prorated. Contact Human Resources for assistance at (970) 491-6947.

If you fail to complete your enrollment in the CSU Online Benefits Enrollment System electing to either enroll or “opt out” of a medical plan within the stipulated timeframe, you will be automatically enrolled in the Green plan post-tax with employee only coverage effective the first of the month following your date of hire.

Benefits Open Enrollment Period

The Open Enrollment period occurs each year with coverage effective the first of the following plan year. You may enroll, cancel, waive, add, drop or change insurance coverage. You may also add or delete individuals. Human Resources will announce Open Enrollment information electronically to employees. This information as well as specific enrollment instructions will be available on the website at: www.hrs.colostate.edu/benefits/fap.html

Effective Date of Coverage / Payroll Information

Changes made during Open Enrollment are effective January 1 of the following calendar year. Premiums, Flexible Spending account, or Health Savings account contributions for January coverage are deducted from your January pay.

Mid-Year Qualifying Event Changes

You are permitted to make mid-year election changes within 30 days of an IRS approved qualifying event. Contact Human Resources for instructions on how to complete the requested election change. It is necessary to provide documentation to Human Resources to substantiate the qualifying event and to establish the eligibility for, and the effective date of, the requested change within 30 days of the qualifying event.
Note: If you have elected to have your premiums deducted post-tax, you are eligible to delete individual(s) or cancel coverage at any time during the plan year without providing documentation.

The effective date for these changes is the first of the month following the requested change.

**Qualifying Events — Coverage Effective Dates**

- **Adding an Eligible Individual**
  Dependents become eligible the first of the month after the qualifying event occurs. For specific provisions relating to birth or adoption, refer to the Newborns/Newly Adopted Child (ren) provisions outlined in the Qualifying Event section.

- **Deleting an Individual**
  Individuals are removed from coverage as of the last day of the month in which the qualifying event occurs.
  
  - **Coverage Cancellation**
    Coverage terminates as of the last day of the month in which the qualifying event occurs.

- **Adding Coverage**
  Coverage begins as of the first of the month after the qualifying event.

**Qualifying Events**

**IRS Guidance on Mid-Year Status Changes**

If you have elected to have your premiums deducted pre-tax, mid-year election changes are regulated by federal law. The Internal Revenue Code Section 125 contains provisions defining “qualifying events” which allow mid-year changes to your insurance and in some cases, health and/or dependent care flexible spending account plan elections. Health spending account (HSA) contributions may be changed at any time during the year.

With the exception of deleting individuals or coverage termination, change in status events use the same eligibility criteria to determine election changes whether premiums are paid on a pre-tax or post-tax basis.

**Common Types of Qualifying Events**

The following list represents allowable IRS qualifying events.

- Change in your legal marital status, a change in domestic partnership or civil union partnership status

  (Note: HealthCare Reform allows coverage of married children up to age 26, therefore, a mid-year qualifying event is not applicable in this circumstance. The only allowable exception to this is if the child enrolls in their new spouse’s plan.)

- Change in the number of eligible individuals of the employee, domestic partner, civil union partner or child(ren).
  - Gain Dependent—birth, adoption, placement for adoption, stepchildren etc.
  - Loss of Dependent—death or attainment of age 26 unless disabled as defined under the eligibility section.

- Change in employee’s, spouse’s, domestic partner’s, civil union partner’s or child’s employment status including strike, lock-out, unpaid leave, commencement or termination of employment, etc.
- Gain / lose entitlement to Medicare or Medicaid
- A change in residence of the employee, spouse, domestic partner, civil union partner or eligible individual, which affects eligibility for coverage
- Judgment, decree, or Qualified Medical Child Support order for health coverage of an eligible child
- Significant change in health coverage of an eligible child
- Significant change in coverage or cost of spouse, common-law-spouse, domestic partner, civil union partner or domestic partner or civil union child’s plan.
- Spouse’s or dependent’s annual enrollment period.

Two new mid-year qualifying events approved by the IRS effective January 1, 2015.

- Reduction in Hours of Service
- Enrollment in a Qualified Health Plan through a Health Care Reform Marketplace.

The type of IRS approved qualifying event determines the changes that are permissible. For example, marriage of the employee would permit a change from employee only coverage to employee + 1 coverage,

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**Are your spouse, common-law spouse, domestic partner, civil union partner or child(ren) eligible for continuation of coverage under COBRA?**

Qualifying events which allow you to modify your existing coverage must be reported within 30 days, however, for those events that are COBRA qualifying events such as a divorce or a child losing dependent status, Federal COBRA regulations require you to report this to Human Resources within 60 days to qualify for COBRA. The enrollment change for ineligible dependents needs to be completed in the CSU Online Benefits Enrollment System. Please refer to the COBRA section for more information. While Federal regulations do not require COBRA to be extended to domestic partner or civil union partners, the University provides the enhanced benefit continuation.
as well as the option to change medical plan elections, e.g., Green Plan to the Gold Plan.

**Official Documentation**

It is necessary to provide documentation with the election in the CSU Online Benefits Enrollment System to substantiate the qualifying event and to establish the eligibility for, and the effective date of, the requested change.

**Examples of Required Documentation**

- Court documents for adoption, divorce, marriage, etc.
- Affidavit of Common-Law Marriage
- Affidavit of Domestic Partnership
- Certificate of Civil Union Partnership
- Secondary, joint financial document dated within the past 60 days that shows you and your spouse/partners name at a shared address
- Documentation of mid-year qualifying events on company letterhead and which should include:
  - Defined qualifying event type and date
  - Name of individual(s) affected by a status change
  - Name(s) of individuals who had been covered under other plan
  - Medical, dental, vision and/or life insurance coverage effective date or termination date (or other benefits as applicable)

**Newborns and Newly Adopted Child(ren) under the age of 18**

- If you wish to add this child to your insurance(s) beyond the first 31 days of automatic coverage, you must complete enrollment in the CSU Online Benefits Enrollment System within 30 days from the date of birth or placement for adoption. You will be responsible for premiums beginning with the first day of the month following the date of birth or placement for adoption.

- If you do not complete the CSU Online Benefits Enrollment System change adding the child within 30 days from the date of birth or date of placement for adoption, the child will not be covered under your plan beyond the first 31 days. You will not be able to enroll the child until the next Open Enrollment period with coverage effective the first of the following calendar year unless you incur a qualifying event.

**Enrollment Options for CSU Benefit Eligible Spouses, Domestic Partners or Civil Union Partners**

**CSU benefit eligible spouses, domestic partners or civil union partners with dependent children** should enroll in the Family Split medical and/or dental coverage option. This will provide for a greater level of institutional support than available under Family coverage, while ensuring the whole family is covered under the same insurance policy for the purposes of maximizing the benefits of family deductibles and out-of-pocket maximums.

**Split Contract Changes**

In the event a spouse, domestic partner or civil union partner loses eligibility, the remaining spouse, domestic partner or civil union partner will have 30 days to modify his/her coverage to reflect this change in the CSU Online Benefits Enrollment System. If the required change is not initiated by the benefits eligible employee within the 30 day period, the remaining benefits eligible spouse, domestic partner or civil union partner will be responsible for the full premium cost of the selected plans and coverage levels.

**Insurance Premium Deductions**

**9-Month Appointment Insurance Premium Deductions**

Employees with 9-month appointments (salary paid over 9-months) have benefit deductions in the spring to ensure benefits coverage through the summer months as follows:

- **April:**
  - Two premium deductions for benefits coverage in April and May

- **May:**
  - Two premium deductions for benefits coverage in June and July

- **August:** (deductions go back to a normal cycle)
  - Premium deduction for benefits coverage in August.
Pre and Post-Tax Deductions

You may elect to have eligible insurance premiums taken from your monthly pay by pre-tax or post-tax deductions, when you initially enroll or during the annual benefits Open Enrollment period. Pre-tax elections are irrevocable, based on Section 125 of the Internal Revenue Code, within the calendar year for which they are made, unless you experience a qualifying event.

Pre-Tax

Insurance premiums deducted from your pay before Medicare, Federal, and State taxes are calculated will reduce your taxable gross salary as provided in Section 125 of the Internal Revenue Code.

Defined Contribution Plan (DCP) contributions are not affected by pre-tax deductions. If you are a PERA member, pre-tax deductions (including those to Flexible Spending Accounts) may affect your retirement highest average salary calculation since they reduce the amount of your monthly salary reported to PERA and the resultant employee and employer PERA contributions. Please contact PERA for more information on how this may affect you.

Plan Availability—Pre/Post-Tax?

Post-Tax

Insurance premiums deducted from your pay after Medicare, Federal, and State taxes are calculated do not reduce your taxable gross salary. You may delete an individual or cancel the plan at anytime.

*If your long-term disability premiums are deducted post-tax and you become disabled, the disability income benefits will not be subject to income tax.

Leaves

Leave Without Pay

An Academic Faculty member on a regular, special or senior teaching appointment, or an Administrative Professional on a regular or special appointment may be granted leave without pay with approval of the Board. Post Doctoral Fellows and Temporary Academic Faculty and Administrative Professionals may apply for leave in accordance with the Parental Leave policy, as designated under the Family Medical Leave policy.

While on leave without pay, you will receive the CSU contribution as applicable during the first 12 months of leave without pay.

You must make arrangements with Human Resources to pay your portions, if any, of the cost of your benefit elections. Payments are due no later than the 1st of each month for the current month’s coverage. If two consecutive payments are missed, your benefit coverage will be terminated as of the last day of the month in which premiums were paid. You will not be eligible for COBRA.

If you cancel your CSU medical insurance, you must certify that you have medical coverage elsewhere. Re-enrollment in the CSU Benefit Plan (Cost Share) cannot take place until the next scheduled annual Open Enrollment period with coverage effective the first of the following plan year.

During your second year of leave without pay, you may continue your insurance elections. However, you will be required to pay the full premium as you will not receive the CSU contribution. Contact Human Resources to make payment arrangements. Any insurances you continued will terminate at the end of the second consecutive year of leave without pay. However, you may be eligible for continuation of medical, dental, vision, employee assistance program, and/or health care flexible spending account coverage through COBRA for up to 18 months (see the COBRA section).

If you are put on a suspended status upon your date of hire, you are not eligible for benefits coverage until you are actually receiving salary from the University. Additionally, the effective date of coverage for plans selected will be delayed until the first date that you meet the actively at work provisions, if applicable.

Sabbatical Leave

Faculty members on sabbatical leave remain eligible for all benefits. Faculty members receive salary during the period of leave as defined in the Academic Faculty and Administrative Professional Manual and continue to receive the CSU contribution during this leave. For further information refer to: http://facultycouncil.colostate.edu/files/manual/table.html

A Faculty member who participates in the PERA retirement plan and is on half pay will receive service credit to the extent provided by PERA. Please refer to PERA’s website at www.copera.org.

A Faculty member who participates in the Defined Contribution Plan (DCP) will receive continued

<table>
<thead>
<tr>
<th>Plan</th>
<th>Pre</th>
<th>Post</th>
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<tbody>
<tr>
<td>Medical</td>
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</tr>
<tr>
<td>Dental</td>
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<tr>
<td>Vision</td>
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<td>Voluntary Group Term Life</td>
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<td>Voluntary AD&amp;D</td>
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<tr>
<td>Health Savings Account (HSA)</td>
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</tbody>
</table>
Survivor Benefits

If you should die while employed by the University, your eligible individual(s) who were enrolled at the time of your death, may be eligible for coverage continuation based on your appointment type.

Regular, Special or Senior Teaching Appointments

If you are a benefits eligible Academic Faculty on a Regular, Special or Senior Teaching Appointment or an Administrative Professional on a Regular or Special appointment, and your surviving eligible individual(s) were enrolled in:

Medical Coverage

Your enrolled survivor(s) may continue coverage in the group medical insurance at no cost to them for a period of one year from the last day of the calendar month in which you died OR until your enrolled survivor(s) becomes eligible for another group medical insurance policy including Medicare/Medicaid, whichever occurs first. At the end of the one-year period, your survivor(s) may elect to continue enrollment in the University’s group medical insurance coverage at their own expense until eligible for another group medical insurance plan (in the case of a surviving spouse, domestic partner or civil union partner) or until no longer eligible according to the terms of the policy (in the case of children).

Dental, Vision, Employee Assistance Program and/or Flexible Spending Accounts

Your survivor(s) may have the option to elect Continuation Coverage through COBRA for up to 36 months. Note: Flexible spending accounts may only be extended through the calendar year in which you die.

Temporary Appointments

If you are on a benefits eligible temporary Faculty or Administrative Professional appointment, are a Post Doctoral Fellow, Veterinary Intern, or a Clinical Psychology Intern and surviving eligible individuals were enrolled in active coverage, your survivor(s) are covered through the last day of the calendar month in which you die. They have the option to elect Continuation Coverage through COBRA for up to 36 months.

See the COBRA section regarding your eligible individuals right to continuation of coverage.

Premiums will be deducted from your pay for the month during which your eligibility terminates. Premiums will not be prorated. However, if premium payments are deducted in the month following the date your eligibility terminates due to the late receipt of notification from your department, such premiums will be refunded. Be advised that any premiums taken on a pre-tax basis are considered taxable income at the time of refund.

### 2019 COBRA Premiums

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>Green or Ram Plan-HDHP</th>
<th>Gold</th>
<th>POS</th>
<th>Dental Basic</th>
<th>Dental Plus</th>
<th>Vision</th>
<th>EAP</th>
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<tbody>
<tr>
<td>Single</td>
<td>$548.76</td>
<td>$663</td>
<td>$752.76</td>
<td>$23.46</td>
<td>$46.92</td>
<td>$5.91</td>
<td>$1.22</td>
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<td>2 Persons</td>
<td>$978.18</td>
<td>$1,214.82</td>
<td>$1,379.04</td>
<td>$42.84</td>
<td>$82.62</td>
<td>$11.79</td>
<td>$1.22</td>
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<tr>
<td>Family</td>
<td>$1,374.96</td>
<td>$1,716.66</td>
<td>$1,954.32</td>
<td>$61.20</td>
<td>$140.76</td>
<td>$19.01</td>
<td>$1.22</td>
</tr>
</tbody>
</table>
Federal Regulations do not require employers to offer continuation of coverage to domestic partners, civil union partners or to the children of the domestic partner, civil union partners and children of civil union partners.

Colorado State University has elected to extend COBRA benefits to domestic partners, civil union partners and their children as referenced in the following COBRA information. You and your spouse or your domestic partner or civil union partner should read the following notice information carefully.

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) Continuation Coverage: Under certain circumstances (qualifying events), you and/or covered individuals have the right to continue participation in The Plan, beyond the time that coverage would normally end ("Continuation Coverage"). The following is a complete description of your COBRA Continuation Coverage rights. Continuation Coverage is available to each covered individual, herein referred to as qualified beneficiary (ies), which includes the employee, spouse, domestic partner, civil union partner and any eligible individuals, under The Plan if a qualified beneficiary's enrollment would end due to an eligible qualifying event.

Qualifying Events

You will become a qualified beneficiary if you lose coverage under The Plan due to one of the following qualifying events:

If you are an employee:
Your employment ends for any reason except that of gross misconduct; OR
Your hours of work are reduced such that you are no longer eligible under The Plan.
If you are the spouse, domestic partner or civil union partner of an employee:

The employee dies;
The employee's work hours are reduced such that he/she is no longer eligible under The Plan;
The employee’s employment ends for any reason except that of gross misconduct;
The employee becomes entitled to Medicare Part A and/or B and cancels coverage under The Plan within 30 days of entitlement; OR
You become divorced or your domestic partnership or civil union partnership is terminated.

If you are an eligible child(ren):
The employee dies;
The employee’s work hours are reduced such that he/she is no longer eligible under The Plan;
The employee’s employment ends for any reason except that of gross misconduct;
The employee becomes entitled to Medicare Part A and/or B and cancels coverage under The Plan within 30 days of entitlement (see Medicare entitlement);
The parents are divorced, the domestic partnership or civil union partner is terminated; OR
The child is no longer eligible to be covered as described under The Plan.

COBRA Period

COBRA Continuation Coverage is a temporary continuation of coverage. When the qualifying event is death of the employee, divorce or termination of a domestic partnership or civil union partnership, or the loss of eligibility for a child under The Plan, COBRA Continuation Coverage may continue for up to 36 months or until they are no longer eligible, whichever comes first.

When the qualifying event is the termination of employment or reduction of work hours to a level such that the employee is no longer eligible for The Plan, COBRA Continuation Coverage may continue up to 18 months.

In the following instances, COBRA Continuation Coverage may end prior to the 18- or 36-month period:
The employee dies;
The date on which a premium payment was due but not paid;
The date the covered individual becomes covered under another employer's group health plan that does not contain any exclusion or limitation that affects coverage of a covered individual's pre-existing condition
The date the covered individual becomes entitled to Medicare (see Medicare Entitlement); OR
The date Colorado State University terminates all of its group health plans.

Medicare Entitlement

COBRA (Consolidation Omnibus Budget Reconciliation Act of 1989) clarified that "entitlement to Medicare" means "enrolled in Medicare. Coverage under The Plan through the University will not end automatically unless you take action to cancel your coverage within 30 days of enrollment.

The Plan reserves the right to retroactively terminate COBRA coverage back to the end of the month prior to Medicare entitlement and seek reimbursement of all benefits paid after Medicare enrollment.

Notification of a Qualifying Event

The Plan will offer COBRA Continuation Coverage to a qualified beneficiary(ies) only after the Plan Administrator has been notified that a qualifying event has occurred.

When the qualifying event is the end of employment, reduction in work hours of employment, or death of an employee, the COBRA Administrator will inform all qualified beneficiaries of the right to obtain Continuation Coverage under The Plan.

If coverage will end because of divorce or termination of a domestic partnership, civil union partnership or a child ceases to be eligible, you or ineligible individuals MUST notify the COBRA administrator within 60 days from the qualifying event or ineligibility month.
COBRA Election

If you or a covered individual wants to continue group health, dental, vision, employee assistance program and/or a health flexible spending account (subject to limitations) plan coverage, the election of coverage must be made within 60 days of the date of the notice or date when your coverage ends, whichever is later. Each qualified beneficiary can individually decide whether or not to continue coverage.

You may have the right to request mid-year enrollment in another group health plan for which you are otherwise eligible (such as a plan offered by your spouse’s, your domestic partner’s or civil union partner’s employer) within 30 days after your group health coverage ends due to a qualifying event listed above.

Information about Healthcare Reform Marketplace

There may be other coverage options for you and your family. You will be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll.

Employees covered by University medical plans may not qualify for the tax credit because the plans offer minimum essential coverage and are affordable. Being eligible for COBRA does not limit your eligibility for coverage or for a tax credit through the Marketplace.

Payments

Continuation Coverage is at your expense and will include a 2% administrative fee. COBRA premiums are 102% of the current premium for active employees. Initial Payment: If you elect Continuation Coverage, you must make your initial payment within 45 days after the date of your election (this is the date the COBRA Election Form is post-marked, if mailed). CSU’s Third Party Administrator will mail you a coupon booklet for payment.

The first payment includes premiums for the period from when your active coverage ended up to and including the month you are making the first payment; therefore, the first payment may be for more than one month’s premium. If you do not make your initial payment for Continuation Coverage within those 45 days, you will lose all rights for Continuation Coverage under The Plan. While not required, you may include your first payment with your COBRA Election Form to expedite the reinstatement of your coverage.

Subsequent Payments: After you make your initial payment for Continuation Coverage, you will be required to pay for Continuation Coverage for each subsequent month of coverage. Payments are due by the date designated in the coupon booklet. If you make a periodic payment on or before its due date, your coverage under The Plan will continue for that coverage period without any break. The Plan will not send periodic notices of payments due for these coverage periods.

Grace Periods for Payments: Although periodic payments are due on the dates shown in the coupon booklet, there is a grace period of 30 days. If you make a payment after the due date, but during the grace period, your coverage under The Plan will be suspended as of the due date and then retroactively reinstated when the payment is received. Any claims submitted while your coverage is suspended may be denied and will have to be resubmitted once your coverage is reinstated. Failure to make a payment before the end of the grace period will result in a loss of all rights to Continuation Coverage under The Plan, and your Continuation Coverage will be terminated.

SPECIAL RULES FOR COBRA

CONTINUATION COVERAGE

Newborns and Adopted Children

If you, your spouse, domestic partner or civil union partner elects COBRA continuation coverage, any child born to or adopted by you, your spouse, domestic partner or civil union partner during the period of continuation coverage will also be entitled to continuation coverage for the remaining period of your entitlement. Such newborns or adopted children must be properly enrolled within 30 days of birth or adoption, and the child’s period of COBRA continuation coverage will end at the same time as would the maximum period of coverage for other covered family members. You MUST notify CSU’s Third Party Administrator within 30 days after the birth or placement of adoption.

Second Qualifying Event

An extension of coverage for up to an additional 18 months may be available to spouses, domestic partners, civil union partners and children who elect Continuation Coverage if a second qualifying event occurs during the first 18 months of COBRA Coverage. The maximum period of Continuation Coverage available under COBRA is 36 months. Second qualifying events include the death of the covered employee, divorce from or termination of a domestic partnership, civil union partnership with the covered employee, OR the loss of eligibility of a child.

You MUST notify the Third Party Administrator within 60 days after a second qualifying event occurs.

Effective February 2004, according to IRS Ruling 2004-22, the covered employee’s “entitlement to Medicare” is no longer a second qualifying event if an active employee’s entitlement to Medicare would not cause the spouse, common-law spouse, domestic partner, civil union partner or domestic partner or civil union partner children to lose coverage under the group health plan.
The 18-month extension rule (36 months total) only applies to the employee's covered spouse, domestic partner, civil union partner and/or children; the COBRA period will remain at 18 months from the date of the qualifying event for the employee.

If the former employee enrolls in Medicare after enrollment in COBRA this extension rule does not apply to the spouse or domestic partner, civil union partner and/or eligible individuals. You MUST notify CSU’s Third Party Administrator within 30 days of the qualifying event if this extension applies to eligible individuals.

Disability Extension

If a covered individual is disabled at the time he or she first becomes eligible for COBRA Continuation Coverage or is disabled within the first 60 days of the Continuation Coverage period, the maximum period of Continuation Coverage is extended to 29 months. In addition, all covered individuals who became qualified beneficiaries due to the same qualifying event as the disabled covered individual are also eligible for the additional 11 months of COBRA Continuation Coverage.

Coverage will still end for any of the other reasons listed above, such as failure to pay premiums when due, etc. In addition, the covered individual must also provide notice within 31 days of the date he/she is finally determined to no longer be disabled. Coverage will end on the first day of the month beginning 31 days after the covered individual is determined to no longer be disabled.

The cost of Continuation Coverage will increase to 150% of the group rate after the 18th month of Continuation Coverage for all enrolled qualified beneficiaries.

If the covered individual becomes disabled after the first 60 days of the Continuation Coverage period, he/she must notify the Third Party Administrator within 60 days of the date he/she is determined to be disabled under any one of the following: the Social Security Act; PERA; or the CSU Long-Term Disability Plan. This notification must be received PRIOR to the end of the initial 18 months of coverage.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

USERRA gives employees benefit protection to the extent provided by such law. Employees on military leave have a right to COBRA-like health benefit continuation. Contact Human Resources for more information.

Health Care Flexible Spending Account

If you are enrolled in this plan at the time the coverage would end due to a COBRA qualifying event, you have the right to continue coverage if there is a positive account balance at the time of the qualifying event. COBRA Continuation Coverage is only available for the remainder of the plan year in which the qualifying event occurs, and is not subject to the 18- or 36-month period.

Administrative

For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, contact the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa.

Questions

If you have any general questions regarding COBRA please contact HealthSmart Benefit Solutions, COBRA Administrator at (800) 423-4445.

Address Change/Marital, Domestic Partnership or Civil Union Partnership Status

If you are enrolled in COBRA and your marital, domestic partnership or civil union partnership status or address changes, contact HealthSmart Benefit Solutions, COBRA Administrator, at (800) 423-4445.

Disclaimer: This COBRA Election Notice is subject to change due to changes in the University’s Plan or due to changes in federal law.

Health Insurance Portability and Accountability Act (HIPAA)

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) you may have rights to Special Enrollment under this Plan, outside of the initial or annual Open Enrollment period if you or your eligible individuals have declined coverage.

Special Enrollment

A special enrollment period under HIPAA, is offered for three situations:

1. The loss of other health coverage provided that:
   • you and/or your eligible individuals were covered by another group or individual health plan or Medicaid at the time that coverage was initially offered and;
   • the other coverage was the reason for declining enrollment and;
   • you enroll no later than 30 days after the loss of other coverage.

In order to qualify for the special enrollment period, Human Resources must receive a written statement on company letterhead from the other employer stating coverage and end date, type of
coverage and who had been covered or a HIPAA certificate from the former carrier stating coverage end date and covered individuals. The enrollment must also be requested within 30 days of the Special Enrollment right in the CSU Online Benefits Enrollment System.

If the other coverage was COBRA continuation, special enrollment can only be requested after the exhaustion of COBRA continuation coverage. You do not have any special enrollment rights if you lose your coverage as a result of failure to pay premiums.

2. The addition of a new spouse, common-law spouse, same or opposite gender domestic partner or civil union partner, domestic partner or civil union partner’s unmarried or married children including natural children, legally adopted children, foster children placed with you for adoption, stepchildren, children in which legal guardianship has been designated and children defined under a Qualified Medical Child Support Order (QMCSO). Enrollment must be completed within 30 days after the qualifying event.

