UNIVERSITY OF DENVER

Employee Benefits Guide

July 1, 2024 – December 31, 2024

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If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 56-57 where Notice of Creditable Coverage begins for more details.

Benefits **Overview**

Eligibility

The University of Denver is proud to offer a comprehensive benefits package to employees holding a benefited position that is at least half time (20 hours per week). Many of the plans also offer coverage for your eligible dependents.

The complete benefits package is briefly summarized in this booklet. To view the plan documents, which give you more detailed information about each of these programs, please visit **www.du.edu/human-resources/benefits**.

You and your dependents are eligible for the University of Denver benefit plans on the first day of the month following your date of hire into a benefited position. If your hire date occurs on the first of the month, your benefits may start on your hire date or the first of the following month.

Eligible dependents include:

- Your legal spouse, including common-law and civil union, and domestic partner (both same and opposite sex).
- Your child who is less than 26 years of age. Children include your natural or legally adopted child, a stepchild, the child of your domestic partner or civil union, or a child who is less than 26 and has been placed under your legal guardianship.
- Your child, who satisfies the above definition of child, age 26 or older, and who is mentally or physically incapable of earning a living, and is primarily supported by you.

Elections made now will remain in effect until the next open enrollment unless you or your family members experience a qualifying life event. If you experience a qualifying life event, you must contact Human Resources within 30 days of event.

Qualifying Life Events

Each year, you have the opportunity to make changes to your benefits during the open enrollment period. You may make a change in your coverage during the plan year only if you have a qualified change in your family or employment status. You may change your coverage election upon the occurrence of one of the qualifying life events listed below, provided you apply for the change in coverage within 30 days of the qualifying life event:

- Marriage, divorce, or legal separation
- Birth or adoption of a child
- Death of your spouse/partner or covered dependent
- Covered dependent no longer qualifies as an eligible dependent
- A significant change in the cost or coverage of your dependent's benefits
- Qualified Medical Child Support Order

For a complete listing of qualifying life events, visit **www.du.edu/human-resources/benefits**. Changes to your benefits must be made within 30 days of the event and must be consistent with your change in status.

Payroll and Leave Information

Exempt Employees (Exempt from overtime)

- Monthly payroll: All premiums are taken from each paycheck on the first of each month for coverage for that month.

Non-Exempt Employees (Eligible for overtime)

- Biweekly payroll: Medical insurance premiums are deducted from the first and second paychecks of each month to pay for coverage for that month. All other benefit deductions are taken from the first check of the month.

Leaves without pay and other non-paid time

Premiums for voluntary coverage are normally taken from your payroll check as described previously. If you are on a leave without pay that results in your premiums not being taken from your payroll check and you wish to continue coverage, you are responsible for remitting payment for those premiums. For more information, please contact Human Resources at **303.871.7420** or **benefits@du.edu**.

Premiums for faculty and other employees whose work schedules are on an academic year, or on another contract year basis, are taken from payroll as described previously during those months in which you receive a payroll check. For the summer months in which you do not receive a payroll check, the monthly premiums will be taken from the first paycheck received in the fall.

Holiday, Vacation, Sick, and Leave of Absence

Paid Holiday

The University provides several paid holidays, including: New Year's Day, Martin Luther King, Jr. Day, Memorial Day, Juneteenth (June 19), Independence Day, Labor Day, Thanksgiving Day, Thanksgiving Holiday, Chancellor's Holiday Party (Half Day), Winter Break (the last 5 week days of the calendar year).

Paid Vacation & Sick Leave

Benefited, non-faculty employees receive accrued paid time off. Please contact Human Resources at **303.871.7420** or **benefits@du.edu** for further details.

Paid Parental Leave

The University provides up to 12 weeks of partially- or fully- paid Parental Leave for all benefited faculty and benefited staff to assist and support new parents with balancing work and family matters. The University will continue to pay the employer's portion of the employee's health insurance premium while the employee is on Parental Leave.

Please review the **Interim Leave Policy** for details.

Other Forms of Leave

University policies provide for other kinds of leave, such as bereavement, jury duty, sabbaticals, military etc. Contact Human Resources at **303.871.7420** or **benefits@du.edu** for additional information.

What's New?

Dual-Carrier Option and Benefit Plan Year Change

Effective July 1, 2024, health benefits will be offered through both Kaiser Permanente and Cigna Healthcare. We understand that your health and the health of your family is your top priority. These are the University's top priorities, too, which is why we are striving to offer you the best employee health benefit plans available. For more information on benefit offerings through each medical carrier, see pages 9 and 17.

Additionally, the University will be moving the benefits plan year to January 1st through December 31st.

What does this mean for you?

- Deductibles and Out-of-Pocket Maximum amounts will continue to accumulate on a calendar-year basis.
- Flexible Spending Account (FSA) and Health Savings Accounts (HSA) will also be moving to a calendar-year basis to align with IRS maximums.
- Open Enrollment will be held May 1, 2024 through May 15, 2024 with an effective date of July 1, 2024 through December 31, 2024. You will have another opportunity to participate in open enrollment towards the end of the year. Be on the lookout for more information to follow regarding the next upcoming open enrollment.

Medical
Plan Options

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses, but identifying the problems early can often be treated at minimal cost to you. Comprehensive healthcare also provides peace of mind. In case of an illness or injury, you and your family are covered with excellent medical benefits through the University of Denver's medical plan offerings. You will have access to in-network benefits from health care providers and facilities. The University of Denver offers you a choice of two plans through Cigna Healthcare and Kaiser Permanente: a Copay and DHMO Plus Plan and a High Deductible Health Plan (HDHP).

Which Plan Is Best For You?

The Copay and DHMO Plus Plans

- Set copays for less expensive and most utilized services and a coinsurance for higher cost and lesser utilized services.
- Copays and coinsurance apply towards your annual out-of-pocket maximum.
- The plan splits higher costs services with you (80% paid by the plan and 20% paid by you) up to the out-of-pocket maximum.
- If you reach your out-of-pocket maximum, all services are paid at 100% for the remainder of the year.

The High Deductible Health Plans (HDHP)

- Tax-qualified plan for a Health Savings Account (HSA). With an HSA you are able to set aside pre-tax funds into an account to be used for qualified medical expenses. For more information on how your HSA works, please see the HSA section of this booklet starting on page 25.
- You pay the full negotiated cost for medical services and prescription drugs until you meet your annual deductible (with the exception of preventive care which is covered at 100%).
- There are no copays with the exception of prescription drugs (once your deductible has been met).
- After the deductible is met, you and the plan share the costs (80% paid by the plan and 20% paid by you) until you reach the annual out-of-pocket maximum.
- If you reach your out-of-pocket maximum, all services are paid at 100% for the remainder of the year.

All Plans

- Cover 100% of the cost for preventive care services like annual physicals and routine immunizations.

Copay and DHMO Plus Plans vs. HDHP Plans

Depending on which carrier you decide to enroll with (Cigna or Kaiser), the Copay and DHMO and HDHP (High Deductible Health Plan) plans use the same doctors and hospitals. Both options cover 100% of the cost for preventive care services like annual physicals and routine immunizations. The way you plan for care is different with each plan.

Below is a chart highlighting the key differences in the plans:

	Copay and DHMO Plus Plans	HDHP Plans
Per-Paycheck Cost for Coverage	Highest	Lowest
Calendar Year Deductible	Lowest	Highest
Calendar Year Out-of-Pocket Maximum	Lowest	Highest
Using the Plan	Pay more with each paycheck and less when you need care	Pay less with each paycheck and more when you need care
Savings/Spending Account Options	Healthcare FSA	Health Savings Account (HSA) Limited Purpose FSA

**Please see the example on pages 10 and 18 for further clarification on the differences between the Copay and DHMO Plus plans vs. the High Deductible Health Plans.

Cigna Medical
Network Options

LocalPlus Provider Network

If you live in the LocalPlus service area, you will have access to Cigna's LocalPlus provider network. The LocalPlus network is designed to improve the quality of care that you receive from all of your medical providers. LocalPlus is designed to deliver cost-effective, quality care for today's busy, on-the-go families.

More providers make it easier to choose and use quality care. The LocalPlus provider network has roughly 5,000 primary care physicians and over 14,000 specialists in the Denver metro area alone.

While traveling, or for dependents who live away from home and outside of the LocalPlus Network area, you will have full access to providers available through the Away From Home Care network. This feature provides coverage at the same in-network cost you would pay at home. There are no out-of-network benefits other than urgent and emergency care for the LocalPlus network.

To find out if your doctor is a participating provider in the LocalPlus network, please visit Cigna's website, **www.cigna.com**.

- The LocalPlus network is available in the following CO Counties*: Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Eagle, Jefferson, La Plata, Larimer, Mesa, Montezuma, Routt, Summit, Weld
- The LocalPlus network includes the following major provider groups*: Boulder Valey IPA, Community Medical Associates, Colorado Care Partners, Colorado Health Neigborhoods**, PHP Prime, UCHealth Integrated Network, New West Physicians and Optum Medical Group
- The LocalPlus network includes the following major Hospitals* and Hospital Systems:
  - Front Range: Boulder Community Health, Centura Health**, Children's Hospital Colorado, Craig Hospital, Denver Health Medical Center, HealthONE, National Jewish Health, SCL Health System, UCHealth
  - Mountain (Eagle, Routt and Summit counties): Centura St. Anthony Summit Medical Center, UCHealth Yampa Valley Medical Center, Vail Valley Medical Center West
  - West (La Plata, Mesa and Montezuma counties): Animas Surgical Hospital, Centura Mercy Regional Medical Center, Southwest Memorial Hospital, St. Mary's Medical Center

This listing is not all-inclusive. For a complete listing, contact the Cigna OneGuide by calling **800.CIGNA24** (800.244.6224) or visit **Cigna.com**.

*Listing is not all-inclusive. For a complete listing, contact your Cigna representative or visit **Cigna.com**.

Colorado Health Neighborhoods practices in Denver Metro and Boulder counties **only.

***Excludes Penrose Hospital and St. Francis Medical Center.

Open Access Plus (OAP) Provider Network

If you do not live or work inside the LocalPlus service area, you have access to the Cigna Open Access Plus provider network. The OAP Network contains participating physicians nationwide. To find out if your doctor is a participating provider in the network, please visit Cigna's website, **www.cigna.com**.

Cigna Medical Plan Options

Summary of Covered Benefits	Copay Plan	HDHP Plan
Network Type	Open Access Plus (OAP) and LocalPlus****	Open Access Plus (OAP) and LocalPlus****
Calendar Year Deductible* (single / family)	$0 / $0	$1,600 / $3,200***
Calendar Year Out-of-Pocket Max (single / family)*	$2,000 / $4,500**	$3,200 / $6,400**
DOCTOR'S OFFICE		
Virtual Care Visit	$25 copay	20% after deductible
Primary Care Office Visit	$25 copay	20% after deductible
Specialist Office Visit	$40 copay	20% after deductible
Preventive Care	100% covered	100% covered
DIAGNOSTIC TESTING/ IMAGING		
Diagnostic Lab and X-ray	Based on place of service	20% after deductible
Advanced Imaging (MRI, CT/PET Scan)	$100 copay	20% after deductible
HOSPITAL SERVICES		
Emergency Room	20% coinsurance	20% after deductible
Urgent Care	$50 copay	20% after deductible
Inpatient	20% coinsurance	20% after deductible
Outpatient Surgery	20% coinsurance	20% after deductible
Chiropractic Care (80 days per calendar year combined with cognitive, occupational, physical, pulmonary & speech therapy)	$25 copay	20% after deductible
PRESCRIPTION DRUGS		
Retail (30-day supply)		Plan deductible then,
Tier 1	$15 copay	$15 copay
Tier 2	$30 copay	$30 copay
Tier 3	$60 copay	$60 copay
Specialty	20% coinsurance up to $75	20% up to $75
Mail Order (90-day supply)		Plan deductible then,
Tier 1	$30 copay	$30 copay
Tier 2	$60 copay	$60 copay
Tier 3	$120 copay	$120 copay

*Deductibles and out-of-pocket maximums reset every calendar year.