3. Medicaid Coverage
   • Termination of Medicaid or CHIP coverage—If you and or eligible individual(s) are covered under a Medicaid plan or under a State child health plan (SCHIP) and coverage of the employee or individual under such a plan is terminated as a result of loss of eligibility.
   • Eligibility for employment assistance under Medicaid or SCHIP—If the employee or individual becomes eligible for premium assistance under Medicaid or SCHIP, including under any waiver or demonstration project under or in relation to such a plan. This is usually a program where the state assists employed individuals with premium payment assistance for their employer’s group health plan rather than direct enrollment in a state Medicaid program.

Summary of Privacy Practices
This Summary of Privacy Practices summarizes how medical information about you may be used and disclosed by the Colorado State University Self-Funded Plan (the “Plan”) or others in the administration of your claims, and certain rights that you have. For a complete, detailed description of all privacy practices, as well as your legal rights, please refer to the accompanying Notice of Privacy Practices. This Summary is not intended to be a comprehensive statement of your privacy rights. In case of conflict between this Summary and the complete Notice, the Notice will be controlling.

Our Pledge Regarding Medical Information
We are committed to protecting your personal health information. We are required by law to (1) make sure that any medical information that identifies you is kept private; (2) provide you with certain rights with respect to your medical information; (3) give you a notice of our legal duties and privacy practices; and (4) follow all privacy practices and procedures currently in effect.

How We May Use and Disclose Medical Information About You
We may use and disclose your personal health information without your permission to facilitate your

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Procedures for Requesting Verification of Insurance Coverage at CSU

You may contact the Human Resources—Benefits Unit if you need to obtain verification of University insurance enrollment. If you experience a qualifying change in status during the middle of a calendar year and you wish to change your benefits coverage at your spouse, domestic partner or civil union partner’s employer, a letter will be required.

This letter helps the employer determine what enrollment changes are permissible under IRS qualifying event rules and the prospective date changes can become effective.

Generally, the request will include:
- The name of the individual for whom the verification is requested;
- The last date that the individual was covered under the plan; and
- The name of the participant that enrolled the individual in the plan.

After receiving a request that meets these requirements, the Plan will act in a reasonable and prompt fashion to provide the information to you. If you have any questions, please contact Human Resources at (970) 491-MyHR (6947).
Your Rights Regarding Your Medical Information

You have the right to inspect and copy your medical information, to request corrections of your medical information, and to obtain an accounting of certain disclosures of your medical information. You also have the right to request that additional restrictions or limitations be placed on the use or disclosure of your medical information, or that communications about your medical information be made in different ways or at different locations.

How to File a Complaint

If you believe your privacy rights have been violated, you have the right to file a complaint with us or with the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you file a complaint.

If you have any questions regarding the use or disclosure of Protected Health Information, please contact CSU Human Resources at (970) 491-MyHR (6947). The full notice is available at http://www.hrs.colostate.edu/pdfs/hipaa-privacy-practices.pdf.

Required Government and Regulatory Information

Newborns’ and Mothers’ Health Protection Act of 1996

This Federal Law requires that the Plan may generally not 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.

This law also 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, the Plan may not require that a provider obtain prior authorization for prescribing a length of stay not more than 48 hours (or 96 hours).

Women’s Health and Cancer Rights Act of 1998

The Women’s Health and Cancer Rights Act of 1998 (WHCRA) requires that you be informed of your rights to surgery and prostheses following a covered mastectomy.

The Colorado State University employee medical benefit Plan provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymph edema) for an enrolled employee and/or covered individual. This coverage will be provided in consultation with the patient and patient’s attending physician and will be subject to the same deductibles, coinsurance and/or co-payments otherwise applicable under the Plan.

Call your chosen medical plan’s Member Services line for more information.

This law also requires written notice of the availability of the coverage be delivered to all plan participants upon enrollment and annually thereafter. This notice serves to fulfill that requirement.

Medicare Part D Notice

If you and/or your eligible individuals have Medicare or will become eligible for Medicare in the next 12 months, Federal law gives you more choices about your prescription drug coverage. You may obtain a copy of the annual notice at: www.hrs.colostate.edu/pdfs/medicare-part-d-notice.pdf

Mandatory Reporting Requirement for Group Health Plans

The Centers for Medicare and Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other private group health plan (GHP) insurance in addition to Medicare. There are federal rules that determine whether Medicare or the other insurance pays first.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a new federal law that became effective January 1, 2009, requires that group health insurance plans begin to report information about Medicare beneficiaries who have other group coverage. This requirement will assist CMS and other health insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

CSU is required to submit Social Security Numbers for ALL employees, spouse’s and eligible individuals' covered on insurance plans using a secure transmission method as required by law.
protocol. This information is required to be entered during the enrollment process in the CSU Online Benefits Enrollment System. CSU is assessed a daily penalty for each social security number not provided.

**Family Medical Leave Act**

The Family Medical Leave Act of 1993 entitles all eligible employees up to 12 workweeks of leave during a 12-month period for (a) the birth or placement for adoption or foster care of a child, or (b) the serious health condition of the employee, spouse, child, or parent.

Colorado State University has elected to extend similar coverage to employees with domestic partners and civil union partners. For further information, refer to the Academic Faculty and Administrative Professional Staff Manual, appendix 3 at the website: [www.facultycouncil.colostate.edu/files/manual/table.html](http://www.facultycouncil.colostate.edu/files/manual/table.html)

**Genetic Information Nondiscrimination Act (GINA)**

Congress passed the Genetic Information Nondiscrimination Act (GINA) establishing a national and uniform standard to fully protect workers from genetic discrimination.

This group health plan does not discriminate in premium amounts, contributions charged or eligibility for coverage based on any individual’s genetic information. The plan does not use, request or require genetic information about anyone covered by the plan. Genetic information, within the context of GINA, includes the following:

- an individual’s genetic tests,
- the genetic tests of an individual’s family members (up to fourth-degree relatives by birth, marriage or adoption), manifestation of disease or disorder in family members of an individual,
- an individual’s request for or receipt of genetic services, and
- genetic information of a fetus carried by an individual or his or her family.

**Healthcare Reform**

**Grandfathered Health Plan**

The CSU Benefits Plan (Cost Share) believes the POS and Green medical plans are “grandfathered health plans” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator, Human Resources, at (970) 491-MyHR (6947). You may also contact the U.S. Department of Health and Human Services at [www.healthcare.gov](http://www.healthcare.gov).

**Summary of Benefits Coverage (SBC)**

Employer sponsored group health plans are required to provide clear, consistent and comparable information about health plan coverage to participants beginning in calendar year 2013. This summary of benefits (SBC) will be issued in a regulatory compliant format and will help participants better understand the coverage they have and allow an easy comparison with different insurance options. It will summarize key features of the plan or coverage, such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions. The Summary of Benefits Coverage (SBC) information is located on the Human Resources website at [www.hrs.colostate.edu](http://www.hrs.colostate.edu).
Medical Benefits

Plan Description

Medical insurance for you, the employee, is a Core Requirement (refer to Core Requirement in the Administrative Provision section). CSU offers two major medical plans and a preferred provider plan. All plans are self-insured and administered, including claims processing, by a third party administrator - Anthem.

Following are summaries of the medical plans, or call Anthem at (800) 542-9402 for specific details.

Enrollment/Changes

Refer to Enrollment and Changes in the Administrative Provisions section.

Effective Date of Coverage

New Hires

The first of the month following the month of hire unless specific arrangements are made with Human Resources to make coverage effective as of the date of hire.

Open Enrollment

January 1st following the Open Enrollment period.

No Medical Coverage

In order to “opt-out” of medical coverage you must certify that you have comparable medical coverage elsewhere. If you fail to do so, you will be automatically enrolled in Employee Only coverage on the Green plan—Post Tax.

Premiums

Refer to the Premium Summary section for rates.

Termination of Coverage

Refer to Termination of Coverage in the Administrative Provisions section for eligibility and rights to continue insurance.

Choosing Your Options

You have four medical care options to choose from to provide flexibility in finding an option that fits your individual needs. The plans include medical coverage services like maternity care, surgery, hospitalization, and office visits with providers, but they have different deductibles, copayments, and coinsurance.

Please review these differences in benefits and costs carefully to determine which option best fits you and, if appropriate, your family’s circumstance.

Gold Plan Freeze

The Gold Plan is frozen to new enrollment effective January 1, 2018. If you were enrolled in the Gold Plan prior to this date, you may maintain your enrollment in the plan. However, if you switch enrollment to another plan, you will not be allowed to re-elect the Gold Plan at a later date.
In addition, outside of Colorado you will have access to a National Blue Cross and Blue Shield PPO network of contracted providers. Your benefit will be the highest level when you receive covered services from a PPO contracted provider. You are responsible for any applicable copayments and coinsurance. Anthem will pay the PPO contracted provider directly.

OUT-OF-NETWORK NON-CONTRACTED PROVIDERS:

Non-contracted facilities or providers have not entered into any agreement with Anthem. They may bill Anthem or the patient. By law Anthem is required to reimburse you unless an assignment of benefits which directs payment to the out of network provider has been authorized. Anthem may require a copy of the assignment of benefits for their records. You may be obligated to pay more out-of-pocket expenses when you visit a Non-participating provider because Non-participating providers are not required to accept Anthem Blue Cross and Blue Shield’s maximum benefit allowance. The difference between Anthem Blue Cross and Blue Shield’s maximum benefit allowance and the non-participating provider’s billed charge is your responsibility and does not apply toward the deductible or out-of-pocket annual maximum. The determination of a maximum benefit allowance is the maximum amount Anthem approves for a covered service. Deductible and coinsurance amounts are based on this maximum benefit allowance.

Green, Gold and Ram Plan–HDHP

With these plans you have one level of coverage, and you can access any eligible licensed provider to receive coverage. When you choose Participating Providers, the provider agrees to accept Anthem Blue Cross and Blue Shield’s maximum benefit allowance as payment in full and you are responsible for the deductible, coinsurance and non-covered services.

PARTICIPATING PROVIDERS:

Within the State of Colorado, you have access to the Anthem Blue Preferred network of PPO Contracted Providers. In addition, outside of Colorado you will have access to a National Blue Cross and Blue Shield PPO network of contracted providers. Your benefit will be the highest level when you receive covered services from a PPO contracted provider. You are responsible for any applicable copayments and coinsurance.

Anthem will pay the PPO contracted provider directly. Your benefit will be the highest level when you receive covered services from a Participating Provider. These Providers (such as a hospital or a physician) have entered into an agreement with Anthem Blue Cross and Blue Shield or the local Blue Cross and Blue Shield to bill directly for covered services, and to accept Anthem Blue Cross and Blue Shield’s maximum benefit allowance as payment in full for these services. You are responsible for any applicable deductible and
co-insurance. Anthem Blue Cross and Blue Shield will pay the participating provider directly.

**NON-PARTICIPATING PROVIDERS:**
Non-contracted facilities or providers have not entered into any agreement with Anthem. They may bill Anthem or the patient. By law Anthem is required to reimburse you unless an assignment of benefits which directs payment to the out of network provider has been authorized.

Anthem may require a copy of the assignment of benefits for their records. You may be obligated to pay more out-of-pocket expenses when you visit a Non-participating provider because Non-participating providers are not required to accept Anthem Blue Cross and Blue Shield’s maximum benefit allowance.

The difference between Anthem Blue Cross and Blue Shields maximum benefit allowance and the non-participating provider’s billed charge is your responsibility and does not apply toward the deductible or out-of-pocket annual maximum. The determination of a maximum benefit allowance is the maximum amount Anthem approves for a covered service. Deductible and coinsurance amounts are based on this maximum benefit allowance.

To locate a Contracted Provider, you may go to Anthem’s website at [www.anthem.com](http://www.anthem.com) and select “Find a Doctor” to view the online provider directory. Use a Plan Selection of PPO, for any of the CSU medical options as they use the same network of providers.

**Coordination of Benefits**

Anthem coordinates benefits when a member has coverage with more than one health benefit plan. Refer to the Anthem Certificate of Insurance Booklet located at [www.anthem.com](http://www.anthem.com) for a complete description of Coordination of Benefits.
This and the following pages contain a limited description of the benefit coverage available through this group plan. Coverage is governed at all times by the complete terms of the Master Group Insurance Policy issued to Colorado State University (CSU). Great care is taken to assure the accuracy of this guide, but in the event of any discrepancies between the information in this guide and in such other documents, Anthem’s coverage certificate will govern (Green, Gold, POS, Ram-HDHP). Anthem’s coverage certificate is available online at www.hrs.colostate.edu/benefits/fap-insplans.html.

<table>
<thead>
<tr>
<th>Topic</th>
<th>1. ANNUAL DEDUCTIBLE</th>
<th>2. COINSURANCE/COPAYMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a) Individual</td>
<td></td>
</tr>
<tr>
<td>1. ANNUAL DEDUCTIBLE</td>
<td>$500</td>
<td>$750, plus a separate deductible for outpatient retail and specialty prescription drugs of $150.</td>
</tr>
<tr>
<td>b) Family</td>
<td>$1,000 for all family members.</td>
<td>No one family member may meet more than $500 of the $1,000 family deductible.</td>
</tr>
</tbody>
</table>

2. COINSURANCE/COPAYMENTS

- **Coinsurance:**
  - Refer to the below benefits for specific details.
  - Coinsurance is required up to the out-of-pocket annual maximum.
  - Coincidence is required up to the out-of-pocket annual maximum. Subject to certain exclusions as identified below.

- **Copayments:**
  - Refer to the below benefits for specific details.
  - Does not apply.

- **Coinsurance:**
  - You pay 30% or 10% after deductible. Coinsurance is required up to the out-of-pocket annual maximum. Subject to certain exclusions as identified below.

- **Copayments:**
  - Does not apply.

- **Coinsurance:**
  - You pay 20% after deductible. Coinsurance is required up to the out-of-pocket annual maximum. Subject to certain exclusions as identified below.

- **Copayments:**
  - Does not apply.

- **Coinsurance:**
  - You pay 20% after deductible. Coinsurance is required up to the out-of-pocket annual maximum. Subject to certain exclusions as identified below.

- **Copayments:**
  - Does not apply.

Coinsurance options reflect the amount you will pay. The difference between what you pay and 100% is the amount the Plan pays for PPO (participating) providers. For non-participating providers you also pay the difference between Anthem’s Maximum allowed amount and the amount billed by the non-participating provider.
<table>
<thead>
<tr>
<th>Topic</th>
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<th>Gold Plan (frozen to new enrollment)</th>
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<td>Participating and Non-participating Providers</td>
</tr>
<tr>
<td>3. OUT-OF-POCKET ANNUAL MAXIMUM^2</td>
<td>• $1,250 in coinsurance, plus</td>
<td>• $3,000 in coinsurance, plus</td>
<td>• $4,500 includes coinsurance and deductible for pharmacy and medical</td>
<td>• $5,000 in coinsurance, plus</td>
</tr>
<tr>
<td>a) Individual</td>
<td>• Copayments</td>
<td>• Deductible, plus</td>
<td>Plus—charges for non-participating providers that are above Anthem’s maximum allowed amount.</td>
<td>• Deductible, plus</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Copayments, plus</td>
<td></td>
<td>• $1,000 in coinsurance for retail and specialty outpatient prescription drugs, plus</td>
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<tr>
<td></td>
<td></td>
<td>• Charges for non-participating providers that are above Anthem’s maximum allowed amount.</td>
<td>Plus—charges for non-participating providers that are above Anthem’s maximum allowed amount.</td>
<td>Charges for non-participating providers that are above Anthem’s maximum allowed amount.</td>
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<td></td>
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<td></td>
<td>No one family member may meet more than $1,250 of the $2,500 family out-of-pocket annual maximum.</td>
</tr>
<tr>
<td></td>
<td>No one family member may meet more than $3,000 of the $6,000 family out-of-pocket annual maximum.</td>
<td>No one family member may meet more than $4,500 of the $9,000 family out-of-pocket annual maximum.</td>
<td>No one family member may meet more than $6,550 of the $13,100 family out-of-pocket annual maximum.</td>
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</tr>
<tr>
<td>b) Family</td>
<td>• $2,500 in coinsurance, plus</td>
<td>• $6,000 in coinsurance, plus</td>
<td>• $10,000 in coinsurance, plus</td>
<td>• $13,100 includes deductible and coinsurance</td>
</tr>
<tr>
<td></td>
<td>• Copayments.</td>
<td>• Deductible, plus</td>
<td>• Deductible, plus</td>
<td>Plus—charges for non-participating providers that are above Anthem’s maximum allowed amount.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Copayments, plus</td>
<td></td>
<td>• $2,000 in coinsurance for retail and specialty outpatient prescription drugs, plus</td>
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<td></td>
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<td></td>
<td></td>
<td>Charges for non-participating providers that are above Anthem’s maximum allowed amount.</td>
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<td></td>
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<td></td>
<td>No one family member may meet more than $5,000 of the $10,000 family out-of-pocket annual maximum. For prescription drugs no one family member may meet more than $1,000 of the $2,000 family out-of-pocket annual maximum.</td>
</tr>
<tr>
<td></td>
<td>No lifetime maximum</td>
<td>No lifetime maximum</td>
<td>No lifetime maximum</td>
<td>No lifetime maximum</td>
</tr>
<tr>
<td>4. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE</td>
<td>Covered in full after you pay $15 per office visit copayment and 10% for laboratory and x-ray services. Copayment does not apply if an office visit is not billed.</td>
<td>You pay 30% after deductible</td>
<td>You pay 20% after deductible</td>
<td>You pay 20% after deductible</td>
</tr>
<tr>
<td>5. ROUTINE MEDICAL OFFICE VISITS</td>
<td>You pay 20% after deductible</td>
<td>You pay 20% after deductible</td>
<td>You pay 20% after deductible</td>
<td>You pay 20% after deductible</td>
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<td>Participating and Non-participating Providers</td>
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<tr>
<td>6. PREVENTIVE CARE</td>
<td></td>
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<tr>
<td>a) Well baby services, (0 up to 12 months)</td>
<td>Covered in full</td>
<td>You pay 30% after deductible</td>
<td>Participating Provider: Covered in full not subject to deductible</td>
<td>Participating Provider: Covered in full not subject to deductible</td>
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<td></td>
<td></td>
<td></td>
<td>Non-Participating Provider: You pay 20% not subject to deductible</td>
<td>Non-Participating Provider: You pay 20% not subject to deductible</td>
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<tr>
<td></td>
<td>includes routine physicals, associated laboratory, X-rays and immunizations</td>
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<tr>
<td>b) Children’s services</td>
<td>Covered in full</td>
<td>You pay 30% after deductible</td>
<td>Participating Provider: Covered in full not subject to deductible</td>
<td>Participating Provider: Covered in full not subject to deductible</td>
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<td></td>
<td></td>
<td></td>
<td>Non-Participating Provider: You pay 20% not subject to deductible</td>
<td>Non-Participating Provider: You pay 20% not subject to deductible</td>
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<td></td>
<td>12 months through age 12, includes routine physicals, routine associated laboratory and X-ray and immunizations</td>
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<tr>
<td>c) Adults’ services</td>
<td>Covered in full</td>
<td>Not covered</td>
<td>Participating Provider: Covered in full, not subject to deductible</td>
<td>Participating Provider: Covered in full, not subject to deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Non-Participating Provider: You pay 20% not subject to deductible;</td>
<td>Non-Participating Provider: You pay 20% not subject to deductible;</td>
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<tr>
<td></td>
<td>includes associated laboratory and X-ray, mammogram screening, preventive colorectal cancer screenings and immunizations</td>
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<td>7. MATERNITY</td>
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</tr>
<tr>
<td>a) Prenatal care</td>
<td>Covered in full after you pay $15 per office visit copayment and 10% for laboratory and x-ray services. Copayment does not apply if an office visit is not billed.</td>
<td>You pay 30% after deductible</td>
<td>You pay 20% after deductible</td>
<td>You pay 20% after deductible</td>
</tr>
<tr>
<td>b) Delivery &amp; inpatient well baby care</td>
<td>You pay 10% after $125 per admission copayment</td>
<td>You pay 30% after deductible</td>
<td>You pay 20% after deductible</td>
<td>You pay 20% after deductible</td>
</tr>
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<td>Participating and Non-participating Providers</td>
</tr>
<tr>
<td>8. PRESCRIPTION DRUGS</td>
<td>Copayments for retail pharmacy and specialty pharmacy for each 34-day supply: Tier 1 - $10 copayment Tier 2 - $20 copayment Tier 3 - $40 copayment</td>
<td>Not covered</td>
<td>You pay 20% after separate deductible for outpatient retail or specialty prescription drugs of $150 per member or $300 per family.</td>
<td>You pay 20% after separate deductible for outpatient retail or specialty prescription drugs of $150 per member or $300 per family up to separate out-of-pocket annual maximum for outpatient retail or specialty prescription drugs of $1,000 per member or $2,000 per family. You pay 20% after deductible</td>
</tr>
<tr>
<td></td>
<td>Copayments for mail order service (90-day supply maximum): Tier 1 - $20 copayment Tier 2 - $40 copayment Tier 3 - $80 copayment</td>
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<tr>
<td>IMPORTANT NOTES</td>
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<td>Applicable to all plans:</td>
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<td></td>
<td>• Specialty Pharmacy: Participating pharmacy (34-day supply). Specialty pharmacy drugs often require special handling such as temperature controlled packaging and overnight delivery and are often unavailable at a retail pharmacy or through the mail order service. Benefits are only provided when you receive services from a specialty pharmacy as determined by Anthem for those specialty pharmacy drugs included on Anthem's specialty drug list.</td>
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<td></td>
<td>• Smoking Cessation Prescription Drugs: Includes coverage for smoking cessation prescription legend drugs when enrolled in a smoking cessation counseling program approved by Anthem.</td>
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<td></td>
<td>• Birth Control: Certain oral, injection and contraceptive devices obtained by a physician’s prescription are covered at 100%.</td>
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<tr>
<td></td>
<td>• Prescription drugs are covered only when received from a participating pharmacy (34 to 90-day supply), participating specialty pharmacy (34-day supply) or participating mail order service.</td>
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<tr>
<td></td>
<td>• Prescription Drugs will always be dispensed as ordered by your provider and by applicable State Pharmacy Regulations, however you may have higher out-of-pocket expenses. You may request, or your provider may order, the brand-name drug. However, if a generic drug is available, you will be responsible for the cost difference between the generic and the brand-name drug, in addition to your tier 1 copayment. By law, generic and brand-name drugs must meet the same standards for safety, strength and effectiveness.</td>
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<tr>
<td></td>
<td>• Anthem reserves the right, at our discretion, to remove certain higher cost generic drugs from this policy. For drugs on our approved list, contact Customer Service at (800) 542-9402 or access our website at <a href="http://www.anthem.com">www.anthem.com</a>.</td>
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<td>--------------------------------------------------------</td>
</tr>
<tr>
<td><strong>9. INPATIENT HOSPITAL</strong></td>
<td>You pay 10% after $125 per admission copayment</td>
<td>You pay 30% after deductible</td>
<td>You pay 20% after deductible</td>
<td>You pay 20% after deductible</td>
</tr>
<tr>
<td>IMPORTANT NOTES</td>
<td>Pre-certification from Anthem BCBS must be received before a hospital admission or within 5 days after an emergency admission for full benefits to be payable. Consultation for a second opinion (and third if necessary) is paid at 100%.</td>
<td>Pre-certification from Anthem BCBS must be received before a hospital admission or within 5 days after an emergency admission for full benefits to be payable. Consultation for a second opinion (and third if necessary) is paid at 100%. If you use a non-participating provider, you are responsible for making sure this pre-certification has been obtained.</td>
<td>Pre-certification from Anthem BCBS must be received before a hospital admission or within 5 days after an emergency admission for full benefits to be payable. Consultation for a second opinion (and third if necessary) is paid at 100%. If you use a non-participating provider, you are responsible for making sure this pre-certification has been obtained.</td>
<td>Pre-certification from Anthem BCBS must be received before a hospital admission or within 5 days after an emergency admission for full benefits to be payable. Consultation for a second opinion (and third if necessary) is paid at 100%. If you use a non-participating provider, you are responsible for making sure this pre-certification has been obtained.</td>
</tr>
<tr>
<td><strong>10. OUTPATIENT/AMBULATORY SURGERY</strong></td>
<td>You pay 10% after you pay $125 per admission copayment. This includes colonoscopies with a medical diagnosis.</td>
<td>You pay 30% after deductible</td>
<td>You pay 20% after deductible</td>
<td>You pay 20% after deductible</td>
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<tr>
<td><strong>11. LABORATORY AND X-RAY</strong></td>
<td>You pay 10%</td>
<td>You pay 30% after deductible</td>
<td>You pay 20% after deductible</td>
<td>You pay 20% after deductible</td>
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<tr>
<td><strong>12. EMERGENCY CARE</strong>³</td>
<td>You pay 10% after $60 copayment per emergency room visit, applied to inpatient hospital copayment if admitted.</td>
<td>You pay 30% after deductible</td>
<td>You pay 20% after deductible</td>
<td>You pay 20% after deductible</td>
</tr>
<tr>
<td>Topic</td>
<td><strong>Point-of-Service</strong></td>
<td><strong>Gold Plan</strong></td>
<td><strong>Green Plan</strong></td>
<td><strong>Ram Plan-HDHP</strong></td>
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<td></td>
<td><strong>PPO Plan</strong></td>
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<tr>
<td><strong>PPO Participating Providers (In-Network)</strong></td>
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<tr>
<td><strong>Non-PPO Participating Providers (Out-of-Network)</strong></td>
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<td><strong>Participating and Non-participating Providers</strong></td>
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</tbody>
</table>

| 13. AMBULANCE | a) Ground | You pay 10% after $60 per trip copayment | You pay 10% after $60 per trip copayment | You pay 20% after deductible | You pay 20% after deductible |
|               | b) Air    | You pay 10% after $125 per trip copayment | You pay 10% after $125 per trip copayment | You pay 20% after deductible | You pay 20% after deductible |

| 14. URGENT, NON-Routine, AFTER HOURS CARE | a) Inpatient care | You pay 10% after $125 per admission copayment | You pay 30% after deductible | You pay 20% after deductible | You pay 20% after deductible |
|                                           | b) Outpatient care | Covered in full after you pay $15 per office visit copayment and 10% for laboratory and x-ray services. Copayment does not apply if an office visit if not billed. | You pay 30% after deductible | You pay 20% after deductible | You pay 20% after deductible |

| 15. MENTAL HEALTH CARE | a) Inpatient care | You pay 10% after $125 per admission copayment | You pay 30% after deductible | You pay 20% after deductible | You pay 20% after deductible |
|                        | b) Outpatient care | You pay 10% after $15 per office visit copayment | You pay 30% after deductible | You pay 20% after deductible | You pay 20% after deductible |
|                        | c) Important Note | Copayments for other mental health care do not count towards meeting your out-of-pocket annual maximum. | You pay 30% after deductible | You pay 20% after deductible | You pay 20% after deductible |

Contact the behavioral health administrator at (800) 424-4014 for information on how to locate a provider and your benefits.
<table>
<thead>
<tr>
<th>Topic</th>
<th>Point-of-Service PPO Plan</th>
<th>Gold Plan (frozen to new enrollment)</th>
<th>Green Plan</th>
<th>Ram Plan-HDHP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PPO Participating Providers (In-Network)</td>
<td>Non-PPO Participating Providers (Out-of-Network)</td>
<td>Participating and Non-participating Providers</td>
<td>Participating and Non-participating Providers</td>
</tr>
<tr>
<td>16. ALCOHOL &amp; SUBSTANCE ABUSE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Inpatient Care</td>
<td>You pay 10% after $125 per admission copayment</td>
<td>You pay 30% after deductible</td>
<td>You pay 20% after deductible</td>
<td>You pay 20% after deductible</td>
</tr>
<tr>
<td>b) Outpatient Care</td>
<td>You pay 10% after $15 per office visit copayment</td>
<td>You pay 30% after deductible</td>
<td>You pay 20% after deductible</td>
<td>You pay 20% after deductible</td>
</tr>
<tr>
<td>c) Important Note</td>
<td>Copayments for other alcohol and substance abuse care does not go towards meeting your out-of-pocket annual maximum.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Contact the behavioral health administrator at (800) 424-4014 for information on how to locate a provider and/or your benefits.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Inpatient</td>
<td>You pay 10% after $125 per admission copayment</td>
<td>You pay 30% after deductible</td>
<td>You pay 20% after deductible</td>
<td>You pay 20% after deductible</td>
</tr>
<tr>
<td>b) Outpatient</td>
<td>You pay 10% after $15 per office visit copayment (See Benefit Booklet for definitions, limitations, and exclusions)</td>
<td>You pay 30% after deductible (See Benefit Booklet for definitions, limitations, and exclusions).</td>
<td>You pay 20% after deductible (See Benefit Booklet for definitions, limitations, and exclusions).</td>
<td>You pay 20% after deductible (See Benefit Booklet for definitions, limitations, and exclusions).</td>
</tr>
<tr>
<td>18. DURABLE MEDICAL EQUIPMENT</td>
<td>You pay 10%</td>
<td>Not covered</td>
<td>You pay 20% after deductible</td>
<td>You pay 20% after deductible</td>
</tr>
<tr>
<td>Topic</td>
<td>PPO Participating Providers (In-Network)</td>
<td>Non-PPO Participating Providers (Out-of-Network)</td>
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</tr>
<tr>
<td>19. OXYGEN</td>
<td>You pay 10%</td>
<td>Not covered</td>
<td>You pay 20% after deductible</td>
<td>You pay 20% after deductible</td>
</tr>
<tr>
<td>20. ORGAN TRANSPLANTS</td>
<td>You pay 10% after $125 per admission copayment (includes liver, heart, heart-lung, pancreas, cornea, kidney, bone marrow and peripheral stem cell). Precertification required.</td>
<td>Not covered</td>
<td>You pay 20% after deductible (includes liver, heart, heart-lung, pancreas, cornea, kidney, bone marrow and peripheral stem cell). Precertification required.</td>
<td>You pay 20% after deductible (includes liver, heart, heart-lung, pancreas, cornea, kidney, bone marrow and peripheral stem cell). Precertification required.</td>
</tr>
<tr>
<td>21. HOME HEALTH CARE</td>
<td>Covered in full after you pay $15 per visit copayment (up to 100 visits per calendar year).</td>
<td>Not covered</td>
<td>Covered in full (up to 100 visits per calendar year combined in and out-of-network).</td>
<td>Covered in full (up to 100 visits per calendar year combined in and out-of-network).</td>
</tr>
<tr>
<td>23. SKILLED NURSING FACILITY CARE</td>
<td>You pay 10% after $125 per admission copayment (up to 100 days per calendar year in and out-of-network combined) copayment waived if admitted directly to skilled nursing facility from an inpatient acute facility).</td>
<td>You pay 30% after deductible (up to 100 days per calendar year in and out-of-network combined).</td>
<td>You pay 20% after deductible (up to 100 days per calendar year combined in and out-of-network).</td>
<td>You pay 20% after deductible (up to 100 days per calendar year combined in and out-of-network).</td>
</tr>
<tr>
<td>24. VISION CARE</td>
<td>Covered in full after you pay $15 per office visit copayment (limited to one exam per calendar year, eyeglass hardware not covered).</td>
<td>Not covered</td>
<td>You pay 20% after deductible (limited to one exam per calendar year combined in and out-of-network, eyeglass hardware not covered).</td>
<td>You pay 20% after deductible (limited to one exam per calendar year combined in and out-of-network, eyeglass hardware not covered).</td>
</tr>
<tr>
<td>25. RETAIL HEALTH CLINIC VISITS</td>
<td>Covered in full after you pay $15 per office visit copayment and 10% for laboratory and x-ray services</td>
<td>Not Covered</td>
<td>You pay 20% after deductible for participating providers; not covered for non-participating providers.</td>
<td>You pay 20% after deductible for participating providers; not covered for non-participating providers.</td>
</tr>
</tbody>
</table>
## Topic

<table>
<thead>
<tr>
<th>Topic</th>
<th>Point-of-Service</th>
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<td></td>
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<td>Participation and Non-participating Providers</td>
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</tr>
<tr>
<td></td>
<td>Providers (In-Network)</td>
<td>(frozen to new enrollment)</td>
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</tr>
<tr>
<td></td>
<td>Non-PPO Participating Providers (Out-of-Network)</td>
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</tbody>
</table>

### 26. CHIROPRACTIC CARE

| Covered in full after you pay $15 per visit copayment (up to 20 visits per calendar year) and 10% for laboratory and x-ray services. Copayment does not apply if an office visit if not billed. | Not covered | You pay 20% after deductible (up to 20 visits per calendar year combined in and out-of-network). | You pay 20% after deductible (up to 20 visits per calendar year combined in and out-of-network). | You pay 20% after deductible (up to 20 visits per calendar year combined in and out-of-network). |

### 27. SIGNIFICANT ADDITIONAL COVERED SERVICES

**Treatment of Autism Spectrum Disorders**

Benefit level determined by type of service provided.

The following annual maximums based on calendar year, are effective for applied behavior analysis services for In and Out-of-Network services combined. We may exceed these maximums if required by law:

From birth to age eight (up to Member’s ninth birthday): 550 sessions of 25 minutes for each session In and Out-of-Network combined
Age nine to age eighteen (up to Member’s nineteenth birthday): 185 sessions of 25 minutes for each session In and Out-of-Network combined

When a member desires another professional opinion, they may obtain a second surgical opinion.

### 28. COVERED PROVIDERS

- Anthem Blue Cross and Blue Shield PPO Provider Network. See provider directory for complete list or refer to [www.anthem.com](http://www.anthem.com) or [www.bcbs.com](http://www.bcbs.com) for providers outside the state of Colorado.
- Non-contracted providers licensed or certified to provide covered benefits. *(You may incur higher out of pocket expenses with non-contracted providers.)*

EXCLUDED EXPENSES: Charges not covered include (partial list): Glasses & other vision hardware: hearing aids; cosmetic surgery except for injury or birth defects: purely custodial care; dental work except if done within 1 year of an accidental injury to sound natural teeth if an accident occurred while insured; surgery or treatment of Temporomandibular Joint Disorders; charges in excess of reasonable and customary; services considered experimental in nature; charges in connection with impregnation or fertilization; treatment of weak, strained, flat, unstable or unbalanced feet. Sexual Dysfunction: this plan does not pay for prescription drugs for treatment of sexual dysfunction, including but not limited to Viagra.

1. "Network" refers to a specified group of physicians, hospital, medical clinics and other medical care providers that your Plan may require you to use in order to get any coverage at all under the Plan, or that the Plan may encourage you to use because it pays more of your bill if you use their network providers (i.e., go in-network) than if you don’t (i.e., go out-of-network).
2. "Out-of-pocket maximum" The maximum amount you will have to pay for allowable covered expenses under a medical Plan, which may or may not include the deductible or copayments, depending on the contract for that Plan.
3. "Emergency care" means services delivered by an emergency care facility which are necessary to screen and stabilize a covered person. The Plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life-or limb-threatening emergency existed.
4. "Transplants" will be covered only if they are medically necessary and the facility meets clinical standards for the procedure.
Now you can get the health care you need without all the hassle!

Have a health question? Under the weather? With LiveHealth Online, you don’t have to schedule an appointment, drive to the doctor’s office, and then wait for your appointment. In fact, you don’t even have to leave your home or office. Doctors can answer questions, make a diagnosis, and even prescribe basic medications when needed.

With LiveHealth Online, you get:
- Immediate doctor visits through live video.
- Your choice of U.S. board-certified doctors.
- Help at a cost of only $49 per visit, subject to deductible and coinsurance.
- Private, secure and convenient online visits.

What are the qualifications of the doctors you consult via LiveHealth Online?
- U.S. board-certified.
- Average 15 years practicing medicine.
- Mostly primary care physicians.
- Specially trained for online visits.

When can you use LiveHealth Online?
As always, you should call 911 with any emergency. Otherwise, you can use LiveHealth Online whenever you have a health concern and don’t want to wait. Doctors are available 24 hours a day, seven days a week, 365 days a year. Some of the most common uses include:
- Cold and flu symptoms such as a cough, fever and headaches
- Allergies
- Sinus infections
- Family health questions

Start a conversation now.
Just enroll for free at livehealthonline.com or on the app, and you’re ready to see a doctor.
Medical Plans—Appeal Process

Medical Plan Complaints, Appeals and Grievances

If you disagree with Anthem’s denial, in whole or in part, of a medical claim, requested service or supply, you are advised to follow the instructions below, provided by Anthem, which detail the processes for initiating a complaint, filing an appeal or filing a grievance.

Complaints

If a member has a complaint about any aspect of Anthem’s service or claims processing, the member should contact Anthem’s customer service department. A trained representative will work to clear up any confusion and resolve the member’s concerns. A member may submit a written complaint to the address listed below. If the member is not satisfied with the resolution of their concerns by the Anthem customer service associate, the member may file an appeal.

Appeals

While Anthem encourages members to file appeals within 60 days of the adverse benefit determination, the member’s written appeal must be received by Anthem within 180 days of the adverse benefit determination. Anthem will assign a Customer Advocate to assist the member in the appeal process. Members may send written appeals to the following address:

Anthem
Appeals Department
700 Broadway CAT 0430
Denver, CO 80273-0001

An appeal may be filed with or without first submitting a complaint. In the appeal, the member must state plainly the reason(s) why the claim or requested service or supply should not have been denied. The member should include any documents not originally submitted with the claim or request for the service or supply and any information that may have a bearing on Anthem’s decision.

For a thorough, unbiased review, the member may access two internal levels of appeal. In the case of a benefit denial based on utilization review, an independent external review appeal is also available to the member.

Members may designate a representative (e.g., the member’s physician or anyone else of the member’s choosing) to file any level of appeal review with Anthem on the member’s behalf. The member must give this designation to Anthem in writing.

Level 1 Appeal — This is an appeal in which Anthem appoints an internal person(s) not involved in the initial determination to review the denial of the claim, requested service or supply. A person that was previously involved with the denial may answer questions. The person(s) appointed to review a Level 1 Appeal involving utilization review shall consult with an appropriate clinical person(s) in the same specialty as would typically manage the case being reviewed. For utilization review issues, the member will receive a response to the member’s Level 1 Appeal within 20 workdays of receipt of the appeal request. Non-utilization review appeals will typically be resolved within 30 workdays.

Anthem will issue a copy of the written decision to the member and to the provider who submits an appeal on the member’s behalf, if any, within 50 workdays of Anthem’s receipt of the Level 2 Appeal request. A member or member’s representative has the right to request an expedited appeal of a utilization review decision when the timeframes for a standard review would: seriously jeopardize the life or health of the covered person; jeopardize the covered person’s ability to regain maximum function; or for persons with a disability, create an imminent and substantial limitation on their existing ability to live independently. Typically the decision will be made within 72

Level 2 Appeal — This is an appeal of an adverse benefit determination that has not been resolved to the member’s satisfaction under the Level 1 Appeal process. The Level 2 Appeal must be requested within 60 calendar days after the Anthem adverse determination from the Level 1 Appeal. The member may appear or be teleconferenced in to present testimony, introduce documentation the member believes supports their appeal and provide documentation requested by Anthem at a hearing concerning the appeal.

The panel of reviewers shall include a minimum of three people and may be composed of Anthem associates who have appropriate professional expertise. A majority of the panel shall be comprised of persons who were not previously involved in the dispute; however, a person who was previously involved with the dispute may be a member of the panel or appear before the panel to present information or answer questions. In the case of utilization review appeals, the majority of the persons reviewing the appeal shall be health care professionals who have appropriate expertise. Such reviewing health care professionals shall meet the following criteria:

- Have not been involved in the care previously.
- Is not a member of the board of directors of the health plan.
- Have not been involved in the review process for the covered person previously.
- Do not have a direct financial interest in the case or in the outcome of the review.

Anthem also reserves the right to request an expedited appeal of a utilization review decision when the timeframes for a standard review would: seriously jeopardize the life or health of the covered person; jeopardize the covered person’s ability to regain maximum function; or for persons with a disability, create an imminent and substantial limitation on their existing ability to live independently. Typically the decision will be made within 72

- Have not been involved in the care previously.
- Is not a member of the board of directors of the health plan.
- Have not been involved in the review process for the covered person previously.
- Do not have a direct financial interest in the case or in the outcome of the review.

Anthem will issue a copy of the written decision to the member and to the provider who submits an appeal on the member’s behalf, if any, within 50 workdays of Anthem’s receipt of the Level 2 Appeal request. A member or member’s representative has the right to request an expedited appeal of a utilization review decision when the timeframes for a standard review would: seriously jeopardize the life or health of the covered person; jeopardize the covered person’s ability to regain maximum function; or for persons with a disability, create an imminent and substantial limitation on their existing ability to live independently. Typically the decision will be made within 72

- Have not been involved in the care previously.
- Is not a member of the board of directors of the health plan.
- Have not been involved in the review process for the covered person previously.
- Do not have a direct financial interest in the case or in the outcome of the review.

Anthem will issue a copy of the written decision to the member and to the provider who submits an appeal on the member’s behalf, if any, within 50 workdays of Anthem’s receipt of the Level 2 Appeal request. A member or member’s representative has the right to request an expedited appeal of a utilization review decision when the timeframes for a standard review would: seriously jeopardize the life or health of the covered person; jeopardize the covered person’s ability to regain maximum function; or for persons with a disability, create an imminent and substantial limitation on their existing ability to live independently. Typically the decision will be made within 72

- Have not been involved in the care previously.
- Is not a member of the board of directors of the health plan.
- Have not been involved in the review process for the covered person previously.
- Do not have a direct financial interest in the case or in the outcome of the review.

Anthem will issue a copy of the written decision to the member and to the provider who submits an appeal on the member’s behalf, if any, within 50 workdays of Anthem’s receipt of the Level 2 Appeal request. A member or member’s representative has the right to request an expedited appeal of a utilization review decision when the timeframes for a standard review would: seriously jeopardize the life or health of the covered person; jeopardize the covered person’s ability to regain maximum function; or for persons with a disability, create an imminent and substantial limitation on their existing ability to live independently. Typically the decision will be made within 72
hours. Expedited appeals will be evaluated by an appropriate clinical peer or peers who were not involved in the initial denial. Anthem will not provide an expedited review for retrospective denials.

Level 3 Appeal — These are conducted by an independent third party and are available only in those circumstances where benefits were denied and which have gone through the Anthem Level 2 Appeal process. To request a Level 3 Appeal, contact the Colorado State University’s Human Resources Department at the following address:

Colorado State University  
c/o Human Resources  
6004 Campus Delivery  
Fort Collins, CO 80523-6004

The request for a Level 3 appeal must be made within 60 calendar days after the Anthem Level 2 denial.
Health Savings Account (HSA)—Ram Plan-HDHP + HSA

Health Savings Account Administered by Fidelity Investments

24-hour automated account access

(800) 343-0860
http://plan.fidelity.com/cs

The Ram Plan-HDHP + HSA—is it right for you? This plan allows you to enroll in an HSA.

An HSA is designed to help you save for healthcare expenses such as deductibles or co-insurance, for medical, dental, and vision. You may not enroll in the HSA if you are in the Gold, Green or POS plans as they do not meet specified regulatory requirements for a high deductible health plan.

The HSA also helps you to pay for those expenses on a pre-tax basis, saving you federal and often state taxes. An HSA offers triple tax savings to save as much as you can now up to IRS maximums and reap the rewards of a nice nest egg at retirement, if you do not spend the money on healthcare.

The 2019 maximum annual amount that can be contributed to an HSA is $3,500 for an individual or $7,000 for family HDHP coverage, which is employee + 1 or family coverage. To help build your account quickly, CSU will deposit $500 in your HSA account in 2019; IRS contribution maximums are reduced the employer deposit. If you wish to contribute, you may do so pre-tax through payroll deduction.

You never lose funds in an HSA as they roll over from year to year. While CSU is required to report HSA contributions on your W-2, it is your responsibility as the individual account owner to not exceed the IRS allowed maximum.

<table>
<thead>
<tr>
<th>FSA or HSA</th>
<th>FSA</th>
<th>HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulatory Summary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Funds can be used to pay for out-of-pocket medical expenses including deductibles</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Employees over age 55 can make catch-up contributions up to an additional $1,000 per year</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Maximum annual contribution in 2019 is $2,700</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Combined employee / employer 2019 maximum contributions of $3,500 for individuals, $7,000 for families</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Available with Green, Gold, and POS Plans</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Automatic enrollment with the Ram Plan — HDHP</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Enrollment allowed even if covered elsewhere in a non-HDHP medical plan</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Eligible if enrolled in Medicare</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Eligible if spouse has an FSA</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Access 100% of annual election as of January 1, regardless of what has been contributed</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>You can spend only what you have contributed</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Unused balance rolls over from year to year</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Contributions are made on a pre-tax basis</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>You can take it with you if you change jobs or retire</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>CSU contributes $500 to the account in 2019</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>You cannot be covered by a non-HDHP at the same time you are covered by the Ram Plan-HDHP</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Can be claimed as a dependent on another person’s tax return</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Requires a valid US address</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Allows you to invest your funds in a mutual fund as long as account balance is at least $500</td>
<td>NO</td>
<td>YES</td>
</tr>
</tbody>
</table>
Plan Description

CSU offers two dental plans for employees to choose from: Delta Dental Basic and Delta Dental Plus. Both plans are self-insured and administered, including claims processing, by Delta Dental of Colorado.

Following is a Summary of the Dental Benefits which outlines the specific benefits of each plan.

Enrollment/Changes

Refer to Enrollment and Changes in the Administrative Provisions section.

Coverage

Dental coverage is not required. Please review the following Summary of Dental Benefits to determine which plan, if any, is best for you and your family.

Premiums

Refer to the Premium Summary section for rates.

Termination of Coverage

Refer to Termination of Coverage in the Administrative Provisions section for eligibility and rights to continue insurance.

Delta Dental on the Web
(Subscriber Connection www.deltadentalco.com)

- Print ID Card
- Find a Dentist
- Check on Claim Status
- View Benefits
- Print Explanation of Benefits (EOB)

Claims Payments

For both dental plans, claims must be submitted within 12 months from the date of service. If submitted after 12 months, the plan will not make payment.

Dental Providers

You may obtain care from any licensed dentist. Neither dental plan requires the use of network dental providers. The Delta Dental Basic plan does not have an associated network. The Delta Dental Plus Plan has two networks (PPO and Premier). You will receive the best benefits by choosing a PPO dentist.

Coordination of Benefits

Delta Dental Basic

This dental reimbursement plan is always considered the secondary payer when a covered employee or dependent is also covered by another dental insurance plan.

Payments will only be processed after a determination has been made by the other dental plan. This Plan will provide Benefits, which together with the other Plan will not exceed 100% of the allowable expenses.

Delta Dental Plus

When employees and/or dependents are covered by this plan and another dental plan, coordination of benefits will be administered in the following manner. For children covered as dependents on this plan and as dependents on a spouse, domestic partner or a civil union partner’s plan, the plan of the individual whose birthday falls first in the calendar year will be the primary payer. In the case of spouses, domestic partners or civil union partner’s plan where coverage is other than as a dependent will be the primary payer.

If this plan is Secondary, this plan will provide Benefits which together with the other plan will not exceed 100% of the allowable expense of this plan’s maximum benefit.

Pre-Determination of Benefits

Pre-determination of benefits is recommended for any expensive dental services. The typical guideline for obtaining a predetermination of benefits is approximately $400. This will allow you to determine in advance whether a proposed service is covered under the plan and, if covered, the extent of any deductibles and other out of pocket expenses.

Health Care Flexible Spending Accounts

Many unreimbursed dental expenses are considered eligible expenses for a Flexible Spending Account (FSA). Please refer to the FSA section for details.
This plan reimburses for covered services regardless of the frequency of service and without applying Maximum Plan Allowance guidelines, up to the plan’s maximum benefit.

Providers
Freedom of choice – as long as the provider is a licensed dentist. Dental benefits under the Delta Dental Basic Plan (a dental reimbursement plan) are not subject to any contractual arrangements between Delta Dental and the dental providers limiting the amount charged. Dental providers will charge their usual fees to members. There is no dental network associated with this plan.

Exclusions (what this plan does not cover)
- Orthodontia
- Jaw joint problems (generally known as TMJ)
- Any expenses payable by other dental plans under which you or your dependents are covered.

Claims Payments
Claim payments for the Delta Dental Basic Plan will be made direct to the member even if the dentist accepts assignment of benefits. You will be responsible for payment to the dentist. If your dentist will not submit the claim for you, you will need to complete a claim form and submit it to Delta Dental of Colorado. Claim forms are available at www.deltadentalco.com and www.hrs.colostate.edu/benefits/fap-insplans-ancillary.html

A separate claim form must be submitted for each member. Claims must be submitted within 12 months from the date of service or no payment will be made from the plan.

Claims Address
P.O. Box 173803
Denver, CO 80217-3803

Delta Dental Plus

Plan Description
This is a dental insurance plan which allows for varying levels of benefit payments depending upon the type of service provided by your dentist. If you or enrolled dependents are also covered under another dental plan, the Plan’s coordination of benefits rules will apply.

Plan Coverage
Covered expenses will be reimbursed at the following levels after applicable deductibles.

Deductible
- The annual deductible is $50 per person or a maximum of 2 deductibles per family—$100.
- The deductible does not apply to Preventive or Orthodontic services.

Plan Maximums
- Preventive and Diagnostic services do not apply to the annual maximum, making your coverage last longer each year.
- Basic and Major services.
  - $1,750—Annual maximum; per member per calendar year (excludes any orthodontic services)
- Orthodontic Treatment and Appliances
  - $1,800—Lifetime maximum (excludes preventive and diagnostic, basic and major services)
Providers

Freedom of choice – You may use any licensed dentist. Maximum savings will be received when accessing care from a Delta Dental PPO Dentist.

Preventive and Diagnostic Dental Services—100% of Plan Allowable (no deductible)

- Routine oral examinations (2 times per calendar year)
- Routine cleanings (excludes periodontal.) (2 times per calendar year)
- Sealants on the occlusal surface of a permanent posterior tooth for dependent children. (every 3 years until age 16)
- Fluoride treatments for children. (2 times per calendar year until age 14)
- X-rays (in relation to preventive or diagnostic services only)
  - Bitewing x-ray series (2 times per calendar year)
  - Full mouth/Complete Set (every 2 years)
- Emergency palliative treatment for pain
- Space maintainers for covered Dependent Children until age 16 to replace primary teeth.

Basic Dental Services—80% of Plan Allowable (after deductible)

- Fillings, other than gold.
- Root canals. (including non-surgical endodontic treatment)
- Oral Surgery.
  - Oral surgery is limited to tooth removal or preparation of the mouth for dentures and removal of tooth generated cysts.
  - Administration of injectable antibiotic drugs.
- Recementing bridges, crowns or inlays.
- Periodontics. (gum treatments)
  - Including scaling and root planning. (four quadrants in any 24 month period)
- Periodontal Cleanings. (2 in 12 months)
- Non surgical services.
- General or intravenous anesthesia for oral surgery procedures or upon demonstration of dental necessity.

Major Dental Services—60% of Plan Allowable (after deductible)

- Crown, Inlays and Onlays
- Periodontic services. (surgical)
- Bridges (installation and repairs)
- Dentures (relining, rebasing and attachment points)
- Implants (non cosmetic)

Orthodontia—50% of Plan Allowable (no deductible)

- 50% of eligible charges up to a $1,800 lifetime maximum

Covered orthodontic procedures include:
- Moving teeth into proper alignment, position and occlusion
- Preliminary study, including x-rays, diagnostic casts, treatment plan and active treatment
- Post-treatment appliances (retainers); doesn’t include lost or broken appliances
- For an Orthodontic treatment plan started prior to the eligibility date of the patient, Delta Dental will begin periodic payments with the first payment due following the patient eligibility date. The maximum benefit will be determined based upon the prior payment records.