**Important: If you have other family members on the plan, each family member must meet their own individual deductible/out-of-pocket maximum until the total amount of expenses paid by all family members meets the overall family amount.

***Important: All family members contribute towards the family deductible. An individual cannot have claims covered under the plan coinsurance until the total family deductible has been satisfied.

****Important: The LocalPlus network does not cover out-of-network services other than urgent and emergency care. You will have a lower out-of-pocket cost when using in-network providers within the OAP network.

Cigna Copay Plan vs. HDHP Plan Examples

	Copay Plan	HDHP Plan
EXAMPLE OF EMPLOYEE ONLY COVERAGE WITH THREE CLAIMS THROUGHOUT THE PLAN YEAR		
Claim 1— Member goes for their preventive care, annual physical, including routine lab (blood work to check cholesterol levels and routine exam), utilizing an in-network provider,—Total cost = $150		
Member Pays	$0, covered at 100%	$0, covered at 100%
Member's Remaining Balance **Deductible** **Out-of-Pocket Max**	 $0 $2,000	 $1,600 $3,200
Claim 2—Member goes to an in-network pharmacy and fills their 30 day prescription for a tier 2 drug—Total cost = $200		
Member Pays	$30 copay	$200 deductible
Member's Remaining Balance **Deductible** **Out-of-Pocket Max**	 $0 $1,970	 $1,400 $3,000
Claim 3—Member is hospitalized at an in-network facility for 2 days—Total cost = $6,000		
Member Pays	$0 deductible $1,200 coinsurance	$1,400 deductible $1,200 coinsurance
Member's Remaining Balance **Deductible** **Out-of-Pocket Max**	 $0 $770	 $0 $400
Estimated Employee Contribution		
Monthly	$97.76	$0.00
Annual	$1,173.12	$0.00
EXAMPLE OF EMPLOYEE + FAMILY COVERAGE WITH THREE CLAIMS THROUGHOUT THE PLAN YEAR		
Claim 1—Member and their 3 dependents goes for their preventive care, annual physicals, including age appropriate routine lab and immunizations, utilizing an in-network provider—Total cost = $600		
Member Family Pays	$0, covered at 100%	$0, covered at 100%
Member's Family Remaining Balance **Deductible** **Out-of-Pocket Max**	 $0 Individual / $0 Family $2,000 Individual / $4,500 Family	 $3,200 Family $6,400 Family
Claim 2—Member's spouse/partner goes to an in-network pharmacy and fills their 30 day prescription for a tier 2 drug, 4 months—Total cost = $800		
Member Family Pays	$120 copay ($30/month)	$800 deductible ($200/month)
Member's Family Remaining Balance **Deductible** **Out-of-Pocket Max**	 $0 Individual / $0 Family $1,880 Individual / $4,380 Family	 $2,400 Family $5,600 Family
Claim 3—Member's child (dependent) has an emergency room an in-network facility—Total cost = $3,000		
Member Family Pays	$0 deductible $600 coinsurance	$2,400 deductible $800 coinsurance
Member's Family Remaining Balance **Deductible** **Out-of-Pocket Max**	 $0 Individual / $0 Family $1,400 Individual/ $3,780 Family	 $0 Family $2,400 Family
Estimated Employee Contribution		
Monthly	$640.40	$307.40
Annual	$7,684.80	$3,688.80

Health Advocate

The University of Denver wants to ensure that you and your family have the information you need to make the best health and wellness decisions for you. To assist with this, the University offers 24/7 access to help when you need it for all your health care or medical bill needs – for you and your family, including parents and parents-in-law. Health Advocate offers you expert assistance with all of your insurance needs including medical, dental, vision, life & disability. Get the answers you need, when you need them, **at no additional cost to you.** You do not have to be enrolled in the University's health plan to access this benefit.

Health Advocate compliments the services available from Cigna One Guide, and is the primary resource for individuals not enrolled in the Cigna medical plans.

Don't know where to turn? We point the way.

- Find the right professionals based on your needs
- Locate specialists, schedule appointments, arrange tests or special treatments
- Answer questions about diagnoses, test results, treatments, medications and more

Services for the whole family

Employees, spouses/partners, dependent children, parents and parents-in-law are all eligible.

Want to maximize your benefit dollars? We can help you save.

- Get the estimated fees for services in your area
- Find options for non-covered and alternative health services
- Receive information about generic drug options
- Address questions and concerns related to your medical bills
- Get help negotiating discounts on medical or dental bills over $400 not covered by insurance

Need eldercare or special needs services?

- Find in-home care, adult day care, group homes, assisted living and long-term care
- Get access to a range of services for parents of children with special needs or autism spectrum disorders
- Clarify or get help applying for Medicare, Medicare Supplement plans and Medicaid
- Coordinate care among multiple providers
- Arrange transportation to appointments

How it works

Employees and their family members can call 866.799.2725.	**Caller speaks to a dedicated personal health advocate and receives live, individualized assistance.**	**Personal health advocate continues to support the individual until the issue is resolved.**

* Health advocacy services are NOT health insurance or medical services, and this program does not provide either for health care services or for the reimbursement for financial losses of health care services.

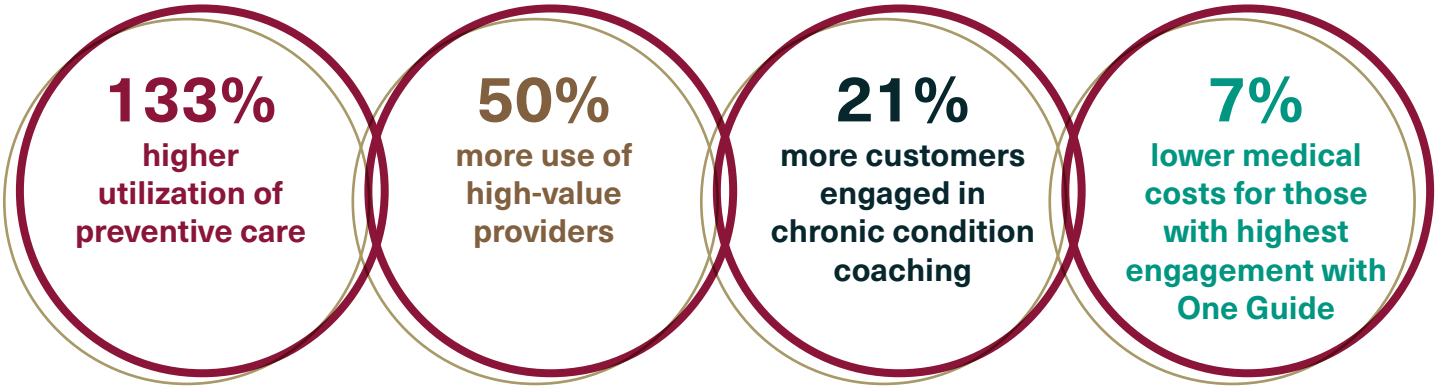
Cigna One Guide

Navigating healthcare can be complex. With Cigna One Guide, employees don't have to do it alone. One Guide combines intelligent technology with empathetic human support to help guide employees to engage in their health and get the most value from their health plan.

It's personal, proactive and predictive.

One Guide leverages powerful data analytics that your One Guide team will use for everything from health status to communication preferences. As a result, One Guide can anticipate employees' needs and proactively recommend the programs and resources that are more relevant to them – such as incentives and coaching opportunities.

It's effective. The One Guide solution drives results such as:



Technology powers the experience.

Easier to navigate. Easier to use. Easier to manage benefits.

Personalized Opportunities

- Immediate access to information customers value most
- Dynamic content based on each customer's plans
- Content prioritized and displayed based on extensive user analytics
- Account balances, coverage and claims information
- Health assessments and incentives

Quick Access to Finding and Getting Care

- Guidance in finding the right doctor, lab, pharmacy or convenience care center
- Easy connection to health coaches, case managers, pharmacists and other resources

One-click Access to Live Support

- Personal guides accessible via phone, app, web or click to chat
- Dedicated one-on-one support in complex situations, for those who need it most
- Education on plan features, ways to maximize benefits and earn incentives

If you are currently enrolled in a Cigna medical plan, you can start using Cigna's One Guide by downloading the myCigna app or call 800.244.6224 to talk with your personal guide.

If you are not currently enrolled in a Cigna medical plan, you can reach out to the One Guide pre-enrollment line at 888.806.5042.

myCigna and Motivate Me

Manage Your Health through myCigna

Your online account will be available once your eligibility is received by Cigna. **myCigna** gives you access to these features:

- Search for in-network providers, procedures, cost estimates, and more.
- See a list of your most recent claims, their status, and reimbursements.
- Make sure your contact information is up-to-date so you don't miss out on important notifications about your plan.

It's as easy as 1, 2, 3.

1. Visit **www.mycigna.com** using your computer or mobile device.
2. Follow the registration instructions. You will need your DU ID or Cigna ID number (found on the front of your ID card).
3. Start managing care for you and your family – find a doctor, schedule an appointment, transition your prescriptions and more.

Download the myCigna® app today.

Cigna MotivateMe

The University of Denver wants to assist you in achieving your health goals. When you get involved in wellness goals sponsored by the University through myCigna.com, you can earn up to $100 in a Visa gift card mailed to your address. Incentives are given for completing the following activities:

- Health assessment
- Biometric screening
- Annual preventive exams
- Pharmacy steerage
- Digital Diabetes Prevention Program
- Coach by phone
- And a variety of other healthy activities

The rest is up to you

For more information or help setting up your account, vis it **myCigna.com** or call **800.244.6224**. You can also find information by downloading the myCigna Mobile App for your mobile device.**

*Incentive awards may be subject to tax; you are responsible for any applicable taxes. Please consult with your personal tax advisor for assistance.

**The downloading and use of the myCigna Mobile App is subject to the terms and conditions of the App and the online stores from which it is downloaded. Standard mobile phone carrier and data usage charges apply.

How Do I Participate in the MotivateMe® Program?

1. Create an account on **www.myCigna.com**.
2. Once you reach the Home Dashboard, select the "Wellness" tab on the far right.
3. Click "Wellness Incentives" in the drop-down menu.
4. Scroll down to see your available incentives. Not all incentives are immediately listed, so make sure you select "View All Incentives."
5. Select "Let's Go" to begin completing each incentive.
6. Once an incentive is complete, select "Redeem."

Once you select Redeem, this will initiate the mailing process for your gift card. For more information, please visit **www.du.edu/human-resources/employee-wellbeing/cigna-motivateme**.

Cigna Virtual Care Options

TeleHealth Through MDLive

Convenient, low cost option.

Virtual care for minor medical conditions costs less than the ER or urgent care visits, and may be even less than an in-office primary care provider visit.

- Get care via video or phone, 24/7/365 – even on weekends and holidays.
- Connect with board-certified doctors and pediatricians.
- Have a prescription sent directly to a local pharmacy, if appropriate.

Board-certified doctors and pediatricians can diagnose, treat and prescribe most medications for minor medical conditions, such as:

- Acne
- Allergies
- Asthma
- Bronchitis
- Cold and Flu
- Constipation
- Diarrhea
- Earaches
- Fever
- Headaches
- Infections
- Joint aches
- Pink eye
- Rash
- Respiratory infection
- Shingles
- Sinus infection
- Skin infection
- Sore throats
- Urinary tract infection

Cigna partners with MDLive for minor medical virtual care. This can be accessed via **www.myCigna.com**.