EXCLUSIONS

The following Services are not Benefits:

a) Services for injuries or conditions which are compensable under Worker's Compensation or employer's liability laws, or Services which are provided to the Covered Person by any federal or state government agency or are provided without cost to the Covered Person by any municipality, county or other political subdivision, or any Services for which the Covered Person would have no obligation to pay in absence of this coverage, except as such exclusion may be prohibited by law.

b) Any Covered Service Started when the person was not eligible for such Service under this Contract.

c) Services for treatment of congenital (present at birth) or developmental (following birth) malformations, except intraoral dental.

d) Services for treatment of a condition which is related to or developed as a result of cleft lip and/or cleft palate, unless otherwise included as a Covered Service.

e) Services for cosmetic reasons.

f) Services related to protecting, altering, correcting, stabilizing, rebuilding or maintaining teeth due to improper alignment, occlusion or contour.

g) Services related to periodontal stabilization of teeth.

h) Habit appliances, night guards, occlusal guards, athletic mouth guards and gnathological (jaw function) Services, bite registration or analysis, or any related Services.

i) Charges for prescription drugs.

j) Dental treatment which is experimental or investigational in nature and not yet approved by the American Dental Association.

k) Any procedures done in anticipation of future need.
(except Covered Preventive Services).

l) Hospital costs and any additional fees charged by the Dentist or hospital for hospital services or visits, or charges for use of any facility.

m) Orthodontic Services including any related diagnostic, preventive or interceptive Services (surgical and other treatment of malalignment of teeth and/or jaws), unless shown as covered on the Summary of Dental Plan Benefits.

n) Myofunctional therapy or speech therapy.

o) Services for the treatment of any disturbances of the temporomandibular joint (TMJ), facial pain, or any related conditions, including any related diagnostic, preventive or interceptive Services.

p) Services not performed in accordance with the laws of the State in which Services are rendered, Services performed by any person other than a person authorized by license to perform such Services, or Services performed to treat any condition, other than an oral or dental disease, malformation, abnormality or condition.

q) Oral hygiene instructions or dietary instructions.

r) Completion of forms, providing diagnostic information or records, or duplication of x-rays or other records.

s) Replacement of lost, stolen or damaged appliances.

t) Repair of appliances altered by someone other than a Dentist.

u) Any Services including any associated Services or procedures not specifically included in Covered Services.

v) Services for which charges would not have been made if this coverage had not existed, except for Services as provided under Medicaid.

w) Missed appointment charges.

x) Preventive control programs, including home care items.

y) Plaque control programs.

**Claim Payments**

Claims under the Delta Dental Plus plan will be processed according to Delta Dental’s processing standards and contractual arrangement with the dentist. Maximum savings are received when using a PPO Dentist.

**PPO Dentist** – Payment is based upon the PPO dentist’s allowable fee, or the fee actually charged, whichever is less.

**Premier Dentist** – Payment is based upon the Premier Maximum Plan Allowance, or the fee actually charged, whichever is less.

**Non-Participating Dentist** – Payment is based upon the Premier Maximum Plan Allowance, or the fee actually charged, whichever is less.

**Submission of Claims** – Delta Dental PPO and Premier dentists will submit claims direct to Delta Dental of Colorado and will only charge you the deductible and/or coinsurance you are responsible for (if any).

Non-participating dentists may require that you pay the full fee at time of service and submit your own claim. If your dentist will not submit the claim for you, you will need to complete a claim form and submit it to Delta Dental of Colorado. Claim forms are available at [www.deltadentalco.com](http://www.deltadentalco.com) and [www.hrs.colostate.edu/pdfs/delta-dental-claim-statement.pdf](http://www.hrs.colostate.edu/pdfs/delta-dental-claim-statement.pdf).

A separate claim form must be submitted for each member.

**Dental Plan Appeals**

**Adverse Benefit Determination**

An adverse Benefit Determination shall mean a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in

<table>
<thead>
<tr>
<th>Delta Dental Provider Comparison (Illustrative Purposes Only)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DELTA DENTAL PPO DENTISTS IN-NETWORK</td>
</tr>
<tr>
<td>Charged Fee (Filling)</td>
</tr>
<tr>
<td>Maximum allowed*</td>
</tr>
<tr>
<td>Benefit Percentage</td>
</tr>
<tr>
<td>Benefit</td>
</tr>
<tr>
<td>Member not Responsible</td>
</tr>
<tr>
<td>Member Pays</td>
</tr>
</tbody>
</table>

**PPO Dentist** – Payment is based upon the PPO dentist’s allowable fee, or the fee actually charged, whichever is less.

**Premier Dentist** – Payment is based upon the Premier Maximum Plan Allowance, or the fee actually charged, whichever is less.

**Non-Participating Dentist** – Payment is based upon the Premier Maximum Plan Allowance, or the fee actually charged, whichever is less.

You will receive the highest level of coverage by choosing a PPO dentist.

* Allowable fee for a PPO dentist is the fee schedule which the dentist has agreed to charge. Allowable fee for a Premier dentist is the maximum amount per procedure that a Premier dentist can charge based on their contractual agreement with Delta Dental. Allowable fee for a non-participating dentist is equal to the Premier maximum allowable fee, however the dentist may charge the additional balance to the patient as they are not under contract with Delta Dental.
part) for a benefit. An inquiry regarding eligibility or benefits without a Claim for benefits is not a Claim and therefore, cannot be appealed.

The Plan shall provide written or electronic notice of the determination on a Claim in a manner meant to be understood by the Claimant.

If the Claimant does not understand the reason for the Adverse Benefit Determination, the Claimant should contact the Claims Administrator at the address or telephone number printed on the Notice of Determination.

**Appeal Process**

A Covered Person has the right to appeal any adverse determination made on a claim, whether in whole or in part.

An appeal request may be submitted in writing within 180 days of the date of the original Explanation of Benefits to:

Delta Dental of Colorado
Appeals Analyst
PO BOX 172528
Denver, CO 80217-2528

A Covered Person may submit additional documentation in support of the appeal.

**Second Level Appeal**

If the Claimant does not agree with the Claims Administrator’s determination from the first level review, the Claimant may submit a second level appeal in writing within 60 days of the Claimant’s receipt of the Notice of Determination from the first level of review, along with any additional supporting information. Failure to appeal the determination from the first level of review within the 60 day period will render that determination final. The second level of review will be done by the Claims Administrator. The Claims Administrator will review the information initially received and any additional information provided by the Claimant, and make a determination on the appeal based upon the terms and conditions of the Plan and other relevant information. The Claims Administrator will send a written or electronic Notice of Determination for the second level of review to the Claimant within 30 days of receipt of the appeal.

**Third Level Appeal**

These are conducted by an independent third party and are available only in those circumstances where benefits were denied and which have gone through the Level 2 Appeal process.

To request a Level 3 appeal, contact:

**Benefits Appeal Committee**

c/o Human Resources  
Colorado State University  
6004 Campus Delivery  
Fort Collins, CO 80523-6004

The request for a Level 3 appeal must be made within 60 calendar days after the Level 2 denial.

**EyeMed Vision Discount Plan**

The EyeMed Discount Plan is available to all benefits eligible employees of Colorado State University and their benefit eligible dependents. The brochure and ID card for the plan can be downloaded from [www.eyemedvisioncare.com](http://www.eyemedvisioncare.com).
### 2019–Vision Plans

**Anthem, Vision Service Plan (VSP) and EyeMed Vision Care**

The benefit offerings include access to three separate vision plans. The CSU medical plans include eye exam benefits. A voluntary vision insurance plan through VSP is primarily intended as a materials plan (i.e. glasses, contacts), but also provides a secondary eye exam benefit. And thirdly, a discount vision plan is available at no cost through EyeMed Vision Care. Carefully review this summary and other materials referenced below for plan benefit information.

#### Anthem Medical Plans

The Green, Gold, Ram Plan-HDHP and POS medical plans allow participants one eye exam per calendar year subject to normal copays or deductibles and coinsurance (see SPD for complete plan details).

#### The VSP Vision Care Plan

VSP is a voluntary vision insurance plan. Exams and materials are subject to copays and annual benefit allowances. VSP offers contracted providers with discounted service fees.

<table>
<thead>
<tr>
<th>Description</th>
<th>Anthem Medical Plans</th>
<th>EyeMed Vision Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision Exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>POS Plan (POS, Gold, Green, &amp; Ram Plan-HDHP)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision Exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>POS Plan</td>
<td>POS Plan</td>
<td></td>
</tr>
<tr>
<td>• 15 copay every calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(In-network providers only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gold Plan</td>
<td>Gold Plan</td>
<td></td>
</tr>
<tr>
<td>• 80% after the $750 individual medical plan deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Green Plan</td>
<td>Green Plan</td>
<td></td>
</tr>
<tr>
<td>• 80% after the $1,000 individual medical plan deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ram Plan-HDHP</td>
<td>Ram Plan-HDHP</td>
<td></td>
</tr>
<tr>
<td>• 80% after the $1,500 individual medical plan deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Participating and Non-Participating Providers—Green, Gold, Ram Plan-HDHP)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Vision exam is limited to one routine eye exam per calendar year per member; lenses and hardware for glasses are not covered.

#### Note:

Vision exam expenses may only be submitted under one plan.

#### EyeMed Vision Care

A no cost discount plan available through Delta Dental. Discounts on exams and materials are through a discount card. Dental coverage enrollment is not necessary.

#### Anthem Medical Plans

<table>
<thead>
<tr>
<th>Features</th>
<th>Anthem Medical Plans</th>
<th>EyeMed Vision Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network coverage—VSP Providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision Exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription Glasses - $25 copay for lenses and/or frames</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lenses—single vision, lined bifocal, and lined trifocal lenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frames—polycarbonate lenses for dependent children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact Lens Care—In lieu of lenses and/or frame $150 allowance for contacts of your choice; no copay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact Lens Exam—every other calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-of-Network Coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exam—Up to $45</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single vision lenses—Up to $30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lined bifocal lenses—Up to $50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lined trifocal lenses—Up to $65</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frame—Up to $70</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contacts—Up to $105</td>
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<td></td>
</tr>
</tbody>
</table>

| Additional Discounts and Savings                                        |                      |                    |
| Glasses and Sunglasses—average 20-25% savings on non-covered lenses     |                      |                    |
| Options; 20% off additional glasses from any VSP doctor within 12 months of your VSP exam. |                      |                    |
| Contacts—15% discount on fitting and evaluation; copay up to $60        |                      |                    |
| Laser Vision Correction—average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities |                      |                    |
| Low Vision Benefits—refer to www.vsp.com                                |                      |                    |

#### Monthly Premiums

<table>
<thead>
<tr>
<th>Description</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$5.79</td>
</tr>
<tr>
<td>Employee + 1</td>
<td>$11.56</td>
</tr>
<tr>
<td>Family</td>
<td>$18.64</td>
</tr>
</tbody>
</table>

#### EyeMed Vision Care

<table>
<thead>
<tr>
<th>Discounts on exams and materials</th>
<th>Anthem Medical Plans</th>
<th>EyeMed Vision Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network Coverage Only</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discounts on eye exams</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scheduled pricing for lenses and lens options</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discounts on frames and conventional contact lenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Choice of any available frame</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unlimited frequency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discounts on LASIK and PRK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Replacement Contact Lens by mail program</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### EyeMed Provider Network

The network includes private practice optometrists, ophthalmologists, opticians, and some of the nation’s top optical retailers including LensCrafters, Target, Sears Optical and most Pearle Vision locations.
Vision Service Plan (VSP)
Group #30021702
(800) 877-7195

The following is a summary of the coverage available through the voluntary Vision Service Plan (VSP) and is not to be construed as the official plan document which governs claims administration. Please contact VSP for vision coverage related inquiries.

Plan Description

The Vision Care Plan is a voluntary vision insurance plan provided by VSP. Employee premiums are located in the Summary Monthly Premium section of this booklet. This plan provides exams and materials based on a co-pay and annual benefit allowance. Discounts provided by VSP doctors are not a negotiated benefit. VSP Doctors provide the discounts to the participant as a courtesy. To qualify for the extra discounts and savings, services and materials must be received within 12 months of the last covered eye exam from any VSP network doctor. If a participant utilizes Anthem or EyeMed for the eye exam, the VSP discount may be provided subject to the discretion of the VSP provider.

Enrollment/Changes

Refer to Enrollment and Changes in the Administrative Provisions section.

Coverage

Vision enrollment is voluntary and requires employee monthly contributions. Please review the following VSP Summary of Benefits to determine if this plan is beneficial for you and your family.

Premiums

Employee monthly premiums are located in the Summary Premium section of this booklet.

How to Use Your Vision Plan

- To obtain vision care services, call your VSP doctor. To locate a VSP network doctor, call VSP at (800) 877-7195 or visit their website at [www.vsp.com](http://www.vsp.com) or contact Human Resources at (970) 491-MyHR (6947).
- When making an appointment, identify yourself as a VSP member, provide your member identification number and the CSU group name/number. The VSP network doctor will contact VSP to verify eligibility and plan coverage and obtain authorization for eye exam services and eyewear.

Summary of Benefits

<table>
<thead>
<tr>
<th>Description</th>
<th>Level of Coverage from a VSP doctor</th>
<th>Non-VSP Doctor or Provider Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam - once every calendar year</td>
<td>Covered in full after $40 copayment</td>
<td>Reimbursed up to $45</td>
</tr>
<tr>
<td>Basic Lenses – once every calendar year</td>
<td>$25 copayment for lenses, frames or both lenses and frames</td>
<td></td>
</tr>
<tr>
<td>Single Vision</td>
<td>Covered in full after copayment</td>
<td>Reimbursed up to $30</td>
</tr>
<tr>
<td>Lined Bifocal</td>
<td>Covered in full after copayment</td>
<td>Reimbursed up to $50</td>
</tr>
<tr>
<td>Lined Trifocal</td>
<td>Covered in full after copayment</td>
<td>Reimbursed up to $65</td>
</tr>
<tr>
<td>Frames / once every other calendar year</td>
<td>Covered up to $150 allowance</td>
<td>Reimbursed up to $70</td>
</tr>
<tr>
<td>Contact lenses / once every calendar year</td>
<td>Covered up to $150 allowance</td>
<td>Reimbursed up to $105</td>
</tr>
</tbody>
</table>
When you arrive at your appointment, the VSP network doctor will provide an eye exam and determine if eyewear is necessary. The doctor will coordinate the prescription with a VSP approved lab if you choose to purchase glasses or contacts. The doctor will itemize any non-covered charges and have you sign a form to document that you received services.

**Note:** You will not receive a VSP membership card when enrolling in this voluntary benefit option. However, you may download a card at [www.vsp.com](http://www.vsp.com) which has your group number, co-pays and coverage level.

**Eyeglasses**

VSP covers in full single vision, lined bifocal, lined trifocal lenses. Polycarbonate lenses are covered for children (up to age 18). In addition to the coverage provided, VSP network doctors extend cost controls on lens options, which average 20-25% off the network doctor’s usual fees. Cost controlled options include but are not limited to, tints, scratch coating, UV protection, anti-reflective coating, photochromic lenses and progressive lenses (blended/no line).

Frames are covered in full up to $150 allowance. If a frame is selected over the VSP provided allowance, the patient is responsible for the additional amount. VSP doctors provide a 20% discount on amounts over the plan allowance. Typically if a patient selects a frame that is not in the VSP doctor’s inventory, the doctor can order the frame for you.

**Contact Lenses**

Contact lens services and materials are covered instead of frames and lenses. If a patient chooses to purchase contacts instead of glasses, the plan will cover up to $150 towards the doctor’s professional services and materials. Any costs exceeding this allowance are the patient’s responsibility.

You cannot receive both glasses and contacts in the same service period. VSP doctors provide a 15% discount off their professional services for contact lenses (fitting and evaluation).
Basic Term Life

The Hartford Life and Accident Insurance Company

Group Numbers
Basic Term Life - 677984

Basic & Voluntary AD&D - S07449

The following is a brief description of the coverage provided through this group plan. Coverage is governed at all times by the complete terms of the Master Group Insurance policy issued to Colorado State University. The basic group term life and AD&D Insurance Plan is provided by The Hartford Life and Accident Insurance Company. (Referred to as The Hartford or Hartford.)

General information about the plans is provided in this Summary Plan Booklet. Additional information is contained in the Certificate of Coverage, available on line at www.hrs.colostate.edu/benefits/fap-insplans.html

Plan Description

You are enrolled in $70,000 of University provided Basic Group Term Life and AD&D

- For non-accidental deaths, the basic group term life and AD&D Insurance benefit will be $70,000 less any age reduction (see Benefit Reduction) or Accelerated Death Benefit previously paid under this plan.

- For deaths resulting from an accident, the benefit will be equal to $140,000 ($70,000 basic group term life PLUS $70,000 Accidental Death), less any age reductions (see Benefit Reduction) or Accelerated Death Benefit previously paid under this plan.

Benefit Reduction

Basic group term life and AD&D Insurance Benefits reduce to 65% of the Plan coverage amount in January of the year following your 70th birthday and further reduce to 50% of the Plan coverage amount in January of the year following your 75th birthday.

Living Benefits Option (Accelerated Death Benefit)

Accelerated Death Benefits are available if you are diagnosed with a terminal illness, which is expected to result in your death within 12 months and from which there is no reasonable prospect of recovery. You may be eligible to receive up to 80% of your life insurance benefits up to a maximum of $56,000.

Continuation of Life Insurance Benefits Due to Total Disability

If You are Totally Disabled, your Life Insurance Benefits may be continued if:

- the Total Disability began while you were insured under this Policy;
- the Total Disability began before you reached age 60;
- You have completed your Disability Elimination Period; and
- Proof of the Total Disability is given to The Hartford as described.

You must notify The Hartford of your Total Disability during the Disability Application Period which is the nine consecutive months of Total Disability beginning on the date you first become Totally Disabled.

Actively At Work Provision

You must be actively at work for the coverage to begin. Please refer to the Certificate of Insurance from The Hartford for official plan details.

Beneficiary Designations

Beneficiary designations are made using CSU’s Online Benefits Enforcement System. The employee may change beneficiary designations at any time; the change will take effect as of the date signed.

Court Orders: Beneficiary designations may be governed by court orders involving participants. These orders may mandate that the life insurance beneficiary named be a spouse, former spouse, or child (ren). For these court orders to be honored by the life insurance carrier, it is imperative that Human Resources receives copies of any court orders addressing life

46
insurance. Also, the employee must take appropriate steps to change beneficiaries on file to reflect the court order.

**Termination of Coverage**

Your insurance will terminate at the end of the month in which your active service stops or you cease to be in a class of employees eligible for coverage.

**Conversion / Portability**

Subsequent to coverage termination, you will be contacted by The Hartford regarding your Conversion and/or Portability options. If you wish to convert (no age limit) or port (limited to age 70) your coverage, you must do so within 31 days of your notification date. Portability rates match the voluntary life rates; you must request a quote for Conversion rates from The Hartford. If you have questions about the coverage, contact The Hartford at (877) 320-0484.

**Value Added Services**

The Hartford includes several value added services at no cost to you.

**Travel Assistance with ID Theft Resolution Services**

Toll-free emergency assistance is available to you, your spouse, domestic partner, civil union partner or your children 24 hours a day, seven days a week when traveling 100 miles or more away from your primary home for 90 days or less. The Travel Assistance program provides three kinds of services for your business or vacation travels:

- Emergency medical assistance
- Emergency personal services
- Pre-trip planning

Sometimes travel emergencies can be complicated by a lost or stolen wallet or medical information compromised by identity theft. For this reason the travel assistance program is enhanced to include services for Identity Theft Protection & Assistance.

Identity theft is one of the fastest growing crimes in the United States today. And while you may take precautions to protect yourself, anyone can be the victim of ID theft. The identity theft program provides education to prevent or avoid ID theft and resolution services if you suffer the unfortunate experience of having your identity stolen.

Identity Theft Protection and Assistance service relieves the time burden and personal stress caused by identity theft. Caseworkers are available 24/7 to act as your advocate, advising and handling certain administrative tasks on your behalf to rectify any issues you may encounter as a result of identity theft.

The Hartford’s Travel Assistance and Identity Theft Resolution programs are provided by Europ Assistance USA, a leader in the assistance industry. Europ Assist has been helping customers in times of crisis for more than 46 years. They have the expertise to handle the complex issues involved with travel emergencies and identity theft.

Services include:

- Medical referrals
- Medical monitoring
- Medical evacuation
- Repatriation
- Traveling companion assistance
- Dependent children assistance
- Visit by a family member or friend
- Emergency medical payments
- Return of mortal remains
- Medication and eyeglass assistance
- Sending and receiving emergency messages
- Emergency travel arrangements
- Emergency cash
- Locating lost items (i.e. wallet)
- Legal assistance
- Bail advancement
- Translation services
- Identity theft awareness and education
- Identity theft victim solutions

If you would like information, please visit www.thehartford.com/employeebenefits

**Note:** Some restrictions and exclusions apply. See the website for full details.

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Collect from other locations: (202) 828-5885
Fax: (202) 331-1528

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Voluntary Group Term Life

The Hartford Life and Accident Insurance Company

Group #677984

The following is a brief description of the coverage available through this group plan. Coverage is governed at all times by the complete terms of the Master Group Insurance policy issued to Colorado State University.

The voluntary group term life insurance Plan is provided by The Hartford Life and Accident Insurance Company. (Referred to as The Hartford or Hartford.)

Plan Description

This voluntary group term life insurance plan is an optional plan, which allows you to choose levels of coverage, in increments of $10,000, up to $500,000 for the employee and up to $300,000 for the spouse, domestic partner or civil union partner of the employee. You can also elect coverage for your eligible children who are at least 14 days old, up to age 26. Premiums are after-tax and based on your age and the level of coverage you elect.

If you are enrolling your spouse, domestic partner or civil union partner, the premiums will be based on your age and the level of coverage you are electing. If your spouse, domestic partner or civil union partner is also a benefits eligible CSU employee, you may not carry duplicate life coverage (spouse, domestic partner or civil union partner and children). If life insurance coverage is desired, each employee must enroll separately and may not cover the spouse, domestic partner or civil union partner as a dependent for life insurance purposes. Dependent children can be insured under only one parent.

Complete details of this benefit are available in the Certificates of Coverage online at www.hrs.colostate.edu/benefits/fap-insplans.html

Benefit Reduction

Life insurance benefits reduce to 65% of the prior coverage in January of the year following the 70th birthday and further reduce to 50% of the amount of prior coverage in January of the year following the 75th birthday. Premiums will be based on the reduced coverage.

Living Benefits Option

(Accelerated Death Benefit)

Accelerated Death Benefits are available if you are diagnosed with a terminal illness, which is expected to result in your death within 12 months and from which there is no reasonable prospect of recovery. You may be eligible to receive up to 80% of your life insurance benefits up to a maximum of $400,000.

The following Voluntary Group Term Life Exclusions apply: results from suicide, while sane or insane within one year from the date insurance begins. Results from suicide, while sane or insane, within one year from the effective date of any increase in the amount of coverage, the amount of the increase will not be paid.

Continuation of Life Insurance Benefits Due to Total Disability

If You are Totally Disabled, Your Voluntary group term life insurance benefits may be eligible to continue without payment of premium provided:

(a) the Total Disability began while you were insured under this Policy;
(b) the Total Disability began before You reached age 60;
(c) You have completed Your Disability Elimination Period; and
(d) Proof of the Total Disability is given to The Hartford as described.

You must notify The Hartford of Your Total Disability during the Disability Application Period which is the nine consecutive months of Total Disability beginning on the date you first become Totally Disabled. If you exercise your portability privilege, you will not be eligible for waiver of premium due to total disability.

New Hire/Newly Eligible Initial Enrollment

Coverage up to Guarantee Issue Amounts

You may enroll within 30 days of your eligibility date. "Initial" enrollments up to $250,000 in coverage will be guaranteed for the employee, $50,000 guaranteed for the spouse, domestic partner or civil union partner and child life may be added automatically without requiring evidence of insurability.

Coverage above Guarantee Issue Amounts

Initial enrollments in excess of $250,000 for the employee or $50,000 for the spouse, domestic partner or civil union partner will require completion/approval of a Personal Health Application (Evidence of Insurability).

Effective Date

Coverage for guaranteed issue amounts is generally effective the first of the month following your hire/change date providing you meet any applicable actively at work provisions. Insurance premiums are paid in the month of coverage.

For coverage over the guaranteed issue amount, coverage will be effective upon approval from The Hartford.

Actively At Work Provision

You must be actively at work for initial coverage or policy increases to begin. Please refer to the Certificate
of Insurance from The Hartford for official plan details.

**Children’s Life Insurance $20,000**

Child(ren) rates are per UNIT. A unit consists of all eligible child(ren) per family. If your spouse, domestic partner or civil union partner also works at CSU and is eligible for the CSU Benefits Plan, only one of you may choose children’s life insurance coverage. Duplicate coverage is not allowed under this plan.

![Child(ren) Rate Table](image)

<table>
<thead>
<tr>
<th>Child(ren)</th>
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**Benefits Open Enrollment**

**Employee Group Term Voluntary Life**

You may apply for voluntary group term life insurance coverage from $10,000 to $500,000 in $10,000 increments. During the Benefits Open Enrollment period, you can enroll, apply for an increase, decrease, or cancel your spouse, domestic partner or civil union partner voluntary group term life insurance coverage.

Open Enrollment allows you to commence or increase your spouse, domestic partner or civil union partner voluntary group term life coverage in increments of $10,000 up to $30,000 automatically, unless the total policy amount exceeds $50,000, which requires completion/approval of a Personal Health Application (Evidence Insurability).

In addition, for any change, you must enter it in the CSU Online Benefits Enrollment System. Changes made during the Open Enrollment Period will become effective the first of the following plan year.

**Effective Date**

Coverage will not become effective until the later of: the first day of the calendar year after the annual Open Enrollment period ends; the date underwriting approval is granted if applicable; or the first day that you are actively at work after the change is requested.

Coverage will be effective on January 1st of the following calendar year, or the first of the month following the date of the approval notice from The Hartford if the amount applied for requires approval of the Personal Health Application (Evidence Insurability).

You and your eligible dependents must be actively at work for the coverage to begin. Please refer to the Certificate of Insurance from The Hartford for official plan details.

**Qualifying Events Incurred Outside of the Open Enrollment Period**

**Decreases in coverage**

You can decrease or cancel your coverage at any time by making the change in the CSU online enrollment system.

**Increases in coverage**

Applications for increases in coverage outside of the Open Enrollment period are only approved if you have incurred a qualifying event, subject to restrictions, and as defined in the “Change in Coverage” section of the Certificate of Insurance from The Hartford. Application must be made within 30 days from the qualifying event.

The employee and spouse, domestic partner or civil union partner may enroll in coverage up to the guaranteed issue amounts without evidence of insurability when they experience a qualifying event. Guarantee issue amounts are $250,000 employee, $50,000 spouse, domestic partner or civil union partner and $20,000 child(ren).

If you request coverage in excess of guaranteed issue amounts, approval amounts, completion of a Personal Health Application (Evidence of Insurability) and approval by The Hartford is required. Qualifying events are the determining factor in what may be changed mid-year to allow employees flexibility in modifying coverage mid-year.

**Effective Date**

Coverage will be effective the first of month following the specific life event date or the first of the month following the date of the approval notice from The Hartford if the amount applied for requires approval of an Evidence of Insurability Form. You and your eligible dependents...
must be actively at work for the coverage to begin. Please refer to the Certificate of Insurance from The Hartford for official plan details.

**Premiums**

Premiums for the Voluntary group term life insurance are made by post-tax deduction only. Premiums are based on your age as of January 1st of each calendar year.

**To calculate monthly premium**
Locate the amount of coverage you wish to select along the top row of the Employee table. Then locate your age bracket along the left column of the table. Your monthly premium is the amount located where the row and column you have identified meet (down from top row and right from left column). Follow the same method to determine your spouse, domestic partner or civil union partner rate.

The child rate is a flat rate of $1.50 regardless of the number of children you have.

Total the Employee, Spouse, Domestic Partner or Civil Union Partner, if applicable, and Child (if any) rates to obtain your Total Monthly Premium.

**Beneficiary**

Beneficiary designations are made using CSU’s Online Benefits Enrollment System. The employee may change beneficiary designations at any time; the change will take effect as of the date entered in the online system or signed. Court Orders: Beneficiary designations may be governed by court orders involving participants. These orders may mandate that the life insurance beneficiary named be a spouse, former spouse, or child (ren). For these court orders to be honored by the life insurance carrier, it is imperative that Human Resources receives copies of any court orders addressing life insurance. Also, the employee must take appropriate steps to change beneficiaries on file to reflect the court order.

**The employee is the beneficiary for any eligible Spouse, Domestic Partner, Civil Union Partner or Children enrolled in the plan.**

For further details on beneficiary designation and other information, refer to the Certificate of Coverage.

**Termination of Coverage**

Your insurance will terminate at the end of the month in which your active service stops, you cease to be in a class of employees eligible for coverage, you cease to make the required contribution, or the Plan is terminated.

Eligible individuals coverage terminates as of the last day of the month in which the individual loses eligibility (i.e., divorce, termination of a domestic partnership or civil union partnership, attainment of age 26 for voluntary group term life or the last day of the calendar month when the employees insurance terminates, whichever occurs first.)

**Conversion / Portability**

Subsequent to coverage termination, you will be contacted by The Hartford regarding your Conversion and/or Portability options. If you wish to convert (no age limit) or port (limited to age 70) your coverage, you must do so within 31 days of your notification date.

Portability rates match the voluntary life rates; you must request a quote for Conversion rates from The Hartford. A child reaching the plans limiting age of 26 is not eligible for Portability, but may apply for Conversion. If you have questions about the coverage, contact The Hartford at (877) 320-0484.

**Value Added Services**

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Voluntary Employee Life coverage may be purchased in $10,000 increments up to $500,000. Voluntary Spouse, Domestic Partner or Civil Union Partner Life coverage may be purchased in $10,000 increments up to $300,000.
Benefits Open Enrollment

Enrollment
You may enroll, cancel, or change your coverage level during the Benefits Open Enrollment period each year.

Effective Date
Coverage will be effective January 1st of the following calendar year providing you meet any applicable actively at work provisions.

Outside of Open Enrollment

Enrollment
At any time of the year, you can cancel or decrease your coverage by making the change in the CSU Online Benefits Enrollment System.

Amount of Insurance
You may elect any multiple of $25,000 up to a Maximum Amount of $500,000.

Amount of Insurance under Dependent Coverage
The amount of insurance on each of your eligible Dependents is a percent of your amount of Employee Insurance under the Coverage. The percent that applies on any date is shown below. It is based on the persons who are then your eligible dependents.

- Your spouse, domestic partner or civil union partner: 60%
- Your child(ren): 25% on each child
- Your spouse, domestic partner or civil union partner and child(ren): 50% on your spouse, domestic partner or civil union partner, and 15% on each child.

Dependent Coverage
Your dependents are covered as long as they remain eligible. For Voluntary AD&D Insurance, a dependent means any of your children from live birth to 26 years of age.

Exceptions: Your spouse, domestic partner, civil union partner, or child is not eligible for enrollment while on active duty in the armed forces of any country or when insured under the Group Contract as an employee.

It is your responsibility to remove any ineligible individuals within 30 days of a qualifying event. For example, when the child no longer meets the age requirement (turns 26 or becomes an ineligible dependent prior to age 26, or you divorce.)

Termination of Coverage
Your insurance will terminate at the end of the month in which your active service stops, you cease to be in a class of employees eligible for coverage, you cease to make the required contribution, or the plan is terminated.

Actively At Work Provision
You must be actively at work for the coverage to begin. Please refer to the Certificate of Insurance from The Hartford for official plan details.

Conversion
Subsequent to coverage termination, you will be contacted by the Hartford regarding your Conversion options. If you wish to convert your coverage, you must do so within 31 days of your notification date. You must request a quote for Conversion rates from The Hartford. If you have questions, about the coverage, contact The Hartford at (877) 320-0484.

Portability Policy
There is no Portability Policy available for this plan.

Beneficiary Designation
You may name any beneficiary(ies) you wish. If you purchase coverage for your family under the Family Plan, you are automatically your dependents’ beneficiary for loss of life. You may change your beneficiary at any time.
**Accidental Death & Dismemberment Benefit**

**Full Amount of Insurance**
- Loss of life or
- Loss of one hand & one foot, or
- Loss of both hands or both feet, or
- Loss of either hand or foot and sight of one eye, or
- Loss of speech & hearing of both ears

**One-half the Full Amount of Insurance**
- Loss of either hand or foot, or
- Loss of sight of one eye, or
- Loss of speech or hearing of both ears

**Three-Quarters the Full Amount of Insurance**
- One-quarter the Full Amount of Insurance
  - Loss of thumb and index finger of either hand.

**Paralysis Benefit**

**Full Amount of Insurance**
- Quadriplegia (loss of movement of both upper and lower limbs)
- Paraplegia (loss of movement of both upper and lower limbs)
- Triplegia (loss of movement of three limbs)
- Hemiplegia (loss of movement of both upper and lower limbs on one side of the body)

<table>
<thead>
<tr>
<th>2019—Voluntary AD&amp;D Coverage and Benefit Amounts</th>
<th>Monthly Premiums</th>
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<tbody>
<tr>
<td><strong>Employee</strong></td>
<td><strong>Spouse, Domestic Partner or Civil Union Partner</strong></td>
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<tr>
<td>$25,000</td>
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One-Quarter the Full Amount of Insurance
Uniplegia (loss of movement of one limb.)

Monthly COMA Benefit
If a covered insured is injured in a covered accident, which results in a coma for at least 31 consecutive days, the Program will begin payment of a Monthly Coma Benefit. Payment of this benefit will continue each month as long as the insured person remains in a comatose condition, up to a maximum of 100 months. This benefit will be paid at a rate of 1% of the Amount of Insurance less any benefits paid as a result of the same covered accident.

(“Coma” means complete and continuous unconsciousness; and inability to respond to external or internal stimuli, as verified by a physician.)

Extended Dependents Coverage
If you elect the Family Plan coverage and die in a covered accident, your family’s coverage may be continued, at no cost to your family, for a specified period, from the date of your death, provided your spouse, domestic partner, civil union partner and/or dependent children remain eligible under the Plan.

Child Care Expenses Benefit
If you elect the Family Plan coverage and die in a covered accident, the Plan will provide child care assistance to each eligible dependent child who is enrolled in a licensed child care center, or who enrolls in a licensed child care center within 90 days from the date of the covered accident. This important benefit pays 5% of your Amount of Insurance up to $5,000 annually for up to 4 consecutive years, paid annually. If you have no eligible children who qualify, the Plan will pay a lump sum of $500 to your beneficiary.

Spouse, Domestic Partner or Civil Union Partner Education Benefit
If you elect the Family Plan coverage and you die in a covered accident, the Plan will provide a Occupational Training Benefit to your eligible spouse, domestic partner or civil union partner. The expense must be incurred within 2 years of the employee’s date of death. This Training Benefit is a lump-sum payment of the lesser of 5% of your Amount of Insurance or $5,000.

Child Education Benefit
If you elect the Family Plan coverage and die in a covered accident, the Plan will provide an Child Education Benefit to each eligible dependent child who is a full-time student at a college, University, vocational school, or trade school over the 12th grade level at the time of (or enrolls within 365 days of) your death.

This Child Education Benefit is an annual payment of the lesser of 5% of your Amount of Insurance or $5,000. Payments will be made each year for up to 4 consecutive years for each child who qualifies. Benefit payments will cease when the child ceases to be a full-time student or reaches the age of 26. If there are no dependent children who qualify for this benefit, a single lump sum of $500 will be paid to your beneficiary.

Seat Belt/Air Bag Benefit
Because of the added protection seat belts and air bags bring to drivers and passengers every day, this special benefit is provided for you and your family members. If, while insured for this benefit, you or your covered dependent suffer accidental death due to a covered accident in which you or your covered dependent was seated in an automobile with a seat belt properly fastened, the Plan will pay an additional 10% of the Principal Sum, to a maximum of $25,000. An additional Air bag benefit may be payable if the injured person was positioned in a seat equipped with a factory-installed Air Bag and properly strapped in the seat belt when the Air Bag inflated. The Air Bag Benefit pays 5% of the Principal Sum to a maximum of $5,000.

Critical Burn Benefit
If an Insured Employee is accidentally critically burned and requires reconstructive surgery, as determined by a physician, a Critical Burn Benefit may be payable. This Benefit will be equal to the lesser of 25% of the Employee’s Principal Sum or $25,000.

(Critically Burned means burns are certified by a Physician as more severe than second degree burns and result in scarring over at least 25% of the body which will last indefinitely and can only be corrected through reconstructive surgery.)

Exposure & Disappearance
A loss will be covered if an Insured is exposed to the elements because of a covered accident due to forced landing, stranding, sinking or wrecking of a conveyance in which the insured was an occupant at the time of the accident. We will presume an insured suffered a loss of life if his or her body has not been found within one year after a covered accident involving the disappearance of a conveyance in which the insured was an occupant at the time due to accidental forced landing, stranding, sinking or wrecking.

War Risk Benefit
This benefit amends the limitation of the Contract, to offer coverage if death or dismemberment is related to an act of War, whether or not declared. The benefit covers Worldwide territories, excluding the geographical limits, territorial waters, or the airspace above the countries listed below as defined within the
A Loss is not covered if it results from any of these:

1. Intentionally self-inflicted Injury;
2. Suicide or attempted suicide, whether sane or insane;
3. War or act of war, whether declared or not;
4. Injury sustained while on full-time active duty as a member of the armed forces (land, water, air) of any country or international authority;
5. Injury sustained while On any aircraft except a Civil or Public Aircraft, or Military Transport Aircraft;
6. Injury sustained while On any aircraft:
   (a) as a flight instructor or examiner;
   (b) being used for tests, experimental purposes, stunt flying, racing or endurance tests;
   (c) if it is owned, operated or leased by or on behalf of the Policyholder, or any Employer or organization whose eligible persons are covered under The Policy; or
   (d) as a pilot, crewmember or student pilot;
7. Injury sustained while riding or driving in the United States of America, including the District of Columbia.

Only one benefit, the largest to which the owner is entitled, is payable for all losses resulting from one accident. No loss sustained prior to such covered accident shall be included in determining the amount payable.

Value Added Services

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Call (866) 854-5429 or visit www.hartfordlifeconversations.com for more information.
Administered by—Human Resources

The group plan summarized below applies to short-term disabilities commencing on or after January 1, 1999, and is subject to the terms and conditions of this Plan Document for Colorado State University's self-insured Short-Term Disability (STD) Income Replacement Plan. While the plan is intended and expected to continue, the University reserves the right to discontinue or revise it at any time.

Plan Description

1. Short-Term Disability insurance is provided at no cost to you. The plan provides a continuation of income in the event of illness, injury, surgery, or pregnancy for enrolled employees who exhaust their sick and annual leave balances. This plan provides for continuation of the monthly base salary beyond the exhaustion of accrued paid sick and annual leave up to the 60th continuous work day of absence caused by an eligible disability (illness, injury, surgery, or pregnancy). Replacement of covered monthly base salary earnings at 100%.

2. STD benefits commence after an “elimination period” of 10 continuous working days of absence or when all sick and annual leave is exhausted, whichever is later.

3. The STD benefits period of 60 work days runs concurrently with the elimination period, sick leave, and annual leave.

4. Benefits are payable for the duration of the disability based on supporting medical documentation, but no longer than 60 continuous workdays from the commencement date of the disability. The date of disability is determined by the physician, not necessarily when all sick and annual leave is exhausted. Benefits will cease upon the effective date of long-term disability benefits, retirement, the return to work date, or separation from service. Except in the two instances described below, benefits will not be paid during the summer term for participants with 9-month appointments:

a. Benefits will continue into the upcoming summer term for 9-month appointees who have no summer term appointment for that summer term if they had received summer term appointments for two of the past three summer terms and who either:
   - are already receiving benefits on the end date of their current spring semester appointment, or
   - have completed the “elimination period” described in #2 above and who exhaust their accumulated sick leave on the end date of their current spring semester appointment.

In this instance, benefits for the summer term will be equal to the average appointment level and duration of the highest two appointments in the past three summer terms or until the disability ends, whichever is the shorter period.

b. Benefits will be payable on the basis of the level and duration of the approved summer term appointment upon satisfaction of the conditions detailed in #2 above for 9-month appointees who are:
   - already working on a summer term appointment,
   - who have a summer term appointment, for the upcoming summer approved by the President or his designee at the time of the commencement of disability.

Benefits will continue until the end of the approved summer term appointment(s) or until the disability ends, whichever is the shorter period.

5. Required medical documentation specifying the length of an illness, injury, pregnancy, or surgery that will prevent the performance of essential job functions for 10 or more continuous working days.

6. The date of disability is determined by the medical documentation and approval by department.

7. STD benefits are payable once per condition or related condition.

8. STD benefits are paid once the completed application and supporting medical documentation is received, reviewed and approved by Human Resources.

9. An employee who is eligible to receive STD benefits and is able to work part-time can receive partial benefits. Note that the Short-Term Disability period of 60 continuous workdays would not be extended. The hours worked would be paid by the employee’s department.
10. STD benefits are not subject to retirement deductions and taxes.

**Actively at Work Provision**

Coverage for employees absent from work on the effective date of coverage will be deferred until the employee commences or resumes active work.

**Application Procedures**

Short-Term Disability applications are available from Human Resources. The completed application is submitted to the employing department which reviews the application in accordance with the criteria on the Plan Description items above. If the employing department approves the application, the department will forward the application and accompanying documentation to Human Resources.

**Termination of Coverage**

Your insurance will terminate at the end of the month in which your active service stops, you cease to be in a class of employees eligible for coverage, your appointment drops below 50%, or the plan is terminated. There is no Conversion Policy for this Plan.

**Income Replacement Offset**

The monthly Short Term Disability income replacement benefit may be offset by any disability income benefits (Worker’s Compensation payable elsewhere.)
## Long Term Disability Insurance

**Assurant Insurance Company**  
(800) 998-7858

The group plan summarized below applies to total disabilities commencing on or after April 1, 1989, and is subject to the terms and conditions of the Plan Document for Colorado State University’s self-insured Long-Term Disability (LTD) Income Replacement Plan. The plan is intended and expected to continue, but the University reserves the right to discontinue or revise it at any time.

### Plan Description

LTD is provided at no cost to you. The plan provides a monthly income replacement benefit, which begins on the 91st consecutive calendar day of total disability and continues to be payable each month during the term of continuous disability. The last monthly income replacement benefit payment will be made as of the first day of the month in which the earlier of these events occur:

- Termination of disability (recovery or death); or
- Attainment of these age or time limits.

### Age When Disability Starts

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Benefits</th>
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<tbody>
<tr>
<td>Less than 60</td>
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<tr>
<td>60 but less than 65</td>
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</tr>
<tr>
<td>65 but less than 68 ¾</td>
<td></td>
</tr>
</tbody>
</table>

The Attainment of the Age or Maximum Duration of Benefits:
- to age 65
- 4 ¾ years
- to age 70

### Actively at Work Provision

Coverage for employees absent from work on the effective date of coverage will be deferred until the employee commences or resumes active work.

### New Hire / Newly Eligible

Your premiums are taken by payroll deduction on a post-tax basis. This means if you become disabled, the income replacement benefits will not be subject to income tax.

### Income Replacement

Your “Covered Monthly Salary” used to determine benefits is one-twelfth of your base salary (exclusive of any overtime and other forms of additional compensation, except that, for an employee who

- has taught two out of the last three summer sessions or
- has taught one out of the last two summer sessions and has signed a contract to teach the next summer session, basic annual salary will include compensation for the most recent summer session taught).

- PERA and Federal Retirement Plan participants: the monthly income replacement benefit is up to 60% of your “Covered Monthly Salary” as of the date the disability begins, but not to exceed $6,000 per month.

- DCP participants: the monthly income replacement benefit is up to 69% of your “Covered Monthly Salary” as of the date the disability begins, but not to exceed $6,900 per month.

The monthly income replacement benefit payable by the Plan during continuous total disability will increase each year by 3% compounded annually, beginning with the first calendar month following 13 full months of such continuous disability.

### Income Replacement Offset

The monthly income replacement benefit is offset by any income benefits payable from Social Security for yourself and/or your dependent children, Workers’ Compensation, disability benefits payable under any employer group insurance, disability or retirement benefits payable under a public pension plan (e.g. PERA), federal retirement plan and/or the University’s Defined Contribution retirement plan, or benefits payable under the University’s sick leave or salary continuation program. In no event will the monthly income replacement benefit be less than $50 per month, even though this amount may bring your total disability income

### Retirement Plan Enrolled

<table>
<thead>
<tr>
<th>Retirement Plan Enrolled</th>
<th>Monthly Premium—The cost of coverage is provided by the University</th>
</tr>
</thead>
<tbody>
<tr>
<td>Defined Contribution Plan</td>
<td>Cost: 0.45% of your covered monthly salary. Maximum premium is $45.00</td>
</tr>
<tr>
<td>PERA or Federal</td>
<td>Cost: 0.15% of your covered monthly salary. Maximum premium is $15.00</td>
</tr>
</tbody>
</table>
to more than 60% or 69%, respectively, of your “Covered Monthly Salary.”

**Definition of Total Disability**

Total disability under this program is, "during the first 27 months of such total disability the inability of the employee, by reason of sickness, bodily injury or pregnancy, to engage in his or her regular own occupation. Thereafter, it will mean the inability of the employee, by reason of sickness, bodily injury or pregnancy, to engage in any occupation for which the employee is reasonably fitted by education, training or experience." Disability recertification may be requested at any time by the administrator, but is generally recertified every six to twelve months to determine continued eligibility for plan benefits.

**Filing Claims**

An employee applying for LTD must complete an LTD Claim Statement (available in Human Resources), which shall be furnished to Assurant Insurance Company within 12 months after the commencement of disability. Assurant Insurance Company is the University’s third party administrator on the LTD Plan, meaning they review claims and make determinations on behalf of the University’s LTD plan provisions. The LTD Claim Statement shall include any and all supporting medical or other information to support your disability that may be requested by Assurant Insurance Company. The burden of proof for establishing the existence of a qualifying disability rests with the claimant.

**Exclusions**

Benefits are not payable if total disability results from any of the following causes:

- Injury or sickness resulting from war, declared or undeclared.
- Intentional self-inflicted injury or sickness.

Disabilities caused by any condition for which treatment was rendered within the twelve month period preceding enrollment in the plan, will not be covered until twelve consecutive months have elapsed after enrollment in the plan.

**Termination of Coverage**

Your insurance will terminate if your active service stops, if you cease to be in a class of employees eligible for coverage, if your appointment drops below 50%, or if the plan is terminated. There is no Conversion Policy for this plan.
Plan Description

Effective June 1, 2014, you have access to a voluntary Group Long Term Care Insurance policy. The benefits, limitations and exclusions are summarized below. In the event of a conflict between this information and the official governing program policy, the policy will govern.

Colorado State University is pleased to sponsor the Colorado State University Group Long Term Care Insurance Program. This program provides eligible employees, retirees and certain family members with affordable coverage that can help protect them from the high costs of long term care services, including care at home, in the community, in assisted living facilities (including Alzheimer’s facilities), and in nursing homes.

Genworth Life Insurance Company (“Genworth Life”) is the underwriting company for the Plan and will serve as Benefits and Claims Administrator under the Plan.

This document summarizes provisions of the Plan in effect on the Effective Date. This document and the related materials do not provide all details of the Plan. More specific information is contained in Group Policy Number 14120 issued by Genworth Life. Certificates of insurance issued to each insured person contain details of the coverage under the Plan.

If you are approved for coverage under this Plan, premiums are paid directly to Genworth Financial on an after-tax basis by the employee.

Key Insurance Facts

Insurance provided under the Plan is intended to be federally tax-qualified long term care insurance within the meaning of Internal Revenue Code Section 7702B(b), as amended.

Who is Eligible?

An employee is eligible to apply for coverage on his or her first day of work if he or she is actively at work in a benefits eligible half-time or greater appointment.

Upon initial benefits eligibility, the underwriting criteria utilized during the application process includes the following:

- Employees age 18-65 will be subject to a reduced underwriting process.
- Employees age 66-69 will be subject to the short form underwriting process.
- Employees age 70+ will be subject to the full (long form) underwriting.

Employees must submit a completed application within 45 days of their benefits eligibility date to take advantage of the less restrictive underwriting criteria listed above (age 18-69). Subsequent to initial benefits eligibility, enrollment applications will be accepted on an ongoing basis whereas comprehensive (full) underwriting will apply in all circumstances. Actively at work means any employee who is performing the usual duties of his/her job at the usual place of work as required by CSU in an eligible half-time or greater position. An employee is considered actively at work while on approved vacations, holidays, and regularly scheduled days off, or during temporary business closures. An employee is not considered to be actively at work if he or she is unable to perform his or her usual duties due to a sickness, accident or injury; or if he or she is on a leave of absence, a sabbatical or retired.

Retirees under the age of 76 may also apply for long term care insurance under the plan.

In addition, an eligible employee’s or a retiree’s family members (spouse, same sex spouse, domestic partner, civil union partner, adult children, siblings, siblings-in-law, parents, grandparents, parents-in-law and grandparents-in-law), between the ages of 18 and 75, may also apply for long term care insurance under the Plan. For the purposes of this Plan, a domestic partner is considered a spouse. A person cannot be eligible in more than one class under the Plan.

To be eligible persons must be at least 18 years of age, maintain a permanent United States residence, and have an active Social Security number or tax identification number issued by the United States government.

What are the Benefits?

Benefits are payable for expenses incurred for:

- Care and services during confinement in a nursing
facility or assisted living facility, up to the Nursing Facility Maximum based on the option selected.

Home and community care which includes adult day care, and nurse or therapist services, home health or personal care services, and incidental homemaker and chore care provided in the insured’s home, up to 100% of the Nursing Facility Maximum.

Bed Reservation is available for temporary absences of up to 60 days per calendar year when room charges are covered in the facility.

Home Assistance Benefit covers: home modifications; assistive devices; supportive equipment; emergency medical response systems; and caregiver training. It pays up to a lifetime limit equal to 3 months of full Nursing Facility Benefits.

Hospice Care Benefit covers services designed to provide palliative care and alleviate discomforts if the insured person is both chronically and terminally ill. Benefits are payable up to the Nursing Facility Maximum for care received in a covered facility, and the limit for the Home and Community Care Benefit when care is received while the insured person is living at home.

Informal care for maintenance or personal care services provided in the insured’s home, by someone who does not normally reside there, a daily benefit up to 1% of the Nursing Facility Maximum per day for up to 30 days per calendar year.

Respite Care Benefit provides short-term coverage to relieve the person who normally and primarily provides the insured person with care in their home on a regular, unpaid basis.

Alternate Care Benefit may, subject to approval and mutual agreement, pay for covered expenses incurred for services, devices or treatments that are Qualified Long Term Care Services not specifically covered under another benefit.