Virtual Behavioral Health

MDLIVE is available for behavioral/mental health virtual care too.

Licensed counselors and psychiatrists can diagnose, treat and prescribe most medications for nonemergency behavioral conditions, such as:

- Addictions
- Bipolar disorders
- Child/Adolescent issues
- Depression
- Eating disorders
- Grief/Loss
- Marriage and Relationship issues
- Men's issues
- Panic disorders
- Parenting issues
- Postpartum depression
- Stress
- Trauma/PTSD
- Women's issues

Schedule an appointment online with a counselor or psychiatrist within minutes by logging onto **www.myCigna.com** or call **888.726.3171**.

Cigna Behavioral Programs

Challenges to mental well-being come in many forms, and so do the ways we can work through them. Whether you need help reducing stress, are feeling motivated to make a change in your life, or need to talk to someone, Cigna offers a variety of behavioral support tools and services through myCigna to help ensure you get the support that works best for you.

Virtual Counseling

- Schedule appointments online with licensed counselors or psychiatrists through our virtual only provider groups.
- Get access to providers with a wide variety of specialties such as autism and substance use, as well as providers who specialize in treating emergency responders.
- Use new modality options, such as private text therapy with providers
- Receive confidential treatment for conditions such as stress and anxiety.

Cigna's Employee Assistance Program

- Up to three free face-to-face sessions with a licensed mental health provider in Cigna's network.
- On-demand seminars, community resources and referrals on a range of topics.
- Virtual behavioral care allows you to speak with a counselor on your phone, tablet or home computer.
- Self-service digital tools and resources
  - iPrevail: provides on-demand coaching, personalized learning and caregiver support. Complete an assessment, receive a program tailored to your needs, and get connected to a peer coach.
  - Happify: self-directed program with activities, science-based games and guided meditations, designed to help reduce anxiety, stress and boost overall health.

Mental Health and Substance Use

- Centers of Excellence (COEs)
- Coaching & Support
- Modality options, such as private text messaging with providers
- Behavioral Awareness Series

Coaching and Support

- Understand a behavioral diagnosis.
- Address challenges with autism spectrum disorders, eating disorders, substance use, opioid use and pain management.
- Learn about treatment choices and how your choices can affect what you'll pay out of pocket.
- Identify and manage triggers that affect your condition.

Lifestyle Management Programs

- Smoking, obesity and stress pose significant threats to physical and behavioral wellness
- These conditions can be managed through healthy lifestyle habits, and we offer services that can help.

Meru Health

www.meruhealth.com/cigna

- 12-week app-based counseling program
- Daily support from licensed clinicians and anonymous peers to treat anxiety, depression and burnout.

Talkspace

www.talkspace.com/cigna

- An online therapy platform that makes it easy and convenient for you to connect with a licensed behavioral therapist from anywhere, at any time.
- Unlimited text, video, and voice messages to your dedicated therapist via web browser or the Talkspace mobile app.

Kaiser Medical
In-Person Care Options

KAISER PERMANENTE®

You Asked! We Listened!

Kaiser will now be offered to employees that live and work in Colorado.

If you live in the Kaiser service area, you have access to Kaiser's provider network. The Kaiser provider network has 13,000+ Kaiser Permanente primary care physicians and over 14,000 affiliated plan providers across Colorado.

At most Kaiser Permanente medical offices, you can see a doctor, fill a prescription, and have lab and imaging services done in the same place.

Kaiser Away From Home Care

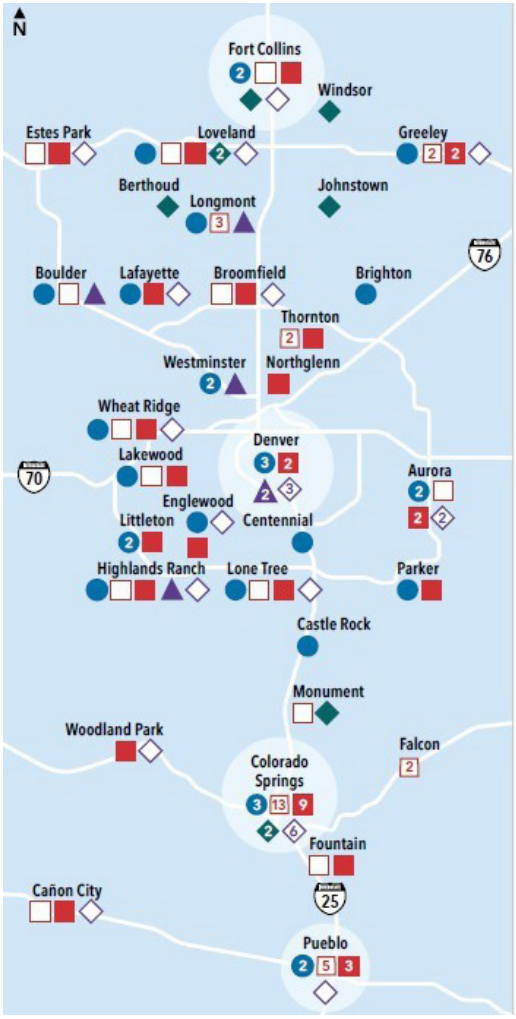
If you are traveling or have dependents that will be living outside of the Kaiser Colorado service area, you have full access to the Kaiser Away From Home Care program. This program provides coverage at the same in-network cost you would pay at home. Outside of the Kaiser Permanente Colorado Service area, members can get urgent and emergency care through Cigna's PPO network providers and urgent care at various MinuteClinic (in select CVS and Target stores) and Concentra urgent care centers.

For the most up-to-date information, visit kp.org/travel or call the Away From Home Travel Line at **951.268.3900**.

Note: There are no out-of-network benefits other than urgent and emergency care for the Kaiser Network.

For the most up-to-date list of providers and facilities included in your plan, visit **kp.org/locations** or call:

- Denver/Boulder: 303.338.3800
- Northern Colorado: 844.201.5824
- Southern Colorado: 888.681.7878
- TTY 711



Colorado medical facilities

30	Kaiser Permanente medical offices	●
41	Urgent care facilities	□
35	Emergency care facilities	■
6	Behavioral health offices	▲
9	Affiliated providers with extended hours	◆
24	Affiliated hospital/inpatient care	◇

*Choice of providers varies by plan, service area, and availability at the time of selection and is subject to change.

Kaiser Medical Plan Options

Summary of Covered Benefits	DHMO Plus Plan****	HDHP Plus Plan****
Network Type	Kaiser Providers	Kaiser Providers
Calendar Year Deductible* (single / family)	$0 / $0	$1,600 / $3,200***
Calendar Year Out-of-Pocket Max (single / family)*	$2,000 / $4,500**	$3,200 / $6,400**
DOCTOR'S OFFICE		
Virtual Care Visit	100% covered	20% after deductible
Primary Care Office Visit	$25 copay	20% after deductible
Specialist Office Visit	$40 copay	20% after deductible
Preventive Care	100% covered	100% covered
DIAGNOSTIC TESTING/ IMAGING		
Diagnostic Lab and X-ray	Based on place of service	20% after deductible
Advanced Imaging (MRI, CT/PET Scan)	$100 copay	20% after deductible
HOSPITAL SERVICES		
Emergency Room	20% coinsurance	20% after deductible
Urgent Care	$50 copay	20% after deductible
Inpatient	20% coinsurance	20% after deductible
Ambulatory Surgical Center	10% coinsurance	10% after deductible
All Other Outpatient Facilities	20% coinsurance	20% after deductible
Chiropractic Care (80 days per calendar year combined with cognitive, occupational, physical, pulmonary & speech therapy)	$25 copay	20% after deductible
PRESCRIPTION DRUGS		
Retail (30-day supply)		Plan deductible then,
Tier 1	$15 copay	$15 copay
Tier 2	$30 copay	$30 copay
Tier 3	$60 copay	$60 copay
Specialty	20% coinsurance up to $75	20% up to $75
Mail Order (90-day supply)		Plan deductible then,
Tier 1	$30 copay	$30 copay
Tier 2	$60 copay	$60 copay
Tier 3	$120 copay	$120 copay

*Deductibles and out-of-pocket maximums reset every calendar year.

**Important: If you have other family members on the plan, each family member must meet their own individual deductible/out-of-pocket maximum until the total amount of expenses paid by all family members meets the overall family amount.

***Important: All family members contribute towards the family deductible. An individual cannot have claims covered under the plan coinsurance until the total family deductible has been satisfied.

****Within your first year with Kaiser, you have the opportunity to take advantage of the **PLUS** benefits where you can choose to see any licensed provider. Services can include primary care, specialty care, and mental health office visits. Plus Benefits outside the Kaiser Network offers 20 service visits and 10 prescriptions per member per year. For more information, please visit **choiceproducts-Colorado.kp.org**.

Kaiser DHMO Plus Plan vs. HDHP Plus Plan Examples

	DHMO Plus Plan	HDHP Plan
EXAMPLE OF EMPLOYEE ONLY COVERAGE WITH THREE CLAIMS THROUGHOUT THE PLAN YEAR		
Claim 1— Member goes for their preventive care, annual physical, including routine lab (blood work to check cholesterol levels and routine exam), utilizing an in-network provider,—Total cost = $150		
Member Pays	$0, covered at 100%	$0, covered at 100%
Member's Remaining Balance **Deductible** **Out-of-Pocket Max**	 $0 $2,000	 $1,600 $3,200
Claim 2—Member goes to an in-network pharmacy and fills their 30 day prescription for a tier 2 drug—Total cost = $200		
Member Pays	$30 copay	$200 deductible
Member's Remaining Balance **Deductible** **Out-of-Pocket Max**	 $0 $1,970	 $1,400 $3,000
Claim 3—Member is hospitalized at an in-network facility for 2 days—Total cost = $6,000		
Member Pays	$0 deductible $1,200 coinsurance	$1,400 deductible $1,200 coinsurance
Member's Remaining Balance **Deductible** **Out-of-Pocket Max**	 $0 $770	 $0 $400
Estimated Employee Contribution		
Monthly	$97.76	$0.00
Annual	$1,173.12	$0.00
EXAMPLE OF EMPLOYEE + FAMILY COVERAGE WITH THREE CLAIMS THROUGHOUT THE PLAN YEAR		
Claim 1—Member and their 3 dependents goes for their preventive care, annual physicals, including age appropriate routine lab and immunizations, utilizing an in-network provider—Total cost = $600		
Member Family Pays	$0, covered at 100%	$0, covered at 100%
Member's Family Remaining Balance **Deductible** **Out-of-Pocket Max**	 $0 Individual / $0 Family $2,000 Individual / $4,500 Family	 $3,200 Family $6,400 Family
Claim 2—Member's spouse/partner goes to an in-network pharmacy and fills their 30 day prescription for a tier 2 drug, 4 months—Total cost = $800		
Member Family Pays	$120 copay ($30/month)	$800 deductible ($200/month)
Member's Family Remaining Balance **Deductible** **Out-of-Pocket Max**	 $0 Individual / $0 Family $1,880 Individual / $4,380 Family	 $2,400 Family $5,600 Family
Claim 3—Member's child (dependent) has an emergency room an in-network facility—Total cost = $3,000		
Member Family Pays	$0 deductible $600 coinsurance	$2,400 deductible $800 coinsurance
Member's Family Remaining Balance **Deductible** **Out-of-Pocket Max**	 $0 Individual / $0 Family $1,400 Individual/ $3,780 Family	 $0 Family $2,400 Family
Estimated Employee Contribution		
Monthly	$640.40	$307.40
Annual	$7,684.80	$3,688.80

Kaiser Resources

Manage Your Health through Kaiser's Website and App

Managing your health online has never been more convenient. Whether you're at home or on the go, **kp.org** and the Kaiser Permanente app give you a simple, secure way to keep up with your care.

- Schedule, view, and cancel routine appointments and see information about past visits.
- View your medical history, including allergies and immunizations, ongoing health conditions, and most lab test results.
- Refill most prescriptions, check the status of a prescription order, and see a list of all your medications.

KAISER PERMANENTE®

Mobile Access

Get the Kaiser Permanente mobile app from the Apple App Store or the Android app from Google Play. Manage your health, find locations and care, refill prescription, view lab results, and more!

Kaiser New Member Connect Team

We understand that joining a new health care organization can be disruptive which is why we want to make sure each member has an enjoyable experience. All new Kaiser members will have access to the New Member Connect Team to help with transitioning your care. Connect at anytime by using the following:

Website:
kp.org/newmember

Search Profiles to Find the Right Doctor

Phone: **844.639.8657**
Monday through Friday, 8 a.m.-5 p.m.

Transition Your Care Seamlessly

Email: **UniversityOfDenver@kp.org**

Connect to Care Onlineorg

Kaiser Permanente DigiDeck—Digital Resource Guide

With Kaiser, you have access to the University of Denver Digideck to help you make an informed healthcare decision for you and your family with resources available in one convenient location. Resources include:

- Easy ways to transition care through New Member Connect
- Wellness Resources
- Benefits
- And much more!

To access, click on the link below or scan the QR code.
University of Denver DigiDeck

Kaiser Virtual Care Options

Get the Right Care—When You Need It and How You Want It

You may not always feel like you have time to visit the doctor. Kaiser's doctors are committed to getting you care however it works best for you — from home, work, or in person.

PHONE
Save yourself an office visit by scheduling a call with a doctor.

EMAIL
Message your doctor's office with non-urgent questions anytime.

E-VISIT
Fill out a short online questionnaire about your symptoms and a nurse will get back to you - usually within 6 hours. Great for coughs, colds, nausea, allergies and more.

VIDEO VISIT
An online alternative to an in-person appointment.

IN-PERSON
Same-day or next-day appointments are often available.
Call 303-338-4545 (TTY 711)

CHAT ONLINE
Connect in real time with a physician by logging into **www.kp.org** and click "Chat". Available Mon-Fri 7am to 10pm and Sat-Sun 8am to 10pm.

Kaiser Employee Assistance Program through TELUS HEALTH

Employees who are enrolled in a Kaiser medical plan are offered the EAP Program through TELUS Health which provides:

- Three free sessions with a licensed mental health professional through all visit formats (in-person, phone, and video counseling).
- Digital self-guided therapy through CareNow which offers self-help resources based on cognitive behavior principles, interactive content, exercises, podcasts, meditation, and videos.

For more information, visit **www.kp.org** or the Kaiser Mobile app.

Virtual Behavioral Health

Everyone needs support for total health — mind, body, and spirit. These wellness apps can help you navigate life's challenges, and make small changes to improve your sleep, mood, relationships, and more. It's self-care made easy, designed to help you live well and thrive.

Calm

The number one app for sleep and mediation—designed to help lower stress, anxiety, and more.

- More than 100 guided meditations
- Sleep stories for deeper, more restful sleep
- Exclusive music tracks for focus, relaxation, and sleep

Headspace Care

Text one-on-one with an emotional support coach anytime, anywhere. Support is just a text message away.

- 24/7 text-based emotional support coaching
- Discuss goals, share challenges, and create an action plan with your coach
- Self-care resources recommended for your need

myStrength

Build a personalized plan to strengthen your emotional health whenever, wherever you need to.

- A personalized support plan
- Tools to manage stress, depression, sleep, and more.
- Hundreds of activities, articles, and videos

Care Options With Cigna and Kaiser

From strains to pains, you never know when you might need treatment. But when that time comes, you can get the care that's right for you by choosing from a number of options that meet your care and financial needs.

For minor illness or injury at times when you can't see your doctor, a call to a nurse helpline or your telemedicine advocate or a visit to a retail clinic may be able to provide the care you need, saving you time and the high costs of an urgent care or an emergency room visit.

VIRTUAL CARE $

Access a doctor by phone when, where, and how it works best for you. Get treatment for minor conditions like allergies, cold/flu, and rashes at your finger tips.

- Sinus infections
- Allergies
- Rashes
- Cold/Flu symptoms
- Diarrhea
- UTI

PRIMARY CARE $$

Your best place to go for routine or preventive care, medication tracking, or getting a referral for unique services e.g. durable medical equipment etc.

- Immunizations/ Preventive care
- Lab services
- Medication concerns
- Lingering pain
- Minor to moderate illnesses
- Non-urgent treatment

DISPATCHHEALTH $$$

DispatchHealth brings comfortable healthcare to your home or location convenient to you. They treat everything an urgent care center can, plus more! Hours of care are 8 AM to 10 PM*. Visit **www.dispatchhealth.com** or download the phone app.

- Cold/flu symptoms
- Asthma & respiratory
- Nausea, vomiting diarrhea
- UTI
- Ear, nose & throat
- Stitches & minor fractures
- Back, neck & joint pain

URGENT CARE $$$

Sometimes you need medical care fast but a trip to the emergency room may not be necessary. Visit a Cigna or Kaiser in-network urgent care center when you can't get in to see your primary doctor and are in need of after-hours care. Urgent care centers can generally treat many minor illnesses and injuries while saving you the time and expenses of an emergency room visit.

- Sprains, dislocations, fractures
- Concussions
- Minor allergic reactions
- Minor to moderate asthma attacks
- Sore throats, ear pain
- Small cuts

EMERGENCY ROOM $$$$

When you feel you need immediate treatment for critical injuries or illnesses that may result in serious injury or are life threatening.

If you believe you are experiencing a medical emergency, go to the nearest emergency room or call 911.

- Heavy bleeding
- Heart attack/chest pain
- Stroke
- Spinal injuries
- Difficulty breathing

Dental Plan Options

Insured by Delta Dental and Beta Health

Good oral care enhances overall physical health, appearance and mental well-being. Problems with the teeth and gums are common and easily treated health conditions. The University of Denver offers you a choice of two dental plans with Delta Dental and one dental discount program with Beta Health.

With the Delta Dental options, you and your family members may visit any licensed dentist, but you will receive the greatest out-of-pocket savings if you see a Delta Dental PPO provider. If you choose to see an out-of-network dentist, you will incur additional out-of-pocket expenses, and you will be billed the difference between the total amount the provider charges and the approved amount (this is called balance-billing*). When you see a Delta Dental PPO or Premier provider, you are protected from balance-billing.

The two Delta Dental plans include the Right Start 4 Kids program. This program provides all covered services for children up to their 13th birthday at 100% with no deductible when you see a PPO or Premier provider (for the same services outlined in the plan, up to the annual maximum, and subject to limitations and exclusions). Orthodontia is not covered at 100% but at the plan's listed coinsurance.

Beta Health

The Beta Health Alpha plan is a network-only dental discount program that provides an average of up to 70% savings on the most commonly performed dental procedures (including cleanings, fillings, crowns, root canals, and even orthodontia for children and adults). Refer to the Plan's fee schedule to see how much each procedure will cost. To take advantage of the savings, you and your family can see one of over 700 Colorado providers. Your provider must be selected at enrollment, but can be changed during the year anytime you wish.

Summary of Covered Benefits	Delta Base PPO Plan		Delta Enhanced PPO Plan		Beta Health Alpha Plan
	PPO	Premier or Out-of-Network	PPO	Premier or Out- of-Network	
Annual Deductible (single/family)	$50/up to $150		$50/up to $150		N/A
Annual Benefit Maximum	$1,000 per member		$1,500 per member		Unlimited
PREVENTIVE DENTAL SERVICES					See Fee Schedule
Oral exam, cleanings, sealants, x-rays	Covered at 100%	Covered at 100%*	Covered at 100%	Covered at 100%*	
BASIC DENTAL SERVICES					
Fillings, simple extractions, oral surgery, endodontics, periodontics	20% after ded.	20% after ded.*	20% after ded.	20% after ded.*	
MAJOR DENTAL SERVICES					
Crowns, dentures, bridges, implants	50% after ded.	50% after ded.*	50% after ded.	50% after ded.*	
Orthodontia Services Adult & children	Not covered		50% to a $1,500 lifetime maximum per member		
Late Entrant Waiting Period**	Not applicable for preventive service, 6 months on basic services and 12 months on major and orthodontia services				None

To find a dental provider visit **www.deltadentalco.com**

*Balance-billing applies if you see an out-of-network provider. The amount you may owe is the difference between the provider's billed charges and the payment received by Delta Dental based off of their "Maximum Allowable Charge" schedule.

** Those who do not enroll in the dental plan when initially eligible as a new hire, or re-enroll, will be considered Late Enrollees and will be subject to a waiting period. The "Late Enrollee" penalty does not apply to those covered by another group dental plan who enroll within 30 days of loss of the other dental coverage and to children who are enrolled on any anniversary prior to the 4th birthday.

Vision
Plan Options

Insured by EyeMed

Your eyes can provide a window to your overall health. Through routine exams your provider may be able to detect general health problems in their early stages along with determining if you need corrective lenses. The University of Denver knows your vision care is personal and so is your relationship with your eye doctor. That's why The University of Denver has partnered with EyeMed to provide you with access to affordable care and quality eyewear at an extensive number of retail and independent providers.

	Base Plan		Enhanced Plan	
Summary of Covered Benefits	**In-Network**	**Out-of-Network Reimbursement**	**In-Network**	**Out-of-Network Reimbursement**
Eye Exam	Under age 19: Twice every plan year; Age 19+: Once every plan year			
	$10 copay	Up to $45	Plan pays 100%	Up to $45
LENSES	**Under age 19: Twice every plan year; Age 19+: Once every plan year**			
Single Vision **Bifocal** **Trifocal**	$25 copay	Up to $35 Up to $50 Up to $65	$10 copay	Up to $35 Up to $50 Up to $65
FRAMES	**Once every two plan years**		**Once every plan year**	
Frames*	Up to $130 allowance; then 20% off balance	Up to $90	Up to $150 allowance; then 20% off balance	Up to $104
CONTACT LENSES	**Once every plan year**			
Elective	Up to $130 allowance; then 15% off balance	Up to $104	Up to $150 allowance; then 15% off balance	Up to $120
Medically Necessary	Covered in full	Up to $210	Covered in full	Up to $210
Laser Correction	15% off retail price or 5% off promotional price	N/A	15% off retail price or 5% off promotional price	N/A
ADDITIONAL DISCOUNTS				
Additional in-network discounts	40% off complete pair of prescription eyeglasses, 20% off non-prescription sunglasses, 20% off remaining balance beyond plan coverage			

*Freedom Pass Special Offer. As an extra benefit, Target Optical locations offer a $0 out-of-pocket option allowing you to select any available frame, any brand – no matter the original retail price point.

Members are required to complete a frames purchase, which is covered based on the benefits (outlined in the vision benefits above). However, members are still responsible for lenses. This may include an additional copay. Discounts are not insured benefits. Proof of offer is required at time of purchase. **Use code 755288.**

To view a full list of providers, visit **www.eyemed.com**

Premium Contributions

The table below shows the employee contributions for the medical, dental and vision plans. Your portion of the cost(s) will be deducted from your paycheck on a pre-tax basis. The portion of the premiums paid by employees for civil union or domestic partner coverage will be withheld on a post-tax basis. The University portion of the premium paid for a civil union or domestic partner will be added to your earnings as taxable income.