Other Plan benefits include:
Care coordination services are available. Professional care coordinators review the insured’s specific situation and develop an appropriate Plan of Care to meet those needs. The cost of this service is not deducted from the Coverage Maximum.

International Nursing Facility Benefit: This benefit will pay for Covered Expenses received while the insured person is outside the United States. Subject to the Coverage Maximum, it pays up to 75% of the Nursing Facility Maximum for confinement in an out-of-country nursing facility. This benefit terminates four years after the date for which it first makes payment.

Waiver of Premiums while the insured is receiving benefits for facility care or home and community care.

Note: In the event of a conflict among this coverage summary and the official certificate of insurance, the certificate issued as part of your policy will govern.

What does the Plan Cost?

Premium rates are available online at Genworth Life’s website at www.genworth.com/groupltc (use Group ID: CSU and Access Code: groupltc). Genworth Life’s customer service can be reached at (800) 416-3624 to learn more about the program and plan options.

The insured pays the cost for the Long Term Care Insurance through bank account reduction. CSU does not provide payroll deduction for Long Term Care Insurance. The cost of coverage depends on the options selected and the age of the applicant.

Benefit Increase Options

The plan provides ways for an insured person to help keep up with the increasing costs of Covered Care over time.

Benefit Increase Options available under the Group Program are:

Future Purchase Options: This benefit will apply if neither of the Automatic options are selected. Every three years the insured is offered the opportunity to increase his or her benefit amounts by 5% compounded annually. The premium for the additional coverage is based on the insured’s attained age as of the effective date of the increase. The offer is not made if the insured is in claim, is benefit eligible, is receiving benefits, or is satisfying the certificate of insurance’s stated Elimination Period.

Automatic 5% Compound Benefit Increases: With this optional benefit, the benefit amounts increase automatically each year by 5% compounded annually while the insurance is in effect and premiums are paid. There is an additional premium for this optional inflation protection.

Automatic 3% Compound Benefit Increases: With this optional benefit, the benefit amounts increase automatically each year by 3% compounded annually while the insurance is in effect and premiums are paid. There is an additional premium for this optional inflation protection.

What Long Term Care Expenses are Covered?

The Plan pays benefits as reimbursement for covered expenses for Covered Care.

Covered Care must:
Constitute Qualified Long Term Care
CONDITIONS FOR RECEIVING BENEFITS

For an insured to be eligible for benefits:

- The insured person must be Chronically Ill.
- Genworth Life must receive a current eligibility certification for the insured person from a licensed health care professional, and;
- Genworth Life must receive ongoing proof which verifies that the Covered Care the insured person receives is needed due to continually being Chronically Ill.

Before benefits are payable, the Elimination Period must be satisfied. Elimination Period means 90 calendar days, beginning with the first day on which a Covered Expense is incurred, before the insured is entitled to Benefits. Days used to satisfy the Elimination Period do not need to be consecutive; and can be accumulated over time. Once satisfied, the insured person will never have to satisfy a new Elimination Period for this coverage.

What are Important Policy Definitions?

Other definitions for this coverage can be found in your Certificate of Insurance.

A Chronically Ill Individual is a person who has been certified by a Licensed Health Care Practitioner as being unable to perform, without Substantial Assistance from another individual, at least two (2) Activities of Daily Living due to a loss of functional capacity. In addition, this loss of functional capacity must be expected to exist for a period of at least 90 days; or a person requiring substantial supervision to protect the person from threats to health and safety due to a Severe Cognitive Impairment.

Activities of Daily Living are bathing, continence, dressing, eating, toileting, and transferring (getting into and out of a bed, chair or wheelchair).

Covered Care means only those Qualified Long Term Care Services for which the insurance pays benefits or would pay benefits in the absence of an Elimination Period.

Covered Expenses means costs incurred for Covered Care. Each benefit defines the Covered Expenses under that benefit. An expense is considered to be incurred on the day on which the care, service or other item forming the basis for it is received by the insured individual.

Nursing Facility Maximum is the maximum amount that will be paid for confinement in a nursing facility, assisted living facility or hospice care facility. This amount is also used to determine other benefit maximums.

Licensed Health Care Practitioner means any of the following who is not a member of the insured person’s immediate family:
- A Physician (as defined in Sec. 1861(r)(1) of the Social Security Act);
- A registered professional nurse;
- A licensed social worker; or
- Any other individual who meets such requirements as may be prescribed by the Secretary of the Treasury of the United States.

A Plan of Care is a written, individualized plan for care and

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<table>
<thead>
<tr>
<th>What Coverage is Available?</th>
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<tbody>
<tr>
<td><strong>Two Optional Levels of Coverage:</strong></td>
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<tr>
<td><strong>Primary Plan</strong></td>
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<tr>
<td>24 months approximate benefit duration</td>
</tr>
<tr>
<td>100% of the Nursing Facility Maximum (NFM) for Home &amp; Community Care</td>
</tr>
<tr>
<td>Informal Care Included</td>
</tr>
<tr>
<td><strong>Preferred Plan</strong></td>
</tr>
<tr>
<td>60 Months approximate benefit duration</td>
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<tr>
<td>100% NFM Home &amp; Community Care</td>
</tr>
<tr>
<td>Informal Care included</td>
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<table>
<thead>
<tr>
<th>Five levels of the Nursing Facility Maximum</th>
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<tbody>
<tr>
<td>$3,000 per month</td>
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<tr>
<th>Three Inflation Protection Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Future Purchase Option Benefit</td>
</tr>
<tr>
<td>Automatic 3% Compound for Life</td>
</tr>
<tr>
<td>Automatic 5% Compound for Life</td>
</tr>
</tbody>
</table>

| Optional Non-forfeiture Benefit Rider: Available to Residents of Alaska, Connecticut, Delaware, Montana and Oklahoma only, for additional premium. This rider allows the insured to retain partial coverage if he or she decides to cancel his or her long term care coverage after it has been in force for more than three years. |  |
support services for the insured that specifies:

The type, frequency and duration of all services required to meet those needs;
The kinds of providers appropriate to furnish those services; and
An estimate of the appropriate cost of such services.

**Coverage Maximum** is the maximum amount of benefits payable to the insured, and is reduced by the amount of claims paid. The Policy Lifetime Maximum is determined by multiplying the Facility Care Maximum by the benefit duration.

**Qualified Long Term Care Services** are necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services which are required

**Severe Cognitive Impairment** is a loss or deterioration in intellectual capacity that: is comparable to (and includes) Alzheimer’s disease and similar forms of irreversible dementia; and is measured by clinical evidence and standardized tests that reliably measure impairment in the person’s: short-term or long term memory; orientation as to people, places or time; deductive or abstract reasoning; and judgment as it relates to safety awareness.

**What are the Exclusions and Other Limitations for the Plan?**

**Exclusions:** Benefits are not paid for any expenses incurred for any Covered Care:
1. For which no charge is normally made in the absence of insurance;
2. Provided outside the United States of America, its territories and possessions; except as described in the International Nursing Facility Benefit;
3. Provided by the insured’s immediate family, unless a benefit specifically states that a member of the immediate family can provide Covered Care. We will not consider care to have been provided by a member of the immediate family when:
   a. He or she is a regular employee of the organization that is providing the services; and
   b. Such organization receives payment for the services; and
   c. He or she receives no compensation other than the normal compensation for employees in her or his job category;
4. Provided by or in a Veteran’s Administration or Federal government facility, unless a valid charge is made to the insured’s estate;
5. Resulting from war or any act of war, whether declared or not;
6. Resulting from attempted suicide or an intentionally self-inflicted injury while sane;
7. Resulting from participation in a felony, riot, or insurrection;
8. Resulting from the insured’s alcoholism or addiction to drugs or narcotics (except for an addiction to a prescription medication when administered in accordance with the advice of a Physician);
9. For which the insured receives, or is eligible to receive, workers’ compensation benefits, occupational disease act benefits, or similar benefits.

Expenses that are in excess of the amount paid or payable under:
- Medicare (including amounts that would be reimbursable but for the application of a deductible or coinsurance amount); and
- Any State or Federal workers’ compensation, employer’s liability or occupational disease law; and
- Any other Federal, State or other governmental health or long term care program or law except Medicaid.

However, this Non-Duplication provision will not disqualify a Covered Expense from being used to satisfy any Elimination Period requirement.

**Coordination of Benefits:** Benefits will be reduced for Covered Care when the total amount payable under this and all other Long Term Care Coverage is greater than the actual expense incurred.

State variations may apply to coverage options and exclusions and limitations. Read the Outline of Coverage in the Information Kit carefully. It will reflect any required state variations and other details of the Plan. All state variations are included in the Certificate of Insurance that is part of the Group Policy.

**Pre-Existing Conditions Limitation:** We will not pay for Covered Expenses incurred for any care or confinement that is a result of a Pre-Existing Condition when the care or...
Confinement begins within twelve (12) months following the initial certificate effective date.

**When Does Long Term Care Insurance Take Effect?**

The coverage effective date is subject to underwriting approval by Genworth Life, and will take effect upon approval. Your coverage will become effective on the Certificate Effective Date show in your policy, subject to the timely payment of the first premium due.

A Deferred Effective Date will apply if you have not been actively at work for the prior 30 calendar day period prior to your Certificate Effective Date. If you cannot satisfy this requirement, your Certificate Effective Date will be deferred until the first day of your regular pay cycle, following the time you have been Actively at Work, after you have been Actively at Work for the prior 30 day calendar day period.

**When Does the Long Term Care Insurance End?**

Coverage ends on the first to occur of:
- The date the insured dies;
- The date coverage is cancelled by the insured;
- The date the policy lifetime maximum is exhausted; or
- The end of the grace period if the amount of any overdue premium is not received.

If a person ceases to be eligible, he or she can continue coverage under the Plan by paying premiums directly to Genworth Life.

**Can an Insured Change Coverage Options?**

Long Term Care coverage selections can be changed at any time, as follows:
- To increase the coverage level to a higher option at any time a request must be sent with satisfactory proof of good health. Upon approval, premiums for the additional coverage will be based on the age of the insured on the date the change is effective.
- To decrease the coverage level, proof of good health is not required. The premium for the reduced coverage will be based on the original issue age.

**What if the Insured’s Employment Status Changes?**

If the status of employment changes, for example, if the insured employee takes an unpaid leave of absence, goes out on long term disability, terminates employment or is no longer benefits eligible, coverage will continue as long as premiums are paid when due. Employees must ensure continued payment is made directly to Genworth Life through a direct billing process. CSU does not offer payroll deduction for Long Term Care insurance.

**What if the Insured Dies?**

Coverage ends at the death of the insured. If the surviving spouse also has coverage, that coverage will remain in place, as long as he or she continues to pay the premiums. If premiums were paid through payroll deductions for the spouse’s coverage, upon the employee’s death, those deductions will end upon the employee’s death, and the billing will be sent to the surviving spouse.

**30 DAY REFUND**

If the insured is not completely satisfied with the Long Term Care Insurance coverage, he or she may return the certificate within 30 days of receipt of the Certificate of Insurance for a full refund of any premiums paid.

**Who is the Plan Administrator?**

Plan administration responsibilities under the Plan have been delegated to the insurance provider, Genworth Life Insurance Company.

You can contact them by calling 1-(800) 416-3624, or in writing at the following address:

Genworth Life Insurance Company
Group Processing Center – Colorado State University
P.O. Box 64010
St. Paul, MN 55164-0010
Health Care and Dependent Care Flexible Spending Accounts

Discovery Benefits, Inc.
(866) 451-3399
Option 1, 1

Plan Description
You have access to a Flexible Spending Account (FSA) which allows you to pay for certain health care and child care expenses with pre-tax dollars. FSAs may allow you to save money as contributions to the accounts are deducted from your wages before Federal, State and retirement deductions are calculated.

The FSA funds can be accessed in two ways. You can pay your providers out of pocket and submit for a reimbursement or you also have access to a Benefits Debit Card. This card can be presented to participating merchants and the transaction is completed at the point of sale. You should save debit card receipts in the event you need to substantiate the expenditure with Discovery Benefits, Inc. The amount of savings you may derive from participating in a Flexible Spending Account will depend on your income, your tax bracket and the amount of money that is withheld from your pay on a pre-tax basis.

Note: Health Care Reform extends medical FSA reimbursement to your adult children up to age 26. Only your “qualified” federal tax dependents are eligible for reimbursement of expenses under a FSA dependent care account. Your pre-tax contributions are deducted in equal amounts from your pay either on a 9-month or 12-month basis. If you are on a Faculty Transitional appointment, deductions will occur on a 4-month or 5-month basis.

Consult your tax advisor if you have questions about participation in the Flexible Spending Accounts.

General IRS Guidelines
FSA’s are governed by the IRS and certain rules apply in order for you to enjoy the potential tax savings.

• Elections must be made prior to the beginning of each plan year and/or your effective date. The FSA plan year is a calendar year and begins each January 1 and ends December 31. Eligible expenses must be incurred during this time frame to be eligible for reimbursement. The IRS definition of “incurred” refers to the date the service is provided regardless of when you are billed or when you pay for it. You are required to re-enroll in an FSA each Open Enrollment period to continue participation in the next plan year.

• If you do not use all of the money in your Health Care or Dependent Care Spending Account for eligible expenses incurred in the same plan year, you will lose any unused dollars at the end of the year.

• IRS guidelines do not allow you to transfer money from one spending account to another. They consider these separate accounts. Carefully consider how much money you need in each account and set aside only the money you need for incurred expenses during the calendar year.

• You are not permitted to make lump-sum contributions to your spending accounts. Your contributions must be made through payroll deduction.

• There is a deduction limit for FSA’s which restrict taxable income from being taken below minimum wage as a result of salary reduction.

• It is important to note that you cannot take the federal tax credit or tax deduction for dependent care or health care expenses reimbursed by your FSA.

Please consult your tax advisor before determining if participation will benefit you or if taking the tax deduction or tax credit on your tax return is more effective.

Enrollment and Administrative Fees

New Hire/ Newly Eligible
Initial Enrollment — You must enroll within 30 days of your eligibility date. This initial enrollment is only applicable until the end of the current calendar year. Benefit elections are generally effective the first of the month following your hire/change date. Flexible Spending Account (FSA) contributions are deducted in the month of coverage.

If you are hired or become eligible after the first of the year, contributions will be deducted in equal amounts from your remaining paychecks.
Benefits Open Enrollment — New Calendar Year

FSA’s do not automatically continue from year to year. You must re-enroll each benefits Open Enrollment period to have an account(s) for the next calendar year. During the annual benefits Open Enrollment period, you must decide whether to participate in a Flexible Spending Account for the following calendar year.

Mid-Year Qualifying Events

Plan your contributions carefully for the entire calendar year, as mid-year changes are subject to restrictions. Election changes are allowed only in the event of a qualifying event as defined by the IRS, examples include:

- Marriage
- Divorce
- Common Law Marriage
- Birth or adoption of a child
- Death of an eligible dependent
- Certain changes in your employment status
- Change of dependent care giver (dependent care account)
- Child turns 13 (dependent care)

If you have a status change during the plan year, you may be allowed to make a change in your benefit election that is consistent with the reason for the change. Complete the requested election change in the CSU Online Benefits Enrollment System within 30 days of the qualifying event. If approved, it will be effective the first of the month following the qualifying event date. Changes due to birth or adoption are effective with the date of birth or placement date for adoptions.

Administrative Fee — paid by CSU

Colorado State University will fund the monthly administrative on your behalf.

Eligible Health Care Expenses

- Acne medicine (covered with medical diagnosis prescribed by a medical practitioner)
- Acupuncture
- Alcoholism treatment
- Ambulance service
- Antifungals (including Monistat, Gyne-Lotrimin, and any other antifungal product)
- Band aids
- Birth control pills
- Braille books and magazines
- Breast pump rental or purchase (with letter of medical necessity)
- Car controls for the disabled
- Chiropractic care
- Condoms
- Contact lenses and solutions
- Cosmetic surgery (medically necessary due to birth defects, accidents)
- Crutches
- Dental fees
- Dental implants
- Dental plan deductibles or copayments
- Dermatologists
- Diagnostic tests
- Doctor’s fees
- Durable medical equipment (with prescription, letter of medical necessity and treatment plan)
- Enemas
- Equipment for the disabled
- Health club membership (with letter of medical necessity and proof of new membership)
- Hearing aids and batteries
- Hearing exams
- Hearing treatment
- Hospital services (excluding phone and TV)
- Immunizations
- Injections
- Insulin
- In vitro fertilization
- Lab fees
- Laboratory and x-ray deductibles or copayments
- Medical nursing home services
- Massage therapy (with prescription and letter of medical necessity and treatment plan)
- Medical plan deductibles or copayments
- Midwife
- Mileage to and from medical services (documentation required)
- Muscle or joint pain ointments
- Nicotine gum or patches (for stop-smoking programs)
- Nursing services
- Ocular vasodilator (such as Visine)
- Optometrist fees
- Ophthalmologist fees
- Organization fees
- Organ transplants
- Orthodontic treatment
- Orthotics
- Oxygen
- Physical exams
- Pedialyte for dehydration
- Periodontal fees
- Physical therapy
- Pregnancy test—over the counter
- Prenatal care
- Prescription drug copayments
- Prescription drugs (dispensed by a pharmacist)
- Prescription eyeglasses
diabetes
- Radiation therapy (with medical diagnosis)
- Radial Keratotomy, PRK, Lasik
- Reading glasses
- Saline solution
- Services for diagnosed severe learning disabilities
- Special schools for the disabled
- Sterilization
- Substance abuse treatment
- Sunburn ointment
- Sunscreen (covered with medical diagnosis prescribed by a medical practitioner)
- Surgery
- Telephone for the deaf or hearing impaired
- Therapy for mental/nervous disorders
- Transportation for medical care
- Vaccinations
- Vision plan deductibles or copayments
- Vitamins (covered with medical diagnosis prescribed by a medical practitioner)
- Wart remover treatments
- Weight loss program/drugs (must be prescribed by a doctor with a specific IRS-approved diagnosis)
- Wheelchairs
- X-ray fees

The following over the counter expenses require a written prescription from a medical practitioner:

- Antidiarrheals
- Antimetics (for treating nausea and vomiting including motion sickness medications)
- Analgesics (all pain relievers)
- Anti-inflammatories (including ibuprofen)
- Antacids
- Antibacterials (including creams, ointments, sprays)
- Antihistamines (for allergies and colds)
- Calamine lotion and other bug bite medications
- Chapstick or lip balm (medicated)
- Cold remedies
- Cough suppressants and expectorants
- Decongestants
- Diaper rash ointments
- Laxatives
- Menstrual cycle products for pain and cramps relief
- Nasal Spray
- Sinus medications (including nasal sinus sprays)
- Sleep aids
- Suppositories and creams

For the most current and complete approved list of eligible expenses, refer to IRS Publication 502.
Non-Eligible Health Care Expenses

- Alcohol, caffeine and tobacco
- Baldness treatments
- Cosmetic surgery, procedures, services and products (non-medically necessary)
- Childcare classes
- Dancing lessons
- Dandruff shampoos
- Diaper service
- Electrolysis
- Electronic toothbrushes
- Expenses for a vacation (even if recommended by a doctor)
- Fiber supplements
- Fingernail or cuticle maintenance products
- Fluoride toothpaste
- Funeral services
- Hair transplants
- Herbal remedies
- Holistic drugs
- Illegal drugs (as defined by Federal law including medications procured from out of the country)
- Insurance premiums
- Lamaze classes
- Maternity clothes
- Moisturizers
- Nutritional supplements
- Rogaine (or similar products)
- Shaving creams or lotions
- Soaps
- Special diet supplements
- Swimming lessons
- Teeth bleaching or whitening, including products
- Veneers

For the most current and complete list of non-eligible expenses, refer to IRS Publication 502 at www.irs.gov

Eligible Health Care Expense Worksheet |

<table>
<thead>
<tr>
<th>Health Care and Dependent Care Account Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are two types of accounts that are offered and you may choose to participate in one or both of these Flexible Spending Accounts.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Care Flexible Spending Account</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Health CareFlexible Spending Account is designed to help you pay for health expenses that are not covered by your basic health plans, including any deductible amounts you have to pay and co-pays or co-insurance amounts required by your insurance plans. Reimbursable expenses may also include expenses that may not be covered by your basic plans, for example, prescription eyeglasses and many over-the-counter drugs available at your local store or pharmacy provided that you obtain a written prescription from a medical practitioner.</td>
</tr>
</tbody>
</table>

| Complete this worksheet to estimate the amount of pre-tax money you wish to contribute to your Health Care Account. Remember, it is important to conservatively estimate what your expenses may be; amounts remaining at year end are forfeited due to IRS regulations. |

<table>
<thead>
<tr>
<th>Eligible Health Care Expense Worksheet</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and dental plan deductibles</td>
</tr>
<tr>
<td>Medical, dental, vision, and prescription drug co-payments</td>
</tr>
<tr>
<td>Routine physicals and immunizations</td>
</tr>
<tr>
<td>Vision exams, prescription eyeglasses, contact lenses &amp; saline solution</td>
</tr>
<tr>
<td>Hearing exams and hearing aids</td>
</tr>
<tr>
<td>Orthodontics (may be reimbursed when services are incurred, or by payment date. If requesting payment date, proof of payment is required.)</td>
</tr>
<tr>
<td>Other Expenses not covered by your medical, dental or vision plans.</td>
</tr>
<tr>
<td>Eligible over the counter (OTC) drugs which a doctor’s prescription has been obtained (maximum individual claim submission is 90 day drug supply per dependent per claim)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Estimates</th>
</tr>
</thead>
<tbody>
<tr>
<td>$___________</td>
</tr>
<tr>
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<tr>
<td>$___________</td>
</tr>
<tr>
<td>$___________</td>
</tr>
</tbody>
</table>

($2,700 maximum) **Total** $___________
Dependent Care Flexible Spending Account

The Dependent Care Flexible Spending Account is similar to the Health Care Flexible Spending Account, except it allows you to pay for eligible dependent day care expenses with pre-tax dollars. To decide whether a Dependent Care Flexible Spending Account is right for you, determine if you will incur eligible expenses. If you are paid 12 months out of the year you may not elect to have dependent care deducted for nine (9) months only. Generally, child and elder care companion services are eligible expenses. For the expense to be eligible, all of the following must be true:

Your dependent(s) must be:

- Under age 13 (stops on 13th birthday) or mentally or physically unable to care for him/herself.
- Spending at least eight hours a day in your home.
- Eligible to be claimed as a dependent on the employee’s federal income tax return. Special rules may apply in divorced or separated situations.
- Receiving care when you are at work and your spouse is at work, searching for work, in school full-time, or is mentally or physically disabled and unable to provide the care.
- Receiving care provided in your home or outside your home by a licensed day or elder care center or by babysitters or companions; this includes relatives, but excludes your dependent children under age 19.

Note: The caregiver must claim the wages you pay him/her on his/her income tax return for the year and you must be able to provide the tax identification number or Social Security Number of the provider when submitting a claim. When you file your personal income tax return, this same information will need to be reported on Form 2441.

If you decide to participate in a Dependent Care Flexible Spending Account, you may contribute up to $5,000 into the account each year. However, if you and your spouse both work, the IRS currently limits your maximum contribution to a Dependent Care Flexible Spending Account as follows:

- If you file separate personal income tax returns, the annual contribution amount is limited to $2,500 for you and your spouse.
- If you file a joint income tax return and your spouse also contributes to a Dependent Care Flexible Spending Account, your combined limit is $5,000.
- If your spouse is disabled or a full-time student, special limits apply. Limits are defined in IRS Publication 503.
- If you and or your spouse earn less than $5,000 combined, the maximum is limited to your combined earnings.

Employment or Benefits Eligibility Ends

Your Flexible Spending Account will terminate on the date in which your active service stops, you cease to be in a class of employees eligible for coverage, you fail to make the required contribution, the plan is terminated, or the end of the plan year.

Any money left in your accounts when you terminate or lose benefits eligibility can only be used to reimburse you for eligible expenses incurred prior to the date your eligibility ends. You have 90 days from this date to submit for reimbursement from your account. Employees enrolled in the Health Care Account may also be eligible for COBRA. If you are enrolled in the Health Care Account at the time your coverage would end due to a COBRA qualifying event, you have the right to continue coverage if there is a positive health care account balance at the time of the qualifying event. COBRA continuation coverage is only available for the remainder of the plan year in which the qualifying event occurs.

Non-Eligible Dependent Care Expenses

- Transportation to and from the dependent care location
- Amounts you pay for child and dependent care while you or your spouse are off work because of illness (including maternity leave), injury, vacation, or leave of absence
- Summer sleep-over camps
- Full or half day kindergarten programs
- Fees for extracurricular classes, e.g., gymnastics, swimming, dance
- Boarding schools
- Nursing homes

For the most current and complete list of non-eligible expenses, refer to IRS Publication 503 at www.irs.gov
Complete this worksheet to estimate the amount of pre-tax money you wish to contribute to your Dependent Care Account. 

**Eligible Dependent Care Expense Worksheet**

<table>
<thead>
<tr>
<th>Eligible Dependent Care Expense</th>
<th>Estimates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursery Schools and day care centers for pre-schoolers</td>
<td>$__________</td>
</tr>
<tr>
<td>Individual providing care for your dependent inside your home or outside your home</td>
<td>$__________</td>
</tr>
<tr>
<td>“Latch-key” programs for elementary school students under age 13</td>
<td>$__________</td>
</tr>
<tr>
<td>Centers providing day care (not residential care) for adults</td>
<td>$__________</td>
</tr>
</tbody>
</table>

($5,000 Maximum) **Total** $__________

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**Reimbursement Process**

**Reimbursement Methods:**

**Benefits Debit Card**

You can use your Benefits Debit Card to pay for eligible items/services at the point of sale with participating merchants. Present your card to the cashier and the amount is deducted directly from your FSA balance. Make sure to retain a copy of an itemized receipt or EOB for substantiation purposes.