Medical	Cigna			
	Copay Plan		HDHP-HSA Plan*	
	University of Denver Contributes	Employee	University of Denver Contributes	Employee
Employee Only	$691.82	$97.76	$610.83	$0.00
Employee & Spouse/Partner	$1,166.30	$407.24	$1,042.05	$174.52
Employee & Child(ren)	$1,051.39	$365.32	$935.70	$159.68
Family	$1,560.41	$640.40	$1,393.62	$307.40

Medical	Kaiser			
	DHMO Plus Plan		HDHP-HSA Plus Plan*	
	University of Denver Contributes	Employee	University of Denver Contributes	Employee
Employee Only	$651.18	$97.76	$603.81	$0.00
Employee & Spouse/Partner	$1,090.63	$407.24	$1,033.10	$174.52
Employee & Child(ren)	$982.77	$365.32	$927.18	$159.68
Family	$1,456.62	$640.40	$1,383.27	$307.40

*If you enroll in the HDHP and open a health savings account (HSA) through Rocky Mountain Reserve the University will contribute $27.64 per month to your HSA.

Dental	Delta Base PPO Plan	Delta Enhanced PPO Plan	Beta Health Alpha Plan
Employee Only	$32.91	$54.93	$10.75
Employee & Spouse/Partner	$64.87	$108.29	$20.25
Employee & Child(ren)	$78.04	$130.24	$23.25
Family	$121.81	$203.00	$29.75

Vision	Base Plan	Enhanced Plan
Employee Only	$6.80	$9.50
Employee & Spouse/Partner	$12.95	$18.04
Employee & Child(ren)	$13.64	$19.01
Family	$20.05	$27.93

Health Savings **Accounts (HSA)**

ROCKY MOUNTAIN reserve

Administered by Rocky Mountain Reserve

A Health Savings Account (HSA) is an individually- owned, tax-advantaged account that you can use to pay for current or future IRS-qualified medical expenses. With an HSA you'll have the potential to build more savings for healthcare expenses or additional retirement savings through self- directed investment options.

Are you eligible for an HSA?

Your HSA is administered through Rocky Mountain Reserve (RMR). You can open and contribute to an HSA if you:

1. Are covered by an HSA-qualified health plan (HDHP);
2. Are not covered by other health insurance (with some exceptions);
3. Are not enrolled in Medicare;
4. Are not enrolled in TriCare;
5. Are not eligible to be claimed as a dependent on another person's tax return;
6. Have not received health benefits from the Veterans Administration with the exception of services for a "service related disability" or an Indian Health Services facility within the last three months; and
7. Are not covered by your own or your spouse/partner's Healthcare FSA.

High Deductible Health Plans and HSA

You must be enrolled in the Cigna or Kaiser HDHP plan to be eligible for an HSA and to make HSA contributions.

How does an HSA Account work?

- You can contribute to your HSA via payroll deductions, an online banking transfer, or send a personal check to RMR. Your employer or a third party, such as a spouse/partner or parent, may contribute to your account as well.
- You can pay for qualified medical expenses with your debit card directly to your medical provider or pay out-of-pocket. You can either choose to reimburse yourself or keep the funds in your HSA to grow your savings.
- Unused funds will roll over year to year. After age 65, funds may be withdrawn for any purpose without a penalty but will be subject to ordinary income taxes.

How much can you contribute to your HSA?

Any contributions made by all parties can not exceed the IRS annual HSA limit. Below are the IRS limit amounts for the 2024 calendar year.

	IRS 2024 Maximum Contribution	The University of Denver Contribution	Employees Maximum Contribution
Self Only	$4,150	$331.68 ($27.64 per month)	$3,818.32
Family	$8,300		$7,968.32
Catch-Up	Age 55+ may contribute an additional $1,000*		

*Employees age 55 or older anytime in 2024, who are not enrolled in Medicare, may contribute an additional $1,000 to their HSA account. Spouses/Partners who are 55 or older and covered under the employee's medical insurance through the University of Denver may also make a catch-up contribution into a separate HSA account in their own name. If you enroll in Medicare mid-year, your catch-up contribution should be prorated.

Flexible Spending Accounts (FSA)

Administered by Rocky Mountain Reserve

Flexible spending accounts (FSAs) allow employees to use pre-tax dollars for healthcare or child/dependent care expenses not covered by insurance plans. Employees contribute a portion of each paycheck to an FSA and save significantly on taxes. Money in an FSA can be used to pay for out-of-pocket medical, dental, and vision expenses, or dependent care expenses. Employees do not need to be enrolled in the employer's health plan to have an FSA. The University of Denver offers you a choice of a healthcare flexible spending account and a dependent care flexible spending account as described in more detail below. Your FSAs are administered through Rocky Mountain Reserve (RMR).

Healthcare FSA

A healthcare FSA is a pre-tax benefit account used to pay for eligible medical, dental, and vision care expenses that aren't covered by your insurance plan or elsewhere. It's a smart, simple way to save money while keeping you and your family healthy and protected. The IRS sets a limit on how much you can contribute to this account each year. For 2024, the contribution limit is $3,200.

Limited Purpose FSA

A limited purpose FSA (LPFSA) is a flexible spending account that only reimburses you for eligible dental and vision expenses. An LPFSA is available to employees who are enrolled in a high deductible health plan (HDHP); you may enroll in both the LPFSA and the HSA. By establishing an LPFSA, you can save money on taxes by using your LPFSA dollars for your dental and vision expenses while preserving your HSA funds for other purposes, including simply saving those funds for the future. The IRS sets a limit on how much you can contribute to this account each year. For 2024, the contribution limit is $3,200.

Dependent Care FSA

A dependent care FSA is a pre-tax benefit account used to pay for dependent care services, such as preschool, summer day camp, before or after school programs, and child or elder daycare. A Dependent Care FSA is a smart, simple way to save money while taking care of your loved ones so that you can continue to work. The IRS sets a limit on how much you can contribute to this account each year.

The 2024 IRS contribution limit is $5,000 if married and filing jointly or single as head of household or $2,500 if married and filing separately.

How does an FSA work?

1. You decide the annual amount (up to the set limit for each account) you want to contribute to either or both FSAs based on your expected healthcare and/or dependent childcare/elder care expenses.
2. Elections are deducted from each paycheck before income and Social Security taxes, and deposited into your FSA. Your entire annual election is available immediately after the beginning of the plan year for the health care FSA and LPFSA. For the dependent care FSA you can only receive the amount that is in your account when your claim is paid.
3. For eligible healthcare and dependent care expenses you can pay with the Healthcare FSA or LPFSA debit card or submit a claim form for reimbursement. For dependent care, you pay for eligible expenses when incurred, and then submit a reimbursement claim form or file the claim online.
4. You are reimbursed from your FSA, so you actually pay your expenses with tax-free dollars.
5. At the end of the calendar year, any unused amount in your Healthcare FSA will be forfeited with the exception of a maximum $640 rollover to be used for the next calendar year. The $640 rollover does not apply to the Dependent Care FSA.
6. You can use the LPFSA only for dental and vision expenses.

If you have extra dollars left at the end of the plan year, check out **www.FSAstore.com** or **www.directfsa.com** to find eligible products that you and/or your family may purchase in lieu of forfeiting funds. Cosmetic procedures such as teeth whitening will not be covered.

HSA & FSA Comparison

Description	HSA	Healthcare FSA	Limited Purpose FSA	Dependent Care FSA
Eligibility	HDHP	Cigna Copay Plan or Kaiser DHMO Plan	HDHP	All employees
2024 Contribution limits	$4,150 Individual $8,300 Family $1,000 Catch-up	$3,200		Up to $5,000, see page 26 for details
Who can contribute?	Employer, employee, spouse/partner, family members**	Employee		Employee
Rollover	100%	Up to $640, see page 26 for details		N/A
Changing contribution	Anytime	Only at open enrollment or with a qualifying event		
Funds available	Once funded	Immediately		Once funded
Receipts needed for reimbursement	No, you should save your bills and receipts for tax purposes	Yes for some expenses		
Is the account portable?	Yes, all funds belong to the account owner	No		
Eligible expenses	Medical, dental & vision expenses*, and some insurance premiums such as LTC and COBRA	Medical dental & vision expenses*, but no insurance premiums	Dental & vision expenses*, but no insurance premiums	Work-related daycare and elder care
Can I use the funds for non-eligible expenses	Penalty of 20% on the used amount, if 65+ income tax is applied	No		
Saving/investment options	Yes	No		

*For a full list of qualified expenses visit **https://www.irs.gov/publications/p502**

**Spouses/partners and covered children over age 19 must contribute to their own individually-owned HSA account

Life and AD&D **Insurance**

Insured by New York Life Insurance

Basic Life & Accidental Death and Dismemberment (AD&D) Insurance

Life insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump sum payment if you die while employed by the University of Denver. The University provides basic life insurance of 1x your current salary to a maximum of $100,000 **at no cost to you**. Benefits will begin to reduce at age 65.

Accidental Death and Dismemberment (AD&D) insurance provides payment to you or your beneficiaries if you lose a limb or die in an accident. The University of Denver provides AD&D coverage of 1x your current salary to a maximum of $100,000 **at no cost to you**. This coverage is in addition to your company-paid life insurance described above.

New York Life provides the below additional benefits through My secure Advantage™ **at no cost to you**. For more information visit **www.du.edu/human-resources/benefits**.

Identity Theft Provides tools and personal guidance to help with identity theft prevention, detection and resolution. Includes a free 30-minute consultation with a Fraud Resolution Specialist.	**Will Prep** Award-winning legal forms makes it easy to take charge of difficult life and health care legal decisions. You have access to hundreds of intelligent, state-specific, web-based forms, including your last will and testament, living will, powers of attorney, and more.
Life Assistance Program Help with life challenges from personal, work and family, caregiving, bereavement, legal, financial to pet care issues, just to name a few.	**Bereavement** Support for employees, their household members and death claim beneficiaries at time of need and from Day One, even if a claim is never submitted.

Voluntary Life and AD&D Insurance

Insured by New York Life Insurance

Voluntary Life Insurance

You may purchase life insurance in addition to your company-provided coverage. You may also purchase life insurance for your dependents if you purchase additional coverage for yourself. You and your spouse/partner are guaranteed coverage as outlined below without answering medical questions if you enroll when you are first eligible. If you elect coverage over the guarantee issue amount the coverage is not effective until evidence of insurability is approved by New York Life.

Employee

- Increments of $10,000 up to $500,000 or five times annual salary, whichever is less.
- Guarantee issue: lesser of 5x salary or $200,000

Spouse/Partner

- Increments of $5,000 up to $250,000, not to exceed the employee covered amount.
- Guarantee issue: $50,000

Child(ren)

- Dependents up to age 26, increments of $2,500 up to $10,000.
- Guarantee issue: $10,000

Voluntary Accidental Death & Dismemberment (AD&D)

You may purchase AD&D insurance in addition to your company-provided coverage. You may also purchase AD&D insurance for your dependents if you purchase additional coverage for yourself.

Employee

- Increments of $10,000 up to $500,000 or 10 times annual salary, whichever is less.

Spouse/Partner

- Increments of $5,000 to $300,000
  - 60% of the employee covered amount if you **do not** have children covered under this policy.
  - 50% of the employee covered amount if you **have** children covered under this policy.

Child(ren)

- Increments of $2,500 to $50,000
  - 15% of the employee covered amount if you **do not** have spouse/partner covered under this policy.
  - 10% of the employee covered amount if you **have** spouse/partner covered under this policy.