**Online Claim Submission**

You can make an out of pocket purchase and file a claim on the Discovery Benefits Consumer Portal. Once a claim is filed on the Discovery Benefits Consumer Portal, print the confirmation page you receive and submit to Discovery Benefits along with a copy of your itemized receipt or EOB.

**Claim Submission**

You can make an out of pocket purchase and file a claim using the Reimbursement Request Form or submitting electronically online through a secure portal. Complete this form and submit to Discovery Benefits along with a copy of your itemized receipt or EOB.

All documentation to be submitted to Discovery Benefits can be sent via mail, fax or email or uploaded via your mobile device or computer. See contact information below:

Discovery Benefits
3216 13th Avenue South
Fargo, ND 58103
Fax: (866) 451-3245

Email: customerservice@discoverybenefits.com

**Itemized Receipts**

When submitting a health care reimbursement claim or substantiation documentation on a card charge, attach a fully itemized receipt that includes the date of service, type of service, and provider’s name and/or a copy of the explanation of benefits (EOB) statement provided by the insurance company.

**Over the Counter (OTC) Drugs**

Claims for over-the-counter drugs must include the itemized cash register receipt attached to the claim form and a copy of the written prescription obtained from a medical practitioner.

You may be reimbursed up to your total annual contribution amount, regardless of how much you have contributed to the account year to date.

**Dependent Care Reimbursement Process**

You can submit a Recurring Dependent Care Reimbursement Form to Discovery Benefits to be set up for automatic reimbursements throughout the plan year. This is a great feature because you will not need to continually submit claims for reimbursement.

You can submit dependent care reimbursement claims as needed by completing a claim form or submitting the receipts electronically through Discovery Benefits secure portal. If you are unable to provide an itemized receipt with the claim, please have your Dependent Care provider sign Section 2b of the Reimbursement Process.
Request Form. Claims cannot be submitted until after the dependent care services have been provided. You will be reimbursed if there are sufficient funds in your account. Otherwise, you will receive reimbursement for the amount in your account and the remainder will be paid when your account balance permits.

Be sure to keep copies of your mailed claims and supporting documentation. No documentation will be returned to you.

Claims Processing Schedule

Claims are processed within two business days from submission. If the claim is approved a reimbursement payment is issued on the following business day.

Year End Claim Filing Due Date—

You will have 90 days following the end of the plan year to submit claims incurred during the plan year.

Note: If your eligibility ended before the end of the Plan year, please reference the filing deadlines for your Flexible Spending Account under the Employment or Benefits Eligibility Ends.

Direct Deposit

All reimbursements will be made to you either by check or direct deposit. You will be responsible for paying the health or dependent care provider.

Online Services

You can view the status of your claims at www.discoverybenefits.com.

Once you are at the site, please click on “Account Login” under the “Participants” tab and enter your username and password. Discovery Benefits will provide you a “Welcome” letter prior to the plan year with the login information. If you have any questions, contact the Discovery Benefits Participant Services Team at 866-451-3399, options 1, 1.

In addition to online availability, you will be notified quarterly via email (if you share your email address with Discovery Benefits) of the amount of money remaining in your account(s). If Discovery Benefits does not have your email address, you will be mailed a statement 60 days prior to the end of the plan year. Unspent account balances will be forfeited at the end of the calendar year.
The privileges/programs listed below are administered by the respective sponsoring campus departments listed below. Please contact the appropriate department listed under each heading for additional information.

**Athletic Ticket Discount**

Faculty and staff receive up to a 20 percent off normal athletic season ticket costs for all CSU ticketed sports. Call (800) 491-RAMS to purchase season tickets.

**Childcare/Preschool**

**CSU Early Childhood Center**

The Human Development and Family Studies Department operates the CSU Early Childhood Center (ECC) on the University campus.

The ECC is dedicated to working in partnership with families to ensure a quality educational experience for their child. and can be reached at (970) 491-7082. The ECC serves children ages 2 to 6 years.

**Sunshine House**

The independently run Sunshine House at Colorado State University offers programs to children ages 6 weeks to 6 years and can be reached at (970) 491-2862.

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**Employee Study Privilege and Reciprocal Study Privilege**

Under the following conditions, Academic Faculty members, Administrative Professionals, Post Doctoral Fellows, Veterinary Interns, and Clinical Psychology Interns with appointments of half-time or greater may register for credit courses at Colorado State University, Colorado State University-Global Campus, Colorado State University-Pueblo, and; subject to the terms of agreement between specific institutions, the University of Northern Colorado, on a space available basis without the assessment of the student portion of total tuition or general fees to the employee.

Ideally, courses taken as an employee under the Employee Study Privilege Program shall contribute to the employee’s success at the University. This is one of several factors taken into account in determining whether or not the value of this benefit is taxable to the employee. Such determinations are made by Human Resources and Business and Financial Services, with reference to the Internal Revenue code (26 U.S.C. sections 127, 132(d) and 117). However, supervisors may approve an employee’s use of study privilege even if the subject matter is not directly related to current job duties.

The employee must obtain the written consent from the head of his or her administrative unit to register for specific courses. Time off to attend courses taught during an employee’s scheduled work hours require advance supervisor approval, which should be granted unless there is no reasonable way for the employee to perform his or her duties at other times. Time off that is granted to attend courses in which an employee enrolls at the request of the department in order to improve job skills should be treated as administrative leave with pay.

Eligible employees may register for courses without being regularly admitted to CSU.

**Employee Study Privilege Eligibility—courses at Colorado State University**

- Academic Faculty with Regular, Special, Senior Teaching or Temporary appointments of half-time or greater;
- Faculty Transitional appointees are eligible for the same benefit available to full-time academic faculty;
- Administrative Professionals with Regular, Special or Temporary appointments of half-time or greater;
- Post-Doctoral Fellows, Veterinary Interns, and Clinical Psychology Interns with appointments of half-time or greater;
- Non-temporary State Classified employees with appointments of half-time or greater;

**Note:** Effective July 1, 2014, the one year continuous eligibility waiting period of half-time or greater service has been eliminated for Temporary Academic Faculty and Administrative Professional employees.

Contact Human Resources at (970) 491-MyHR (6947) regarding eligibility provisions for University Faculty Affiliates employed by USDA (GS9 or above) or Military Science (ROTC).

Eligible Faculty/Staff with full-time appointments may register for up to nine (9) semester credits per academic year **(commencing Summer session and ending Spring semester).**

Credits are prorated based on appointment percentage:

- 100% appt. 9 credits
- 75-99% appt. 7 credits
- 50-74% appt. 5 credits
- Under 50% appt. 0 credits
The above credit maxima include courses which are audited by the employee rather than taken for credit. Tuition will be assessed as soon as credits are taken in excess of the program maximum for the employee.

**Eligible Courses**

The Employee Study Privilege Program includes credit courses which are a part of the Colorado State University Curriculum, as defined by the Colorado State University General Catalog. These courses will be identified with a departmental course number. In particular, the study privilege does not cover the cost of continuous registration.

CSU OnlinePlus (The Division of Continuing Education) offerings are included under this privilege if they are credit bearing at the institution; however, tuition for these courses may be higher than “Resident Instruction” tuition, in which case, the difference must be paid by the employee or by some other source. Courses that provide only continuing education units (CEUs) are not eligible.

**Eligible expenses under the Employee Study Privilege Program include:**

- **Base Tuition** – up to 9 credits per year (credits are prorated based on your appointment percentage)
- **Differential Tuition** – up to 9 credits per year (credits are prorated based on your appointment percentage)
- **Program Charges** – at least one study privilege credit must be utilized each semester to allow eligibility for program charges
- **University Technology Fee and General Fees** - credited (fee waiver) to your student account. This waiver of General Fees removes your free access to the Recreation Center, athletic events, and other campus services
- **University Facility Fee** – prorated according to the number of study privilege credits utilized
- **College Charges for Technology** - prorated according to the number of study privilege credits utilized each semester

**Note:** The University Technology Fee and General Fees will be credited (fee waiver) to your student account even if study privilege credits have been exhausted provided the Employee Study Privilege Registration Form is submitted.

Ineligible expenses under the Employee Study Privilege Program include:

- Undergraduate tuition normally covered by the College Opportunity Fund (COF) – if you take a COF eligible course in a manner that COF cannot be applied (i.e., you do not apply for and authorize COF, or you audit a course), the Employee Study Privilege Program will not cover the portion of tuition that would have been covered by COF
- Special Course fees – a list of associated courses with applicable fees is available at [http://provost.colostate.edu/files/2014/06/Comprehensive-List-AY15.pdf](http://provost.colostate.edu/files/2014/06/Comprehensive-List-AY15.pdf)
- After the exhaustion of available Employee Study Privilege credits, any remaining tuition, charges or fees are not eligible for coverage or the College Opportunity Fund (if applicable)

The employee registration form can be downloaded from the Human Resources website at [www.hrs.colostate.edu/benefits/study-privilege.html](http://www.hrs.colostate.edu/benefits/study-privilege.html).

Faculty and staff may also enroll in credit courses listed on the OnlinePlus website. Registration forms for these courses are located at [www.online.colostate.edu/answers/facstaff/study-privilege.dot](http://www.online.colostate.edu/answers/facstaff/study-privilege.dot)

**Reciprocal Study Privilege**

**Colorado State University-Global**
**Colorado State University-Pueblo**
**University of Northern Colorado**

The Employee Study Privilege Program includes reciprocal provisions that allow employees to take courses at Colorado State University-Global Campus, Colorado State University-Pueblo, and the University of Northern Colorado.

Enrollment requires the agreement to fulfill financial obligations and abide by the policies of the reciprocal educational institution in which student status is obtained. Program eligibility shall be defined and determined by the Employee Study Privilege Program of Colorado State University.

Contact Human Resources at (970) 491-MyHR (6947) or visit [www.hrs.colostate.edu/benefits/study-privilege.html](http://www.hrs.colostate.edu/benefits/study-privilege.html).

Additional forms are required to gain pre-approval under the reciprocal provisions of the Employee Study Privilege Program. The required forms are located at [www.hrs.colostate.edu/benefits/study-privilege.html](http://www.hrs.colostate.edu/benefits/study-privilege.html) and are submitted to Human Resources.

**Faculty / Staff Scholarships**

Awards and amounts to be determined. Scholarships presented to children of faculty and state classified employees. Scholarship availability is dependent on funds raised during the annual faculty/staff drive each spring.

For additional information, contact...
the Vice President for Student Affairs Office at (970) 491-5312.

**Joan Gaynor Kuder Scholarship**

An annual scholarship in the amount of $2,500 is given to two full-time faculty or staff members who have made sustained progress toward a degree at Colorado State University. Applications are available online at the Division of Student Affairs website in November. For additional information, contact the Vice President for Student Affairs Office at (970) 491-5312.

**Tuition Scholarship Program for Spouses, Domestic Partners, Civil Union Partners, and Eligible Children**

The spouse, domestic partner, civil union partner, and Eligible Children of an Eligible Employee shall be qualified to receive a Tuition Scholarship if admitted to Colorado State University, Colorado State University-GLOBAL Campus, or Colorado State University-Pueblo and enrolled in a degree program or as a degree-seeking student with an undeclared major. The tuition scholarship is fifty (50) percent of resident tuition.

This Tuition Scholarship Program is also available to students in programs such as Professional Veterinary Medicine, Teacher Certification, and Principal Licensure. The amount of this Tuition Scholarship shall be a fixed percentage of the undergraduate or graduate tuition that would be assessed to the student for regular on-campus courses at the in-state tuition rate, except for a student in the Professional Veterinary Medicine Program, whose scholarship shall equal this same percentage of the tuition assessed to in-state graduate students.

The student must be enrolled in regular on-campus credits (Test-Out, Advanced Placement, CSU OnlinePlus, and Study Abroad are not considered regular on-campus credits).

Note that, in some cases, this Tuition Scholarship may be taxable income. Applications for this Tuition Scholarship must be processed in accordance with the requirements established by Student Financial Services and Human Resources for this program.

If a person dies while an Eligible Employee, his or her spouse, domestic partner, or civil union partner shall continue to be qualified for this Tuition Scholarship Program until six (6) years after the date of the death, and each of his or her Eligible Children shall continue to be qualified for this Tuition Scholarship Program until the Eligible Child reaches the age of twenty-six (26).

For all cases of separation from employment of an Eligible Employee other than death, the spouse, domestic partner, civil union partner, and Eligible Children of the Eligible Employee shall cease to be qualified for this Tuition Scholarship Program at the end of the academic year in which the separation from employment occurs.

In exceptional circumstances, the Vice President for University Operations has the authority to grant eligibility to someone who might not qualify otherwise for eligibility.

**Employee Eligibility**

**Academic Faculty—Regular, Special or Senior Teaching Appointments**

Faculty on Regular, Special or Senior Teaching appointments of half-time or greater are eligible for the Tuition Scholarship program as of the date of appointment unless otherwise noted.

**Faculty Transitional**

Faculty Transitional appointees are eligible for the same benefit available to full-time academic faculty.

**Administrative Professionals—Regular or Special Appointments**

Administrative Professionals on Regular or Special appointments of half-time or greater are eligible for the Tuition Scholarship Program as of the date of appointment unless otherwise noted.

**State Classified**

Non-temporary State Classified employees with appointments of half-time or greater are eligible for the Tuition Scholarship Program as of the date of appointment unless otherwise noted.

**Eligible Dependent**

Eligibility shall mean and refer to:

**Eligible Child**—shall mean and refer to biological children, adopted children, foster children, stepchildren, and legal wards of either the Eligible Employee or the Eligible Employee’s spouse, domestic partner, or civil union partner as well as any person for whom either the Eligible Employee or the Eligible Employee’s spouse, domestic partner, or civil union partner is standing in loco parentis, provided that the Eligible Child is under twenty-six (26) years of age.

**Spouse**—means a person who is legally married to an Eligible Employee, including a common-law spouse or same-gender spouse when the applicable jurisdiction’s law recognizes such marriages.

**Domestic Partner**—has the meaning described under the University’s benefits plan.

**Civil Union Partner**—has the meaning defined in C.R.S. §14-15-103.
Affidavit and Certification Forms

Domestic partners are eligible if the Affidavit of Domestic Partnership at http://www.hrs.colostate.edu/pdfs/form-domestic-partner-affidavit-scholarship.pdf is completed and adheres to the domestic partner requirements.

The Certification of Dependency for University Benefits http://www.hrs.colostate.edu/pdfs/form-certification-dependency.pdf form must be filled out by both domestic partners and civil union partners. A civil union partner will also be required to turn into Human Resources a Certificate of Civil Union.

Application

You must submit the Tuition Scholarship Program application for Spouses, Domestic Partners, Civil Union Partners and Eligible Children and Certification of Dependency for University Benefits form for any eligible child regardless of tax dependency status (may or may not be YOUR "qualified" federal tax dependent).

Program benefits received by a "non-qualified" federal tax dependent (i.e. domestic partner or the "qualified" dependent children of the domestic or civil union partner) or graduate level course work as defined by the IRS is subject to imputed income, regardless of tax dependency status, which means the value of the benefit received by the student will be treated as taxable income to the employee. Tuition Scholarship Program for Spouses, Domestic Partners, Civil Union Partners and Eligible Children application is available from Student Financial Services http://sfs.colostate.edu/scholarships/csuemployeescholarship.aspx or 103 Administration Annex, (970) 491-6321, and Human Resources, 555 S. Howes, 2nd Floor, (970) 491-MyHR (6947).

Reciprocal Tuition Scholarship for Eligible Family Members

The Reciprocal Tuition Scholarship for Spouses, Domestic Partners, Civil Union Partners and Eligible Family Members includes reciprocal provisions that allow enrollment at Colorado State University-Global Campus and Colorado State University-Pueblo.

Enrollment requires the agreement to fulfill financial obligations and abide by the policies of the reciprocal educational institution in which student status is obtained. Program eligibility shall be defined and determined by the Tuition Scholarship Program for Spouses, Domestic Partners, Civil Union Partners and Eligible Family members of Colorado State University.

Contact Human Resources for additional information at (970) 491-MyHR (6947) or review reciprocal program information at www.hrs.colostate.edu/benefits/index.html#academic.

Additional forms are required to gain pre-approval under the reciprocal provisions of the Tuition Scholarship Program. The required forms are located at www.hrs.colostate.edu/benefits/index.html#aademic and are submitted to Human Resources for approval before providing to the reciprocal University for processing.

Health and Exercise Science / Fitness

Adult Fitness Program

This program at the South College Gym provides an indoor track for walking or jogging, a swimming pool, strength training machines and free weights, treadmills, rowers, recumbent and upright cycles, cross country ski machines, basketball courts and an ample stretching area.

A variety of group classes such Fit Ball, circuit training and water aerobics are offered. Blood pressure measurements are available during all open hours. Personal training, lockers, towels and workout clothing are included with your monthly membership. Hours are:

Monday, Wednesday, Friday: 6 a.m.—8 a.m.; noon—1:15p.m.; 5 p.m.—7 p.m.
Thursday: 5 p.m.—7 p.m.
Saturday: 8 a.m.—10 a.m.

The Adult Fitness Program is open to the public as well as CSU faculty and staff. Please call (970) 491-6910 or visit our website at www.hes.cahs.colostate.edu/outreach/default.aspx?sm=e

Heart Disease Prevention Program

HDPP is part of the Human Performance Clinical/Research Laboratory. This program assesses known risk factors for cardiovascular disease and uses these risk factors in developing individualized strategies for lifestyle changes to reduce one’s risk of developing heart and vascular disease. Program measurements include body composition testing, pulmonary function testing, blood profile, maximal treadmill testing with electrocardiography, and flexibility and strength testing. CSU employees receive a 20% discount on HDPP evaluations. Please call (970) 491-3847 or visit our website at www.hes.cahs.colostate.edu/outreach/default.aspx?sm=e

Youth Sport Camps

A summer-long day-camp program of sports activities. One-week sessions are offered in baseball, basketball, inline hockey, soccer, softball, tennis, and volleyball. In addition, FunLIFE (Learning to Improve Fitness and Eating) camps
are featured every summer, which combines sports and physical activity with healthy lessons and curriculum.

Field sports camps allow campers to get a brief taste of several sports in a short time. Camps are affordable and designed to promote the “Discovering Healthy Lifestyles” tagline of the Department of Health and Exercise Science. With Healthy Lifestyles, All Children are Winners! These camps qualify as eligible dependent care flexible spending account expenses. Please call (970) 491-6318 or visit the camps website at www.hes.cahs.colostate.edu/YSC

After School Program

Through innovative programming and the use of active learning practices focusing on obesity prevention, lifelong fitness, and skill development, the Youth Sport Camps After School Program supports the educational and public service mission of the Department of Health and Exercise Science and Colorado State University. Based on the successful FunLIFE camps model, the after school program includes physically active and educational programming, focusing on developing healthy lifestyles.

Activities may include sports, swimming, yoga, crafts, nutrition lessons, hiking, and other active experiences. The program runs from after school through 6 p.m. Monday-Friday and is open to children from any school.

Please call (970) 491-6318 or visit the website at www.hes.cahs.colostate.edu/outreach/Default.aspx?sm=e

Noon Hour

This South College Gym program offers exercise activities including walking, jogging, weight lifting, swimming, and exercise involving equipment.

Students from the Health and Exercise Science Department can outline exercise programs for participants. Faculty, staff, and retired full-time faculty and staff may sign up for the Noon-Hour Fitness Program at Moby Gym each semester for weight room access, swimming, basketball, aerobics and more.

Hours are from 11:30 a.m. to 1:30 p.m. Monday through Friday. The programs offer lockers, towel and workout clothing. Call (970) 491-5081 for information.

Campus Recreation Center

CSU employees, spouses, domestic partners and civil union partners are eligible to purchase memberships to the Campus Recreation Center.

Membership privileges include use of all activity areas in the Rec Center, including free group fitness classes, Intramurals, and Sport Clubs activities, including participation in non-credit instructional classes, Mind Body classes, specialty instruction classes, massages, personal training, cycling program, and locker rentals are available for an additional fee.

Hours during the academic year are Monday through Friday, 6 a.m.-11:30 p.m.; Saturday, 8 a.m.-8 p.m. and Sunday, Noon-11:30 p.m.

For more information, contact the Student Recreation Center at (970) 491-6359 or www.campusrec.colostate.edu

Morgan Library

Faculty and staff may check out materials and access electronic resources maintained by the Libraries. A librarian is available who can help with orientation to subject material, library services and arrange for use of the Electronic Information Lab to provide library instruction to classes. Call (970) 491-1841.

University Club and Aspen Grille

Membership in the University Club is available to faculty, administrative professionals, state classified personnel, alumni, and retirees of the university. Members receive a discount at the Aspen Grille. Call (970) 491-5587 for information.

RamCard

The RamCard Office is located on the lower level of the Lory Student Center (LSC), Room 31 and can be reached at (970) 491-2344. All employees are eligible to receive a RamCard and experience the convenience it offers.

This card can be used for CSU Dining Center meals and the food court in LSC with the cash balance you provide. You may use your card at Morgan Library to check-out materials. Starting May 19, 2014, CSU Faculty and staff are eligible to ride the new MAX bus rapid transit and all Transfort fixed-routes (excluding Transfort Green and Gold night services and Dial-A-Ride) at no cost. This transportation benefit will also extend to “Around the Horn”, the new on-campus shuttle that will have 13 stops and starts in Summer 2014.

Additional RamCard Discounts are available from local establishments and can be found at: www.housing.colostate.edu/ramcard/uses_discounts.htm

RAMTech

Faculty/staff with a valid employee ID may purchase software at a discount. Retirees may also purchase software. RAMTech is located in the Lory Student Center and can be reached at (970) 491-7625.
Vet Teaching Hospital (VTH) Employee Discount

CSU employees who are actively employed are eligible to receive financial assistance, in the form of a 20% discount, for veterinary care services provided at VTH. The VTH employee discount applies a 20% discount to all VTH charges, including field services, but excluding pharmacy, central supply and D-lab charges. The 20% discount is applied per visit.

The employee must be the owner of the animal receiving veterinary care and be named on the medical record. In some circumstances, the person who is acting on behalf of the owner, as an agent, in the care and welfare of the animal, will qualify for discount eligibility. The employee will be asked to affirm in writing their employment status with CSU. This discount is not applicable to retired employees, students or terminated employees.

Please consult with VTH for exact discount provisions.
Plan Description

All Academic Faculty, Administrative Professionals, Post Doctoral Fellows, Veterinary Interns and Clinical Psychology interns appointed on or after April 1, 1993, are required as a condition of employment under Colorado law to participate in either the University’s Defined Contribution Plan (DCP) for Retirement or, in very limited cases, in the Public Employees’ Retirement Plan (PERA) of Colorado, a defined benefit plan.

Only those newly appointed employees with qualifying prior service in Colorado’s PERA retirement system may be eligible to elect to continue membership in that retirement plan. All other new appointees must enroll in the DCP.

Please refer to the Defined Contribution Plan for Retirement Summary Plan Description for further information. PERA participants should contact PERA directly for PERA eligibility criteria and plan benefits.

Enrollment / Changes

New Hire/ Newly Eligible

To enroll, you must complete your enrollment in the CSU Online Benefits Enrollment System and in addition return the Retirement Election Form within 30 days of your eligibility date. If you meet PERA’s eligibility requirements as determined by PERA, you must elect to participate in PERA no later than 30 days from your date of appointment or you will be enrolled in the DCP. Refer to the PERA Eligibility information section referenced on the following page.

Please understand that your election in the retirement Plan (DCP or PERA) is irrevocable for the duration of any employment in which participation in the University’s retirement plan is required.

DCP participants must select an investment Company (VALIC), Fidelity, or TIAA) and complete a “DCP vendor application” to select the fund(s) they want to invest in and to designate a beneficiary(ies).

Enrollment

Vendor information, including how to enroll is available from Human Resources at (970) 491-MyHR (6947).

Default Procedures

It is very important that you complete your enrollment in the CSU Online Benefits Enrollment System and return the Retirement Election Form. Failure to do so within 30 days of your date of eligibility will eliminate any option you might otherwise have had to select PERA in lieu of the DCP. If you have not enrolled within 30 days of eligibility, you will be placed in a DCP investment company and an investment fund in accordance with a default procedure established by the University.

Further, all retirement plan contributions are placed in a non-interest bearing account until you either make an investment company selection or are defaulted to a vendor. If you terminate employment prior to electing a retirement plan, you will be enrolled in a DCP retirement plan in accordance with default procedures established by the University upon termination.

Benefits Open Enrollment

You may elect to change DCP investment companies during the annual Open Enrollment period for the following January effective date. The investment company you select will be the sole recipient of your contributions until/unless you select a different company at this time. Contact Human Resources for the appropriate DCP provider change form and investment company packet.

Your Contributions

You are required to contribute 8% of your Covered Monthly Salary on a tax-deferred basis to either the DCP or PERA. Please refer to PERA publication and rules for eligibility requirements. Tax-deferred means that your W-2 income from the University for Federal and State income tax withholding and reporting purposes will not include your retirement plan contribution.

“Covered Monthly Salary” includes all salary paid to a participant, including summer salary and supplemental pay, as those terms are defined or described in the Academic Faculty and Administrative-Professional Staff Manual.

For PERA participants, “Covered Monthly Salary” does not include pre-tax: medical, dental, vision, long-term disability, flexible spending account contributions, or; parking permits.