Disability **Insurance**

Insured by New York Life Insurance

Short-Term Disability (STD)

Short-term disability insurance can provide you with the peace of mind that a protected paycheck brings, if you are unable to work because of an illness or injury that occurs off the job. The University of Denver provides STD coverage of **at no cost to you.** The New York Life short-term disability plan provides income, after satisfying the elimination period, if you become disabled due to an injury or illness. Once enrolled in the plan, you can take advantage of the following benefits:

- Elimination Period: 14 days
- Benefit Amount: 60% of base weekly salary
- Benefit Maximum: Up to $1,500 per week
- Benefit Period: Up to 11 weeks of benefit (without the elimination period); Up to 13 weeks (with 2 weeks elimination period)

Long-Term Disability (LTD)

Meeting your basic living expenses can be a real challenge if you become disabled. Your options may be limited to personal savings, spousal income and possibly Social Security. Long-term disability insurance provides protection for your most valuable asset — your ability to earn an income. The University of Denver provides LTD coverage of **at no cost to you.**

- Elimination Period: 90 days
- Benefit Amount: 60% of base monthly salary
- Benefit Maximum: $12,500 per month

This amount may be reduced by other deductible sources of income or disability earnings.

*Durations are set up to last until Social Security Normal Retirement Age. Please see the LTD Insurance Certificate document for complete details.

Voluntary Accident & Critical Illness

Insured by Cigna

Voluntary Accident

Accidental Injury insurance can provide you and your family with the additional financial protection you may need for expenses associated with an unexpected covered accident. While you can't predict life's unexpected events, you can plan for them by choosing benefits that can help protect your financial future.

Regular expenses, big and small, can add up. Think about your ability to pay for those expenses if you or your family member were seriously injured in a covered accident. The plan pays benefits directly to you. What you do with the money is up to you.

Voluntary Accident	
Employee Only	$9.92
Employee & Spouse/Partner	$17.96
Employee & Child(ren)	$22.90
Family	$30.95

This benefit will pay a lump sum in the event of a covered accident. Examples include:

- Fractures
- Dislocation
- Surgery
- Ambulance Transport
- Coma
- Burns
- Laceration
- X-Ray
- And more

Voluntary Critical Illness

The University offers you the opportunity to purchase Critical Illness insurance on a voluntary basis to ease the financial impact of a major illness. If you or a covered family member is diagnosed due to an illness and meets the group policy and certificate requirements, you will receive a payment to use as you see fit. It can be used to help cover your health insurance deductibles, copays, incidental hospital charges (e.g. TV, phone, etc.) or for any purpose you choose. Critical Illness provides payments for illnesses such as organ/kidney failure, arteriosclerosis, carcinoma in situ, benign brain tumor, cancer, heart attack, stroke, etc.

Monthly Rates Per $10,000 & Based on Employees Age	Employee Only	Employee & Spouse/ Partner	Employee & Child(ren)	Family
0-29	$2.49	$3.98	$3.71	$5.22
30-39	$4.42	$6.84	$5.65	$8.07
40-49	$8.16	$12.75	$9.39	$13.98
50-59	$16.19	$25.77	$17.42	$27.01
60-69	$25.85	$41.31	$27.08	$42.53
70-79	$45.53	$70.56	$46.76	$71.78
80+	$72.33	$109.99	$73.57	$111.23

Benefit Amounts for Critical Illness:

- Employee: $10,000, $20,000 or $30,000; Guarantee issue: $30,000
- Spouse/Partner: 50% of employee benefit amount; Guarantee issue: 100%
- Child(ren): 50% of employee benefit amount

If you complete a health screening, this plan will pay you a health screening benefit of $50. These health screenings include annual physicals, biometrics, preventive cancer screenings, etc.

Business Travel **Accident**

Administered by Prudential/IMG Global

Prudential

The University of Denver provides a $200,000 Business Travel Accident (BTA) policy through Prudential. Prudential also partners with IMG Global to provide Travel Assistance Services and insured Evacuation coverages that wrap around the Prudential plan. This benefit gives you 24/7 access to medical and travel assistance services around the world, while on official University business. That way, you never have to worry where you're covered and just have to worry about the situation at hand.

Emergency Medical Assistance	Pre-Trip Information	Emergency Personal Services
■ Medical referrals	■ Visa and passport requirements	■ Emergency travel arrangements
■ Medical monitoring	■ General information on local customs and business etiquette	■ Emergency cash
■ Medical evacuation	■ Foreign currency exchange rates	■ Locating lost items
■ Repatriation	■ Embassy and consular referrals	■ Bail advancement
■ Traveling companion assistance		■ Pet housing & return
■ Dependent children assistance		
■ Visit by a family member of friend		
■ Return of mortal remains		

Multilingual Assistance 24/7

Whether you're traveling for business or pleasure, Travel Assistance services are available when you're more than 100 miles from home for 180 days or less.

Pet Insurance

Administered by MetLife

MetLife

We care about all of your dependents—even the four legged ones! No matter what unpredictable antics your furry family member gets into, your family isn't complete without them. Beginning July 1, 2024, you can enroll in MetLife Pet Insurance and feel confident that their health and your wallet are protected if you're faced with an unexpected trip to the vet.

Why MetLife Pet Insurance?

- Flexible coverages with up to 100% reimbursement and freedom to visit any U.S. licensed vet
- 24/7 access to Telehealth Concierge Services—because accidents and illnesses don't always wait for your vet to be open
- Discounts up to 30% and additional offers on pet care, where available
- Coverage of previously covered preexisting conditions when switching providers
- MetLife Pet mobile app to submit and track claims, manage your pet's health and wellness and find nearby pet services

How does MetLife Pet Insurance work?

1. Select and enroll in the coverage that's best for you and your pet
2. Download our mobile app
3. Take your pet to the vet
4. Pay the bill within 90 days and send it with your claim documents to us via our mobile app, online portal, email, fax or mail
5. Receive reimbursement[1] by check or direct deposit if the claim expense is covered under the policy

Get a quote or enroll today.

Visit www.metlife.com/getpetquote

Call 1-800-GET-MET8

Scan the QR code

403(b) Retirement Plan

Administered by TIAA

The University offers a retirement plan under section 403(b) of the Internal Revenue Code (IRC) to enable you to invest in your retirement via the convenience of regular automatic payroll contributions.

Contributions can be made on a pre-tax or tax-deferred salary reduction basis, which means that your current taxable income is reduced by the amount of your contributions, and that taxes on those contributions and their investment earnings are deferred until they are paid back to you in the form of retirement benefits or other distributions from these plans. You are also able to contribute on a post-tax basis which will reduce your tax liability during retirement. For biweekly-paid employees, retirement contributions will be deducted from each paycheck. Participation in this plan is entirely voluntary.

Eligibility

As an eligible employee of the University, you may elect to make contributions beginning on the first day of the month following your date of hire or date of appointment, whichever is earlier. You will be eligible to receive matching contributions on the first day of the month following the day you have completed 12 months of service with the University.

If you were a retirement benefits-eligible employee and completed one year of service (in a 12-month consecutive month period) with another educational or teaching institution prior to your employment with the University, you will be eligible to receive matching contributions on the first day of the month following your date of hire or date of appointment.

Your Contributions

As a participant you may elect to defer a portion of your compensation each year instead of receiving that amount in cash. Your total deferrals in any taxable year may not exceed a dollar limit which is set by law. The limit for 2024 is $23,000. If you are age 50 or older you may elect to defer additional amounts (called “catch-up contributions”) to the plan. The maximum “catch-up contribution” that you can make in 2024 is $7,500.

There are two types of deferrals: pre-tax 403(b) deferrals and Roth 403(b) deferrals. You can make either or both to the plan.

Pre-tax 403(b) deferrals: If you elect to make pre-tax 403(b) deferrals, then your taxable income is reduced by the deferral contributions so you pay less in federal income taxes. Later, when the plan distributes the deferrals and earnings, you will pay the taxes on those deferrals and the earnings. Therefore, federal income taxes on the deferral contributions and the earnings are only postponed. Eventually, you will have to pay taxes on these amounts.

Roth 403(b) deferrals: If you elect to make Roth 403(b) deferrals, the deferrals are subject to federal income taxes in the year of deferral. However, the deferrals and, in most cases, the earnings on the deferrals are not subject to federal income taxes when distributed to you. In order for the earnings to be tax free, you must meet certain conditions. Please refer to the summary plan description for further information.

403(b) Retirement Plan (cont'd)

Employee Match Feature

Appointed employees are eligible to enroll in the employer match feature of the retirement plan at any time after completing one year of service with the University. Employees may also waive this service requirement with prior service at another qualified educational institution. This service requirement is defined as one year of service as a full-time, retirement benefits eligible employee. A qualified educational institution (per IRC Section 170(b)(1)(A)(ii)) is defined as an educational organization which normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of pupils or students in attendance at the place where its educational activities are regularly carried on.

If an employee contributes 4% and is eligible to participate in the employer match plan, the employee will receive any matching contribution made by the University. The matching contribution is discretionary and may vary as determined by the University. If you have questions regarding the matching contribution, please contact the Human Resources at **303.871.7420** or **benefits@du.edu**.

Employee Contribution Feature

Both appointed and non-appointed employees may enroll in the employee contribution feature at any time. You may also terminate your participation at any time. A wide array of investment options are available through TIAA.

Note: Contributions under the employee contribution feature are not matched by the University.

Distributions

Distributions from this plan are available only upon termination of employment from the University, except for a one-time "in-service" lump sum distribution of up to 10% of your account, which you can request at age 59 1/2 or older. Any distribution from this plan that does not qualify as a "periodic payment" under the IRC, or as a qualifying "roll-over" or "direct transfer" to another qualifying retirement plan must be "rolled-over" to an IRA, which can then be used as the vehicle for cash withdrawals.

Contact TIAA with your questions

Call TIAA at 800.842.2252,
Weekdays, 8 a.m. to 8 p.m. and Saturday, 7 a.m. to 4 p.m., MST

Want to speak with an advisor at no extra cost?
Call 800.732.8353,
Weekdays 6 a.m. to 6 p.m., MST, or schedule online at www.tiaa.org/schedulenow

Get your personalized retirement action plan started
using TIAA's online retirement advisor tool.
Visit www.tiaa.org/retirementadvisor

Student Loan Forgiveness

A student loan forgiveness solution from TIAA and Savi

Are you feeling overwhelmed by student debt? Or trying not to think about it? Public Service Loan Forgiveness (PSLF) is a federal program designed to reduce the burden of student loan debt for people who work in public service. University of Denver is considered a public service employer for the purposes of these programs.

Simply put, PSLF pairs the immediate relief of an income-driven repayment plan (to make your monthly payments affordable) with the longer-term relief of loan forgiveness. You've probably heard some negative press about the difficulties borrowers have faced in attempting to realize the benefits from these programs.

TIAA has joined forces with Savi, a social impact technology company, to help University of Denver employees benefit from forgiveness programs like PSLF. The service helps eligible borrowers to understand their choices, lower their monthly payments, and enroll in a forgiveness program. You can think of them as an advocate – someone who cares as much as you do about finding a good outcome.

What to expect when applying for forgiveness

Savi streamlines the entire process, from helping you enroll in forgiveness programs to ongoing support and payment tracking, ensuring you remain on track from start to forgiveness—all for a small fee.* Here's a snapshot of what will happen.

1. First, you need to enroll in Savi Essential Service.
2. Next, provide your basic information. From there, Savi handles the rest—from checking your forgiveness application for accuracy and completion all the way to submission.
3. After some verifications with us, which Savi handles, everything is sent to your loan servicer.
4. You'll receive reminders from Savi for ongoing things you may need to do afterward, like an annual submission to the PSLF program. That way you stay in compliance with all the particulars that go along with forgiveness programs.

If you haven't yet, take a minute and find out how much you could lower your monthly payment.

Try the free calculator today to see if you might qualify.

Money saved is money in your pocket to use for other financial goals, whether it's building up an emergency fund, saving more for retirement, or paying off other debts.

Visit TIAA.org/du/student today to calculate your savings

*A portion of the fee may be shared with TIAA to offset costs to support the program. In addition, TIAA has a minority ownership interest in Savi.

TIAA

Employee Assistance **Program (EAP)**

Administered by SupportLinc

The University of Denver provides an Employee Assistance Program through SupportLinc to all benefited employees **at no cost.** The EAP program is a health benefit, separate from medical insurance to help you manage life's daily challenges. The EAP is 100% confidential.

You and your immediate family members may receive up to 6 visits per issue per year. SupportLinc can refer you to professional counselors, services and resources that will help you resolve a broad range of personal and work-related concerns such as:

Counseling	Work-Life Benefit
■ Depression, stress or anxiety ■ Relationship problems ■ Grief and loss ■ Family and parenting issues ■ Substance abuse	■ In-person or telephonic legal consultation with a licensed attorney ■ Financial consultation ■ Identity theft consultation ■ Dependent care referral ■ Guidance and referrals for daily living resources such as: home improvement, entertainment services, pet care, auto repair, wellness, travel, handyman, volunteer opportunities, etc.

Access SupportLinc services by calling the 24/7 phone line at **888.881.LINC (5462)** and connect with a Clinician directly. They can further connect you to a Counselor in your area or counseling services via telehealth. They also can address your immediate needs. Please see website details below.

For questions, email **benefits@du.edu**.

Visit the portal at :
www.supportlinc.com

Username: universityofdenver

Or call: 888.881.5462.

Tuition **Waiver**

The Tuition Waiver program is designed to enable benefited employees, their spouse/partners, and/or their dependent children under the age of 25, to enroll in "for-credit" courses at the University of Denver with reduced or no tuition charges. Upon hire, Employees' tuition waiver eligibility is automatically post-dated for the first term following 6 months of benefited service at the University.

Waivers will automatically be available to that spouse/partner or child each term following, according to the employee and spouse/partner's eligibility. Documentation is required in order to verify the relationship of the student to the employee and can include a Common Law Affidavit, Affidavit of Domestic Partnership, recent tax return, birth certificate or documentation of legal guardianship.

Tuition Waiver benefits for graduate students are subject to Federal, State and FICA taxation. As such, the value of the tuition waiver benefit for graduate spouse/partners and children will be reported as taxable income on employees' paychecks. A tax advisor should be consulted for further information about taxation.

Employee and Spouse/Partner

Employee's Work Schedule	Plan Year Credit Maximum* Summer through Spring	Spouse/Partner's Eligibility per Academic Period
Full-time (.93-1.0 FTE)	20 credits/individual	2 classes (5 credits max)
3/4-time (.75-.92 FTE)	16 credits/individual	2 classes (4 credits max)
1/2-time (.50-.74 FTE)	12 credits/individual	2 classes (3 credits max)

* If an employee becomes eligible to use the tuition waiver mid-way through a plan year, the annual credit maximum is prorated for the remaining plan year. The annual limit will renew each Summer period.

Pro-rated Annual Maximums for Newly Eligible Employees

Employee's Work Schedule	Winter Period	Spring Period	Summer Period
Full-time .93-1.0 FTE	15 credits	10 credits	5 credits
3/4-time .75-.92 FTE	12 credits	8 credits	4 credits
1/2-time .50-.74 FTE	9 credits	6 credits	3 credits

Dependent Child

Employee's Work Schedule	Employees Without Tenure / Less than 5 Years of Service	Employees With Tenure / 5 Years of Service or More
	Undergraduate Child / Graduate Child	Undergraduate Child / Graduate Child
Full-time .93-1.0 FTE	70% / 50%	90% / 50%
3/4-time .75-.92 FTE	45% / 35%	60% / 35%
1/2-time .50-.74 FTE	35% / 25%	45% / 25%

Further information about eligibility guidelines, restrictions, definition of terms, how to use the tuition wavier benefits, and legal/tax considerations can be found at **https://www.du.edu/human-resources/benefits/tuition-waiver** or contact Human Resources at **303.871.7420** or **benefits@du.edu**.

Additional **Perks**

These discount offers are open to all University employees unless specifically stated and are subject to change and/or discontinue without notice from the vendor. You may be required to present your University I.D. to receive the advertised discounts. The University does not endorse any of the goods or services offered, nor guarantee any of the offers. For further information about any of the discounts listed you must contact the vendors directly.

Pioneer ID Card

Provides many privileges such as discounts to the University bookstore, library access, and reduced prices for the Newman Center for the Performing Arts and DU athletic events.

DU Athletics and Recreation

Exclusive discount opportunities for admission to select DU Athletic events are available to DU faculty, staff, and retirees during the year.

DU Coors Fitness Center

DU employees enjoy discounts at the Coors Fitness Center, as well as in association with selected Ritchie Center Programs. Discounted Coors Fitness Center memberships are available to faculty, staff and their families, and a 10% discount is available for popular programs such as School Days Off, P.A.S.S. Camp and more.

RTD EcoPass

The EcoPass provides free and unlimited ridership on RTD buses and light rail lines (with certain designated exceptions) as well as discounts on the RTD airport shuttle. For further information, contact Human Resources at **303.871.7420** or **benefits@du.edu**.

DU Employee Perks and Discounts Program

DU has partnered with Beneplace Employee Discounts to offer the best deals on products, services, and experiences that include electronics, rental cars, fitness memberships, theme parks, and more. To access, please visit the (**https://www.du.edu/human-resources/content/employee-perks-and-discounts**) and create an account with your DU Email address.

For more information on the above and additional offers visit:
www.du.edu/human-resources/benefits

Benefit Advocate **Center (BAC)**

Overview

At no cost to you, the University of Denver is pleased to announce an incredibly valuable benefit – Gallagher Benefit Advocate Center (BAC), offered through our benefits broker, Gallagher.

YOUR PERSONAL BENEFITS CONSULTANT

One-stop-shop, complete support

Have you ever felt like you wanted a personal assistant to help coordinate information about your benefits? Our fully licensed advocates will be available to answer your questions, provide support, and offer a one-stop-spot for maximizing your benefits plan and your health.

Find comfort in knowing you're speaking with experts.

From finding an in-network provider, to teaching you the difference between a Flexible Spending Account (FSA) and a Health Savings Account (HSA), or providing assistance. Any conversations with an advocate will be conducted in a confidential manner, fully protecting your privacy.

Start using now!

You can begin using the Gallagher Benefit Advocate Center, **effective now**. Simply call the dedicated toll free number at **833.355.8939**, Monday through Friday, 7:00 a.m. to 5:00 p.m. MST.

You can also email at **bac.duadvocates@ajg.com**. Language assistance is available.

ASK YOUR ADVOCATE TEAM

Gallagher Benefit Advocate Center is ready to help you get the most from your benefit program by providing support. Get assistance with:

Explanation of benefits

Is it unclear to you what the insurance covered on a particular claim and what is your responsibility?

Prescription challenges

Is the pharmacy telling you that your medication is not covered or charging you full price? Do you need help with an authorization from a medication?

Benefits questions

Are you unsure if the insurance company will pay for a certain procedure?

Claims issues

Did you receive a bill from a doctor but don't know why?

Difficult situations

Are you having difficulty getting a referral? Has the insurance carrier denied a procedure and you want to appeal their decision?

Contact **Information**

If you have any questions regarding your benefits or the material contained in this guide, please contact Human Resources.

Human Resources
University of Denver
2199 South University Boulevard, Denver, CO 80208
Phone: **303.871.7420**
Fax: **303.871.6339**
Email: **benefits@du.edu**

Plan	Phone	Website/Email	Group #
BENEFIT ADVOCATE CENTER			
DU BAC	833.355.8939	bac.duadvocates@ajg.com	N/A
MEDICAL			
Cigna	800.244.6224	www.mycigna.com	3344360
Cigna One Guide®	800.244.6224	N/A	3344360
Kaiser	800.218.1059	www.kp.org	00214
Health Advocate®	866.799.2725	N/A	N/A
Dispatch Health	303.500.1518	www.dispatchhealth.com	Cigna: 3344360 Kaiser: 00214
VIRTUAL CARE			
MDLive	888.726.3171	www.MDLIVEforCigna.com	3344360
Cigna Behavioral Programs	Refer to the back of your ID card	www.mycigna.com	3344360
MeruHealth	833.940.1385	www.meruhealth.com/cigna	3344360
TalkSpace	N/A	www.talkspace.com/cigna	3344360
Kaiser Behavioral Programs	Refer to the back of your ID card	www.kp.org	00214
DENTAL			
Delta Dental of Colorado	800.610.0201	www.deltadentalco.com	8826
DENTAL DISCOUNT PLAN			
Beta Health	800.807.0706	www.betaplans.com/Alpha18/	N/A
VISION			
EyeMed	866.723.0514	www.eyemed.com	9846650
HEALTH SAVINGS ACCOUNT & FLEXIBLE SPENDING ACCOUNT			
Rocky Mountain Reserve	888.722.1223	www.rockymountainreserve.com	N/A
LIFE & DISABILITY			
New York Life	800.362.4462	www.newyorklife.com	Life: FLX969778 AD&D: OK971218 STD: LK752793 LTD: LK966486
VOLUNTARY ACCIDENT & CRITICAL ILLNESS			
Cigna	800.754.3207 U.S. Toll Free	www.supphealthclaims.com	AI961819 CI961734
BUSINESS TRAVEL ACCIDENT			
Prudential	855.847.2194 Anywhere Toll Free 317.927.6881	www.imglobal.com	N/A
PET INSURANCE			
MetLife	800.438.6388	www.metlife.com/getpetquote	N/A
403(B) RETIREMENT SAVINGS PLAN			
Teachers Insurance & Annuity Association (TIAA)	800.842.2252	www.tiaa.org	N/A
EMPLOYEE ASSISTANCE PROGRAM			
SupportLinc	888.881.5462	www.supportlinc.com	N/A

Legal Notices

For Plan Year: July 1, 2024 – December 31, 2024

Enclosed are the Annual Notices for our health plans. You and your dependents should read each notice very carefully as they outline important benefits, terms and limitations that apply to our health plan.

- HIPAA Special Enrollment Rights
- HIPAA Notice of Privacy Practices Reminder
- Women's Health & Cancer Rights Act
- Newborns' and Mothers' Health Protection Act
- Uniformed Services Employment & Reemployment Rights Act (USERRA)
- Mental Health Parity and Addiction Equity Act of 2008 "Wellstone Act"
- No Surprise Billing Act
- Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)
- Pregnant Workers Fairness Act C.R.S. § 24-34-402.3
- COBRA General Notice
- Notice of Creditable Coverage
- Marketplace Notice

Should you have any questions after reviewing each notice, you should contact :

Human Resources
University of Denver
2199 South University Boulevard
Denver, CO 80208

Phone: **303.871.7420**
Fax: **303.871.6339**

Email: **benefits@du.edu**

UNIVERSITY OF DENVER

Legal Notices

Patient Protections Disclosure

The University of Denver Health Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Cigna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Human Resources at **303.871.7420** or **benefits@du.edu.**

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights

University of Denver is committed to the privacy of your health information. The administrators of the University of Denver Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Human Resources at **303.871.7420** or **benefits@du.edu.**

HIPAA Special Enrollment Rights

University of Denver Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the University of Denver Health Plan (to actually participate, you must complete an enrollment form and may be required to pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan – your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

Legal Notices

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Human Resources at **303.871.7420** or **benefits@du.edu.**

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

Legal Notices

Women's Health & Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

Plan 1: Cigna Copay Plan (Individual: 20% coinsurance and $0 deductible; Family: 20% coinsurance and $0 deductible)

Plan 2: Cigna HDHP Plan (Individual: 20% coinsurance and $1,600 deductible; Family: 20% coinsurance and $3,200 deductible)

Plan 3: Kaiser DHMO Plan (Individual: 20% coinsurance and $0 deductible; Family: 20% coinsurance and $0 deductible)

Plan 4: Kaiser HDHP Plan (Individual: 20% coinsurance and $1,600 deductible; Family: 20% coinsurance and $3,200 deductible)

If you would like more information on WHCRA benefits, please call Human Resources at **303.871.7420** or **benefits@du.edu**.