Employer Contributions

DCP — Effective July 1, 2017, the University will contribute an amount equal to 12% (9% prior to July 1, 2014; 10% from July 1, 2014 through June 30, 2015; 11% from July 1, 2015 through June 30, 2016; 11.5% from July 1, 2016 through June 30, 2017) of your covered monthly salary to the DCP accounts of Regular, Special, and Senior Teaching appointments of half-time or greater from the date of appointment. Temporary Academic Faculty and Administrative Professionals, Post Doctoral Fellows, Veterinary Interns, and Clinical Psychology

Three companies provide investment services for participants of the Defined Contribution Plan (DCP)

- VALIC
- Fidelity Investments
- TIAA
Interns of half-time or greater will receive the University DCP contribution after one (1) year of continuous service at the required appointment level. To complete one year of service, a 9-month employee must complete 2 consecutive semesters of continuous 1/2 time or greater employment (excluding summer term) and a 12-month employee must complete 12 months of 1/2 time or greater employment. Any interruption in continuous appointment requires the eligible employee to complete one year of service again before CSU will provide the employer match to the DCP.

For any DCP participant who is a PERA “retiree” (as defined by Article 51 of Title 24 of the Colorado Revised statutes) as of the date of employment or reemployment or becomes a PERA “retiree” at any time thereafter, the employer contribution will be reduced by any amount CSU is required to contribute to PERA with respect to the employee, except that the reduction shall not apply to:

- tenured/tenure track faculty members hired prior to July 1, 2005, or to tenured faculty members on a transitional appointment that commenced prior to January 2, 2006.

PERA — Upon initial appointment, some employees may also have the option to enroll in the defined benefit plan of the Colorado Public Employee Retirement Association (PERA). Enrollment in PERA is restricted to those employees meeting PERA’s eligibility criteria which includes, but is not limited to being an active PERA participant with at least 12 months of service credit, an in-active member with that amount of service credit or a current PERA retiree. However, unless you are a PERA retiree, you may not elect PERA as your retirement plan if you have previously been employed by a public college or university in Colorado offering an “ORP” if during that employment you made an election to participate in that institution’s ORP. In addition, if your election at that time was to participate in PERA, you may not now elect the ORP. Such elections are by law irrevocable. Effective January 1, 2011, present PERA retirees may elect either PERA or the ORP as their retirement plan each time they are reappointed. Any election to participate in PERA will require you to make the required employee or working retiree contribution to that Plan and complete the Retirement Election form each time you are reappointed.

Note: PERA is a separate and independent entity and has the authority to make determinations regarding eligibility for membership. CSU cannot mandate, nor is it responsible for, PERA’s determinations regarding eligibility.

If PERA determines that you are not eligible for membership at any time after you file a Retirement Plan Election selecting PERA as your retirement plan, the University must enroll you in the DCP. Please contact PERA to request a determination of your eligibility for membership in PERA.

It is important for you to disclose to PERA if you are receiving or have ever received a PERA annuity. PERA’s website at www.copera.org contains information regarding eligibility as defined by PERA. If PERA determines you are eligible to participate in PERA, you must complete the Retirement Plan Enrollment form no later than 30 days from your appointment date. If this form is not received by this date, you will be defaulted into the DCP retirement option.

If you are eligible as determined by PERA, and choose to enroll in PERA, the University will contribute the percentage of covered salary required by state statute to PERA’s asset pool to fund retirement and other benefits provided by PERA.

The University's contributions to PERA are never vested; instead, you acquire a vested right to future benefits after five (5) years of PERA credited service if you do not request a refund of your contributions upon termination of employment with the University. Please refer to PERA publication and rules for specific details on eligibility and retirement plan features.

CSU Retirement Eligibility

To be considered a “retiree” an academic faculty member, administrative professional or state classified employee who is a participant in the Defined Contribution Plan for Retirement (DCP) or who is a participant in the Colorado Public Employees Retirement Association (PERA) appointed or reappointed on or after July 1, 2005 must be:

- Age 55 or greater with at least 20 years of “service” or
- Age 60 or greater with at least 5 years of “service”

“Service” for this purpose includes periods of employment with Colorado State University during which the person

- Received, or was eligible to receive, the University’s contribution to the DCP or to PERA
- Had an appointment of at least half-time
- Received, or was eligible to receive, the University’s contribution toward benefits, for example health insurance (BenPay, Cost Share or State Classified insurance match).

Periods of “service” need not be
continuous but there must be a minimum of five consecutive years of “service” immediately preceding the date of “retirement”.

Periods of paid or un-paid leaves of up to 1 year in duration during which the person received, or was eligible to receive, the University’s contribution toward benefits shall be counted as “service”.

Academic faculty, administrative professional or state classified employees who are participants in PERA and who were appointed on or before June 30, 2005 or reappointed only on or before that date, who are eligible for “retirement” (full or reduced) under the PERA provisions at the time of separation and who have at least five consecutive years of service at Colorado State University in a half-time or greater, benefit eligible appointment immediately prior to the date of separation are considered “retirees”.

Any academic faculty member, administrative professional or state classified employee may retire only once from the University and any subsequent period of service shall not result in any increase in post-retirement honors, privileges or benefits for such employee. The definition of “retiree” as outlined in this policy, shall apply to any academic faculty member, administrative professional or state classified employee of CSU and shall be used to determine eligibility for any honors, privileges or benefits extended from time to time to retirees from CSU to the extent that such honors, privileges or benefits are under the control of the Board or the University.

**DCP Plan Participants – Retiree Medical Plan Eligibility**

DCP participants may have access to a medical plan with benefits equivalent to those of the active employee major medical Green Plan when they retire providing they:

- Meet the University’s definition of retirement upon separation.
- Have been enrolled in one of the University’s medical plans for at least one full plan year immediately prior to the date of retirement.
- Are under age 65 and not eligible for Medicare.
- Remain continuously enrolled in the University’s retiree medical plan after retirement.

The plan benefits and premiums are subject to change over time. Please contact Human Resources for current premiums and additional eligibility information.

**Receiving Your DCP Money**

**Loans (While employed by CSU)**

You may borrow money from your DCP account to the extent allowed under IRS loan maximums and at rates, terms and conditions established by the investment company servicing your account. You will repay the loan and interest on the balance back to your DCP account under the conditions allowed by the investment company.

**If you Terminate Prior to Age 55**

If you leave CSU prior to “normal” retirement age (55) for any reason other than death or Disability:

- You can leave your account balance in the DCP until age 55 or later. If you choose this option, you continue to have full control over the investment of your account balance according to the provisions of the DCP. When you reach age 55, you can access, depending upon the DCP investment company and type of investment you have selected, your entire account balance in a lump sum, in installment payments, or you can convert your account balance to an annuity which provides monthly payments for life.
- You can roll your account balance into another IRS-approved, tax qualified plan.
- Other tax-qualified plans may include another employer’s 401(a) or 401(k) plan, or an Individual Retirement Account (IRA). In order to avoid tax penalties or federal income tax withholding, you must roll your account balance directly from your DCP investment company to another tax qualified plan.
- If your total account balance is $10,000 or less, you have immediate access to your funds.

**Termination at or after Age 55**

When you leave CSU at or after age 55, you are entitled to your entire DCP account balance. Depending on the DCP investment company and the type of investment you have selected, you may be able to take your account balance as a lump sum payment, in installment payments, or convert it to an annuity which provides monthly payments for life. You can also leave it with the investment company for a distribution at a later date subject to certain limitations established under Federal tax law; or you can roll your account balance into another IRS-approved, tax qualified plan.

Borrowing or withdrawing money from your DCP account may have income tax and other consequences. In addition, the ability to borrow or withdraw, and the limits thereon, may change as tax laws and regulations change. Contact the investment company directly for more information about that company’s loan provision. You are encouraged to seek independent tax advice with respect to the relationship and application of all matters under the DCP to their individual tax circumstances.
Defined Contribution Plan Providers

Fidelity Investments

24-hour automated account access
(800) 343-0860
www.fidelity.com/atwork

Discover the value of choosing Fidelity Investments as your plan Provider

When choosing an investment provider for your retirement savings in the Colorado State University retirement plan, consider Fidelity Investments. Founded in 1946, Fidelity has always been committed to accuracy, top technologies, and the highest ethical standards. When you choose Fidelity, you get:

Experience to meet your needs—Fidelity Investments is well regarded for its comprehensive research, experienced portfolio managers, and global resources. Fidelity serves more than 20 million individuals and institutions, and we bring this experience to help you manage your priorities at every stage of your life. Because we service plans for thousands of tax-exempt organizations, we understand that you may have more complex savings needs above and beyond your retirement plan.

Wide variety of investment choices—Fidelity offers options that allow you to create a diversified portfolio that may be appropriate for you from among the broad categories of stock, bond, and short-term investments. With a wide range of mutual funds to choose from, you’ll have everything you need to create and manage a well-diversified portfolio. And if you don’t want to diversify it yourself, you can choose an all-in-one, diversified investment option with professionally managed Fidelity Freedom K® Funds. Fidelity Freedom K® Funds are designed for investors expecting to retire around the year indicated in each fund’s name. Except for the Freedom K Income Fund, the funds’ asset allocation strategy becomes increasingly conservative as it approaches the target date and beyond. Ultimately, they are expected to merge with the Freedom K Income Fund.

The investment risks of each Fidelity Freedom K® Fund change over time as the funds’ asset allocations change. The funds are subject to the volatility of the financial markets, including equity and fixed income investments in the U.S. and abroad and may be subject to risks associated with investing in high yield, small cap, commodity-linked and foreign securities. Principal invested is not guaranteed at any time, including at or after the target dates.

Convenient account management services—Once you begin making contributions or transfer eligible plan assets to Fidelity Investments, management of your retirement savings will be just a phone call or a mouse click away.

24-hour automated account access by phone—Call (800) 343-0860 virtually 24 hours a day, seven days a week, for mutual fund prices, yields, account balances, exchanges, and more. You also have quick access your account.

Online account information—Through our comprehensive Fidelity NetBenefits® website at www.fidelity.com/atwork, you have a wealth of information and tools, including informative brochures, online tools, and interactive worksheets that help you determine how much you need to save, how to build a diversified portfolio, how to invest through market volatility, and more.

Experience representatives—Knowledgeable Fidelity representatives are committed to helping you take full advantage of the Colorado State University retirement plan. You can call a Fidelity Retirement Representative at (800) 343-0860, Monday through Friday, from 6:00 a.m. to 10:00 p.m. Mountain time.

Flexible Distribution Options—We offer a variety of distribution options for you to choose from to fit your needs, such as: systematic withdrawals, full or partial withdrawals, or you may be eligible to take advantage of an IRA rollover. All withdrawals are subject to plan rules.

One-on-one consultations—One-on-one consultations provide you an opportunity to meet with a Fidelity Workplace Planning and Guidance Consultant to discuss retirement savings and investment options.

To schedule an in-person consultation with your Workplace Planning and Guidance Consultant, Sam Casad, call (800) 642-7131 from 6:00 a.m. to 10:00 p.m. Mountain time, or visit www.fidelity.com/atwork/reservations.

Choosing a provider for your Colorado State University retirement plan is an important step toward a more sound financial future. When you select Fidelity Investments, we’ll make every effort to address your ongoing needs.
Before investing in any investment option, please carefully consider the investment objectives, risks, charges, and expenses. For this and other information, call Fidelity at (800) 343-0860 or visit www.fidelity.com for a free mutual fund prospectus, or, if available, a summary prospectus. Read it carefully before you invest.

Keep in mind that investing involves risk. The value of your investment will fluctuate over time and you may gain or lose money.

Fidelity Facts, FMR LLC, 2012
Guidance provided by Fidelity is educational in nature, is not individualized and is not intended to serve as the primary or sole basis for your investment or tax-planning decisions.

Products or services mentioned above may be offered beyond your employer sponsored retirement plan.

Fidelity Brokerage Services LLC, Member NYSE, SIPC, 900 Salem Street, Smithfield, RI 02917
598261.1.0
TIAA’s High Ratings

TIAA, the insurance company that backs TIAA Traditional and our other guaranteed products, is one of just three U.S. insurance companies to receive the highest ratings from all major rating agencies.

CREF Investment Expertise

CREF is one of Wall Street’s largest institutional investors. Our investment managers combine a long-term perspective with in-depth knowledge of domestic and international markets. TIAA’s retirement plans provide participating institutions and individuals with a range of options to help meet their retirement plan administration and savings goals as well as income and wealth protection needs. They include variable annuities, mutual funds, tax-deferred and post-tax annuities, IRAs and brokerage accounts. Annuity account options are available through contracts issued by TIAA. These contracts are designed for retirement or other long-term goals, and offer a variety of income options, including lifetime income. Payments from the variable annuity accounts are not guaranteed and will rise or fall based on investment performance.

Objective Guidance

To help you stay on track for the long-term, you will need to develop an appropriate and diversified asset allocation strategy. TIAA provides objective Advice through an independent, industry leading investment authority. TIAA delivers what Forbes magazine calls “the most extensive personalized workplace advice” - delivered by consultants who receive no sales commissions as part of their compensation.

Powerful Online Tools

TIAA’s Web Center is available 24-hours a day, seven days a week and provides secure access to performance information and interactive retirement planning tools.

On-Campus Service

TIAA’s non-commissioned consultants are on campus frequently to meet with employees on an individual basis and periodically conduct retirement planning workshops for campus staff.

Enroll Today. It’s Easy

You can schedule an individual retirement session online, or call our Denver office at (800) 842-2009.

Upholding the values that make us unique.

Our Leadership: A tradition of providing exceptional value at low cost.

Our Values: An unwavering commitment to integrity, objectivity and stability.

Our Goals: A continued focus on innovation and excellence. You should consider the investment objectives, risks, charges and expenses carefully before investing. Please call (877) 518-9161, or visit our Web Center at www.tiaa-cref.org for a prospectus that contains this and other information. Please read the prospectus carefully before investing.

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Be sure to read the prospectus carefully before making any decisions or remitting any money.

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TIAA Individual & Institutional Services, LLC, and Teachers Personal Investors Services, Inc. distribute securities products.

TIAA (Teachers Insurance and Annuity Association), New York, NY and TIAA Life Insurance Co., New York, NY issue insurance and annuities.
Why Choose VALIC?

Financial Strength and Stability
VALIC has concentrated specifically on developing retirement plans for people like you—the employees of universities and colleges.

VALIC is the world’s leading U.S.-based international insurance and financial services organization.

Personal Service
Your highly trained financial advisor will assist you face-to-face, at work or at home, at a time that’s convenient for you. Have a question during the evening or on the weekend? Call your financial advisor—he or she will be happy to help you!

Annual account reviews will be performed (more frequently if your prefer) to monitor your progress toward meeting your retirement planning goals.

Choice
Select from funds managed or sub-advised by well-known and respected managers including Vanguard, T. Rowe Price, Templeton, SunAmerica, American Century, Ariel, INVESCO, and more.

VALIC allows you to customize your investment mix by diversifying your portfolio among several different asset classes (fixed income, bonds, small cap, mid cap, large cap, and foreign stocks).

If investing in the stock market makes you uncomfortable, you can invest all or a portion of your retirement contributions in one of the fixed account options that feature safety of principal, a guaranteed rate of return, and the earning power of a highly competitive interest rate.

Special Contract Features
There are no account maintenance fees, no withdrawal or surrender charges, no fees or limits associated with switching between funds, and no costs for transferring to other carriers.

Loans
Offers tax-free loans that allow you to borrow against a portion of your accumulated account value.

Specialized Retirement Planning and Asset Allocation
Laptop computers and advanced software make your retirement planning easier and fact based. Using 4SIGHT and Portfolio Optimizer, your financial advisor can customize a diversified investment portfolio based on your personal risk tolerance, retirement time horizon, and goals.

Portability
VALIC is licensed in all 50 states, so you will always have a financial advisor nearby to assist you with your retirement planning needs. Your retirement dollars can move with you, subject to your employer’s plan provisions.

Multiple Retirement Income Options
You retain control of your investments and can receive the proceeds of your account in systematic withdrawals, a lump-sum distribution, or in an annuity.

Worried You are Choosing the Wrong Funds?

GPS is a fee-based service that offers objective advice from independent financial expert Ibbotson Associates, In. You may choose the GPS service that automatically implements your investment advice, provides ongoing asset management, and offers access to services via a financial advisor.

See a local VALIC financial advisor for more information on GPS.

A World of Information at Your Fingertips
For information about retirement, fund profiles and performance, financial calculators, and a variety of investment-related topics, visit www.valic.com/csu.
CSU offers employees the opportunity to contribute on a pre-tax basis to voluntary tax-deferred investment accounts. These accounts can supplement your basic retirement plan.

Options currently available include:

- **403(b) Tax-Deferred Annuities and Custodial Accounts**
- **PERA 457 Deferred Compensation Plan**
- **PERA 401(k) Plan**

### 403(b) Tax-Deferred Annuities and Custodial Accounts

CSU has established relationships with three vendors to provide 403(b) arrangements for both "Traditional" and "Roth" accounts. A "Traditional" account is funded with pre-tax contributions and a Roth is funded with post-tax contributions.

To enroll, complete a salary deferral election form and the required vendor application. New enrollments / changes are due by the 10th day of the month for the change to be effective for the monthly payroll cycle.

The authorized vendors are:

- **VALIC**
- **FIDELITY INVESTMENTS**
- **TIAA**

These companies agree to strictly adhere to rules set forth under the final 403(b) regulations published by the Department of Treasury in the July 26, 2007 Federal Register.

These vendors must ensure that requests for exchanges or transfers from a current or past participant in CSU’s 403(b) plan are processed only to one of the following:

1. Variable Annuity Life Insurance Company, VALIC - available to all current employees and former employees with an established CSU 403(b) contracts or custodial accounts;

2. TIAA - available to all current employees and former employees with an established CSU 403(b) contracts or custodial accounts;

3. Fidelity Investments - available to all current employees and former employees with an established CSU 403(b) contracts or custodial accounts.

4. Purchases of permissive service credit by contract-to-plan transfers to a qualified defined benefit plan that is a governmental plan [as defined in section 414(d)], such as Colorado PERA.

### PERA 457 Deferred Compensation Plan

This plan is offered by Colorado PERA to all CSU employees. The plan is managed and administered by Colorado PERA.

An enrollment packet is available from Human Resources. Your initial enrollment form must be submitted to PERA. You will then be sent a secure PIN by PERA which allows you to complete the enrollment process online and to make future changes to contribution amounts or fund selections. Payroll deductions are initiated the month following completion of the online enrollment process.

### PERA’s 401(k) Plan

PERA manages the 401(k) plan. You may begin participation by completing a salary deferral election form and the necessary PERA application available in Human Resources. New enrollments / changes are due by the 10th day of the month for the change to be effective for that monthly payroll cycle.
2019–Tax-Deferred Investments

A tax-deferred investment (TDI) serves as a tax-deferred supplement to your basic retirement plan. This table identifies and compares the University’s tax-deferred investment options. You can enroll in a tax-deferred investment plan at any time during the year.

<table>
<thead>
<tr>
<th>403(b) Plans</th>
<th>PERA 457</th>
<th>401(k) Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tax-Deferred Annuities &amp; Custodial Accounts</strong> (Traditional and Roth)</td>
<td>Deferred Compensation Plan (Traditional and Roth)</td>
<td>(Traditional and Roth)</td>
</tr>
<tr>
<td><strong>Maximum Contribution</strong></td>
<td>$18,500 in 2019*</td>
<td>$18,500 in 2019 separate limit from 401(k) &amp; 403(b)*</td>
</tr>
<tr>
<td><strong>To Enroll or Make Changes</strong></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Contact Human Resources for the Salary Reduction Agreement form.</td>
<td>Contact PERA for general information and to make changes to your monthly contribution.</td>
</tr>
<tr>
<td></td>
<td>Contact the vendor for their enrollment packet.</td>
<td>Contribution changes must be made online through PERA by the 25th of the month prior of the month in which the deduction would begin.</td>
</tr>
<tr>
<td><strong>To Enroll or Make Changes</strong></td>
<td></td>
<td>Contact PERA for general information.</td>
</tr>
<tr>
<td></td>
<td>To make changes to your monthly contribution, complete a PERA 401(k) Change Form available in Human Resources no later than the 10th of the month in which the deduction would begin.</td>
<td></td>
</tr>
<tr>
<td><strong>Loan Provisions</strong></td>
<td>Yes, if contract permits</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Active Service Withdrawal</strong></td>
<td>Disability, age 59 ½ or financial hardship</td>
<td>Financial hardship</td>
</tr>
<tr>
<td><strong>Penalty on Early Withdrawals</strong></td>
<td>Traditional 403(b) - Yes, unless rolled over or separated from service after January 1st in the year in which you turn age 55</td>
<td>Traditional 457 - No, must separate from service</td>
</tr>
<tr>
<td></td>
<td>Roth 403(b) - Yes, must separate from service, be at least age 59 ½ and have had the account for at least 5 years</td>
<td>Roth 457 - Yes, must separate from service, be at least age 59 ½ and have had the account for at least 5 years</td>
</tr>
<tr>
<td><strong>Fees</strong></td>
<td>Variable — please check with the plan vendor</td>
<td></td>
</tr>
<tr>
<td><strong>Catch-up for Participants Age 50 and Over</strong></td>
<td>Participants age 50 and over may make additional contributions of $6,000 in 2019**</td>
<td></td>
</tr>
<tr>
<td><strong>Investment Providers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VALIC—403(b)</td>
<td>PERA 457</td>
<td>PERA 401(k)</td>
</tr>
<tr>
<td><a href="http://www.valic.com/csu">www.valic.com/csu</a></td>
<td><a href="http://www.copera.org">www.copera.org</a></td>
<td><a href="http://www.copera.org">www.copera.org</a></td>
</tr>
<tr>
<td>(970) 229-9300</td>
<td>(800) 759-7372</td>
<td>(800) 759-7372</td>
</tr>
<tr>
<td>TIAA—403(b)</td>
<td></td>
<td></td>
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<tr>
<td><a href="http://www.tiaa.org/colostate">www.tiaa.org/colostate</a></td>
<td></td>
<td></td>
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<tr>
<td>(800) 842-2776</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FIDELITY INVESTMENTS—403(b)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><a href="http://www.fidelity.com/atwork">www.fidelity.com/atwork</a></td>
<td></td>
<td></td>
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<tr>
<td>(800) 343-0860</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The above sections of the Internal Revenue Code permit certain employees (eligibility criteria vary by plan, contact Human Resources for details) of the University to exclude from current taxable income that portion of their salaries invested in a tax-deferred investment with pre-tax contributions. State and federal income taxes are deferred on the excluded portion until it is withdrawn and actually received by the employee. Income taxes can be postponed on the “deferred” amount until retirement or some other later time chosen by the employee.

The above summary is general information and is not intended to replace IRS regulations on vendor products, sales literature or a product prospectus.

* The Internal Revenue Service code may further limit the maximum contributions you may make if you participate in more than one kind of tax-deferred plan. Check with plan vendor.

**This additional contribution is a combined limit between 401(k) and 403(b) plans. This catch-up contribution provision can be used at the same time as the traditional 457 catch-up contribution provision.
## 2019–Quick Provider Reference

<table>
<thead>
<tr>
<th>Dental Plans</th>
<th>Group Numbers</th>
<th>Phone Numbers</th>
<th>Websites</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delta Dental Basic</td>
<td>9709</td>
<td>800-610-0201</td>
<td><a href="http://www.deltadentalco.com">www.deltadentalco.com</a></td>
</tr>
<tr>
<td>Delta Dental Plus</td>
<td>9684</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Defined Contribution Plan    |               |                     |                                              |
| Fidelity Investments         | 800-343-0860  | www.fidelity.com    |                                               |
| TIAA                          | 800-842-2776  | www.tiaa-cref.org   |                                               |
| VALIC                         | 800-448-2542  | www.valic.com       |                                               |

| Employee Assistance Program  |               |                     |                                              |
| ComPsych Guidance Resources  | 800-497-9133  | www.guidanceresources.com |                                           |

| Flexible Spending Accounts (FSA) |               |                     |                                              |
| Discovery Benefits              | 866-451-3399  | www.discoverybenefits.com |                                         |
| Claims Submission Fax           | 866-451-3245  |                     |                                               |

| Life Insurance                 |               |                     |                                              |
| The Hartford                   |               |                     |                                              |
| Basic                          | 677984        | 800-523-2233        | www.hartfordlife.com                        |
| Voluntary                      | 677984        |                     |                                               |
| Europ Assist (Travel Assistance)| S07449        | 800-243-6108        | www.thehartford.com/employeebenefits        |

| PERA Life Insurance            | 595121        | 866-277-1649        | www.copera.org                              |
| UNUM                          |              |                     |                                               |

| Medical Plans                  |               |                     |                                              |
| Anthem                         |               |                     |                                              |
| Green                          | C10223M002    | 800-542-9402        | www.anthem.com                              |
| Gold                           | C10223M001    |                     |                                               |
| Point-of-Service               | C102230007    |                     |                                               |
| Ram Plan-HDHP                  | C10223M014    |                     |                                               |

| PERA Infoline                  | 800-759-7372  | www.copera.org      |                                               |

| Voluntary AD&D                 |               |                     |                                              |
| The Hartford                   | S07449        | 800-523-2233        | www.hartfordlife.com                        |
| Europ Assist (Travel Assistance)| 800-243-6108  |                     | www.thehartford.com/employeebenefits        |

| Tax-Deferred Investments       |               |                     |                                              |
| Fidelity—(HSA administrator)  | 800-343-0860  | www.fidelity.com/atwork |                                      |
| TIAA                          | 800-842-2776  | www.tiaa-cref.com/colo     |                                      |
| VALIC                         | 800-448-2542  | www.valic.com         |                                               |
| PERA 457 Plan                 | 800-759-7372  | www.copera.org       |                                               |
| PERA 401(k) Plan              | 800-759-7372  | www.copera.org       |                                               |

| Vision Plan                   |               |                     |                                              |
| Vision Service Plan (VSP)     | 30021702      | 800-877-7195        | www.vsp.com                                  |

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