Newborns' and Mothers' Health Protection Act

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

Uniformed Services Employment & Reemployment Rights Act (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) was enacted in 1994 following U.S. military action in the Persian Gulf. USERRA prohibits discrimination against individuals on the basis of membership in the uniformed services with regard to any aspect of employment. Since its enactment, USERRA has been modified and expanded by additional federal laws, such as the Veterans Benefits Improvement Act of 2008 (2008 Act). Please contact Human Resources for additional details about USERRA.

Mental Health Parity and Addiction Equity Act of 2008 "Wellstone Act"

Under the Wellstone Act, large group health plans (i.e., employers who employ 51 or more employees) that choose to offer mental health and substance abuse benefits under their health plan are not allowed to set annual or lifetime dollar limits, nor office visit or inpatient day limits on mental health and substance abuse benefits that are lower than any other limits imposed by the medical plan for other medical and surgical benefits. In addition, the group health plan must provide the same out-of-network coverage for mental health and substance abuse coverage that is available for out-of-network medical and surgical benefits.

Legal Notices

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're <u>never</u> required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

Legal Notices

When balance billing isn't allowed, you also have the following protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed, contact

https://www.cms.gov/nosurprise/consumers or call **800.985.3059** to obtain more information and complaints.

Visit **https://www.cms.gov/nosurprises/consumers** for more information about your rights under federal law.

Visit **State Balance-Billing Protections | Commonwealth Fund** for more information about your rights under applicable state laws.

Legal Notices

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **866.444.EBSA (3272).**

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. Contact your state for more information on eligibility.

ALABAMA – Medicaid

http://myalhipp.com
855.692.5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program
http://myakhipp.com/ | 866.251.4861
CustomerService@MyAKHIPP.com
Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid

http://myarhipp.com
855.MyARHIPP (855.692.7447)

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
916.445.8322 | Fax: 916.440.5676| Email: hipp@dhcs.ca.gov

COLORADO – Medicaid and CHIP

Health First Colorado (Colorado's Medicaid Program)
https://www.healthfirstcolorado.com
Member Contact Center: 800.221.3943 | State Relay 711
Child Health Plan Plus (CHP+)
https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
Customer Service: 800.359.1991 | State Relay 711
Health Insurance Buy-In Program (HIBI)
https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 855.692.6442

FLORIDA – Medicaid

www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
877.357.3268

GEORGIA – Medicaid

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
678.564.1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
678.564.1162, Press 2

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64
http://www.in.gov/fssa/hip/ | 877.438.4479
All other Medicaid
https://www.in.gov/medicaid/ | 800.457.4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid: https://dhs.iowa.gov/ime/members | 800.338.8366
Hawki: http://dhs.iowa.gov/Hawki | 800.257.8563
HIPP: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | 888.346.9562

KANSAS – Medicaid

https://www.kancare.ks.gov/
800.792.4884 | HIPP Phone: 800.967.4660

Legal Notices

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP):
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
855.459.6328 | KIHIPP.PROGRAM@ky.gov
KCHIP: https://kynect.ky.gov | 877.524.4718
Medicaid: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid

www.medicaid.la.gov or www.ldh.la.gov/lahipp
888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)

MAINE – Medicaid

Enrollment: https://www.mymaineconnection.gov/benefits/s/?language=en_US
800.442.6003 | TTY: Maine relay 711
Private Health Insurance Premium: https://www.maine.gov/dhhs/ofi/applications-forms
800.977.6740 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

https://www.mass.gov/masshealth/pa
800.862.4840 | TTY: 711| Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
800.657.3739

MISSOURI – Medicaid

http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
573.751.2005

MONTANA – Medicaid

http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
800.694.3084 | Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

http://www.ACCESSNebraska.ne.gov
Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178

NEVADA – Medicaid

http://dhcfp.nv.gov
800.992.0900

NEW HAMPSHIRE – Medicaid

https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
603.271.5218 | Toll free number for the HIPP program: 800.852.3345, ext. 5218

NEW JERSEY – Medicaid and CHIP

Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid
609.631.2392
CHIP: http://www.njfamilycare.org/index.html
800.701.0710

NEW YORK – Medicaid

https://www.health.ny.gov/health_care/medicaid/
800.541.2831

NORTH CAROLINA – Medicaid

https://dma.ncdhhs.gov
919.855.4100

NORTH DAKOTA – Medicaid

https://www.hhs.nd.gov/healthcare
844.854.4825

OKLAHOMA – Medicaid and CHIP

http://www.insureoklahoma.org
888.365.3742

OREGON – Medicaid and CHIP

http://healthcare.oregon.gov/Pages/index.aspx
800.699.9075

PENNSYLVANIA – Medicaid and CHIP

https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
800.692.7462
CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 800.986.KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

http://www.eohhs.ri.gov
855.697.4347 or 401.462.0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

http://www.scdhhs.gov
888.549.0820

SOUTH DAKOTA – Medicaid

http://dss.sd.gov
888.828.0059

TEXAS – Medicaid

http://gethipptexas.com
800.440.0493

UTAH – Medicaid and CHIP

Medicaid: https://medicaid.utah.gov
CHIP: http://health.utah.gov/chip
877.543.7669

Legal Notices

VERMONT – Medicaid
Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access 800.250.8427
VIRGINIA – Medicaid and CHIP
https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid and Chip: 800.432.5924
WASHINGTON – Medicaid
https://www.hca.wa.gov/ 800.562.3022

WEST VIRGINIA – Medicaid
https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid: 304.558.1700 CHIP Toll-free: 855.MyWVHIPP (855.699.8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm 800.362.3002
WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ 800.251.1269

To see if any other states have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, contact either

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 1/31/2026)

Paperwork Reduction Act Statement

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

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

Legal Notices

Pregnant Workers Fairness Act C.R.S. § 24-34-402.3

The Pregnant Workers Fairness Act makes it a discriminatory or unfair employment practice if an employer fails to provide reasonable accommodations to an applicant or employee who is pregnant, physically recovering from childbirth, or a related condition.

Requirements

Under the Act, if an applicant or employee who is pregnant or has a condition related to pregnancy or childbirth requests an accommodation, an employer must engage in the interactive process with the applicant or employee and provide a reasonable accommodation to perform the essential functions of the applicant or employee's job unless the accommodation would impose an undue hardship on the employer's business.

The Act identifies reasonable accommodations as including, but not limited to:

- provision of more frequent or longer break periods;
- more frequent restroom, food, and water breaks;
- acquisition or modification of equipment or seating;
- limitations on lifting;
- temporary transfer to a less strenuous or hazardous position if available, with return to the current position after pregnancy;
- job restructuring;
- light duty, if available;
- assistance with manual labor; or modified work schedule.

The Act prohibits requiring an applicant or employee to accept an accommodation that the applicant or employee has not requested or an accommodation that is unnecessary for the applicant or the employee to perform the essential functions of the job.

Scope of accommodations required:

An accommodation may not be deemed reasonable if the employer has to hire new employees that the employer would not have otherwise hired, discharge an employee, transfer another employee with more seniority, promote another employee who is not qualified to perform the new job, create a new position for the employee, or provide the employee paid leave beyond what is provided to similarly situated employees.

Under the Act, a reasonable accommodation must not pose an "undue hardship" on the employer. Undue hardship refers to an action requiring significant difficulty or expense to the employer. The following factors are considered in determining whether there is undue hardship to the employer:

- the nature and cost of accommodation;
- the overall financial resources of the employer;
- the overall size of the employer's business;
- the accommodation's effect on expenses and resources or its effect upon the operations of the employer;

If the employer has provided a similar accommodation to other classes of employees, the Act provides that there is a rebuttable presumption that the accommodation does not impose an undue hardship.

Adverse action prohibited:

The Act prohibits an employer from taking adverse action against an employee who requests or uses a reasonable accommodation and from denying employment opportunities to an applicant or employee based on the need to make a reasonable accommodation.

Legal Notices

COBRA General Notice

Model General Notice of COBRA Continuation Coverage Rights
(For use by single-employer group health plans)
**** Continuation Coverage Rights Under COBRA****

Introduction
You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

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

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Human Resources.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

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

Legal Notices

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, **Children's Health Insurance Program (CHIP),** or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov.**

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period1 to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit **https://www.medicare.gov/medicare-and-you.**

1 **https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods**

Legal Notices

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa.** (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.healthcare.gov.**

Keep your Plan informed of address changes

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

Plan contact information

University of Denver
Human Resources
2199 S. University Blvd.
Denver, Colorado 80208
United States
303.871.7420

Legal Notices

Notice of Creditable Coverage

Important Notice from University of Denver About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with University of Denver and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **University of Denver has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current University of Denver coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits.

If you do decide to join a Medicare drug plan and drop your current University of Denver coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with University of Denver and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

Legal Notices

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage:

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through University of Denver changes. You also may request a copy of this notice at any time.

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

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

For More Information About Medicare Prescription Drug Coverage:

- Visit **www.medicare.gov.**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call **800.MEDICARE (800.633.4227)**. TTY users should call **877.486.2048**.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at **800.772.1213** (TTY **800.325.0778**).

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

Date:	July 1, 2024
Name of Entity/Sender:	University of Denver
Contact:	Human Resources
Address:	2199 South University Boulevard Denver, Colorado 80208 United States
Phone Number:	303.871.7420

Legal Notices

Marketplace Notice

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%1 of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1 2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

1 Indexed annually; see **https://www.irs.gov/pub/irs-drop/rp-22-34.pdf** for 2023.

2 An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit **HealthCare.gov** or call the Marketplace Call Center at **800.318.2596**. TTY users can call **855.889.4325**.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Human Resources.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name University of Denver		4. Employer Identification Number (EIN) 84-0404231
5. Employer address 2199 S. University Blvd.		6. Employer phone number 303.871.7420
7. City Denver	8. State Colorado	9. ZIP code 80208
10. Who can we contact about employee health coverage at this job? Human Resources		
11. Phone number (if different from above)	12. Email address benefits@du.edu	

Here is some basic information about health coverage offered by this employer:

As your employer, we offer a health plan to:

☑ All employees. Eligible employees are:
Full-Time working 20 hours or more per week

☐ Some employees. Eligible employees are:

■ With respect to dependents:

☑ We do offer coverage. Eligible dependents are:
Your legal spouse, including common-law and civil union, and domestic partner (both same and opposite sex), your child who is less than 26 years of age, and your child who satisfies the above definition of child, age 26 or older, and who is mentally or physically incapable of earning a living, and is primarily support by you.

☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

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The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15)

☐ No (STOP and return form to employee)

15. For the lowest cost plan that meets the minimum value standard[1] offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan?

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

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16. What change will the employer make for the new plan year?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan?

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

1 An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).

Notes

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UNIVERSITY OF DENVER

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

This benefit guide prepared by

Gallagher

Insurance | Risk Management | Consulting

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