



UNIVERSITY OF
DENVER

EARLY RETIREE BENEFITS GUIDE
JULY 1, 2023 – JUNE 30, 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 32-33 where Notice of Creditable Coverage begins for more details.



Eligibility Overview

The University of Denver is proud to offer you, as an eligible retiree, access to valuable benefits you earned through years of service.

Employees hired prior to January 1, 1992, who have attained age 55 with at least 10 years of service, are eligible for early retiree medical benefits. Employees hired January 1, 1992 and later, who have attained age 55 with at least 20 years of service, are eligible for early retiree medical, dental and vision benefits.

If you are enrolled in the DU group health, dental, and/or vision plan the day preceding your official retirement and you are under the age of 65, you will be eligible to continue your health, dental, and/or vision insurance. Coverage will be continued for the eligible dependents of the retiree, even in the event that the retiree predeceases the dependents, given that they were enrolled on the University group health plan at the time of retirement or the retiree's death. These eligible dependents are responsible for paying each month's total premium following the retiree's death. The retired employee or surviving dependent's premium share is **due on the first of each month**.

As a retiree, the University will pay **\$60.00 per month** toward the cost of your health insurance premium. Your portion of the insurance premium may change at future benefits contract renewals each year. Open Enrollment will occur each year in June for the retiree non-Medicare health, dental, and vision plans. If at any time the University's group health plan coverage is canceled the retiree and dependents cannot re-enroll in the group plan. At this time, retirees would have to enroll in an individual non-DU plan. At retirement, dental and vision can be continued or canceled. If canceled, the retiree can re-enroll during open enrollment. Please see page 18 for premium contribution information.

If you have been employed with the University for 30 years or longer and/or have obtained Emeritus Status, you will be eligible to continue your group life insurance during retirement. The University will continue to pay for your Basic Life Insurance coverage and you may elect to continue to pay for any Voluntary Life Insurance coverage that you have at the time of retirement. Both of these reduce to a 65% payout at age 65 and then terminate at age 70. You may also elect to "Port" or "Convert" your Basic and/or Supplemental Life Insurance coverage within 31 days of your retirement. Please contact Human Resources at benefits@du.edu or **303.871.7420**.

Please note: All early retirees (those under age 65) are offered medical plans through Cigna. You will receive open enrollment details from our retiree plan billing administrator, Benistar.

If an early retiree (under age 65) has a spouse on a Kaiser Senior Advantage Plan, the early retiree (under 65) must move to a Cigna plan and the spouse (over 65) can remain on the Kaiser Senior Advantage plan.

For more information on the Kaiser plan options, please contact Human Resources at benefits@du.edu or **303.871.7420**.



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.

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 Valley IPA, Community Medical Associates, Colorado Care Partners, Colorado Health Neighborhoods, New West Physicians, Optum Medical Group, PHP Prime, UCHHealth Integrated Network
- 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, UCHHealth
 - Mountain (Eagle, Routt and Summit counties): Centura St. Anthony Summit Medical Center, UCHHealth 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.

**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

Insured by Cigna

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. The University of Denver offers you a choice of two plans through Cigna: a Copay Plan and a High Deductible Health Plan (HDHP).

Which Plan Is Best For You?

The Copay Plan

- 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 calendar year.

The High Deductible Health Plan (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 14.
- You pay the full Cigna-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 calendar year.

Both Plans

- Use the same Cigna network, doctors, and hospitals.
- Cover 100% of the cost for preventive care services like annual physicals and routine immunizations.

Copay Plan vs. High Deductible Health Plan

Both the Copay and HDHP plans use the Cigna LocalPlus and Open Access Plus (OAP) network which means that the doctors and hospitals that are in-network under the Copay plan will also be in-network with the HDHP option. 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 Plan | HDHP Plan |
|--|---|---|
| Per-Paycheck Cost for Coverage | Higher | Lower |
| Calendar Year Deductible | Lower | Higher |
| Calendar Year Out-of-pocket Maximum | Lower | Higher |
| 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 | Not Applicable | Health Savings Account (HSA) |

**Please see the example on page 8 for further clarification on the differences between a copay plan and a high deductible health plan.



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 | \$1,500 / \$3,000*** |
| Calendar Year Out-of-Pocket Max (single / family)* | \$2,000 / \$4,500** | \$3,000 / \$6,000** |
| 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% | 20% after deductible |
| Urgent Care | \$50 copay | 20% after deductible |
| Inpatient | 20% | 20% after deductible |
| Outpatient Surgery | 20% | 20% after deductible |
| Chiropractic Care (80 days per calendar year combined with cognitive, occupational, physical, pulmonary and 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% 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.

Copay Plan vs. High Deductible Health 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 | \$0 | \$1,500 |
| Out-of-Pocket Max | \$2,000 | \$3,000 |
| 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 | \$0 | \$1,300 |
| Out-of-Pocket Max | \$1,970 | \$2,800 |
| Claim 3—Member is hospitalized at an in-network facility for 2 days—Total cost = \$6,000 | | |
| Member Pays | \$0 deductible \$1,200 coinsurance | \$1,300 deductible \$1,200 coinsurance |
| Member's Remaining Balance | | |
| Deductible | \$0 | \$0 |
| Out-of-Pocket Max | \$770 | \$300 |
| 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 | \$0 Individual / \$0 Family | \$3,000 Family |
| Out-of-Pocket Max | \$2,000 Individual / \$4,500 Family | \$6,000 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 | \$0 Individual / \$0 Family | \$2,200 Family |
| Out-of-Pocket Max | \$1,880 Individual / \$4,380 Family | \$5,200 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 | \$2,200 deductible \$800 coinsurance |
| Member's Family Remaining Balance | | |
| Deductible | \$0 Individual / \$0 Family | \$0 Family |
| Out-of-Pocket Max | \$1,400 Individual/ \$3,780 Family | \$2,200 Family |

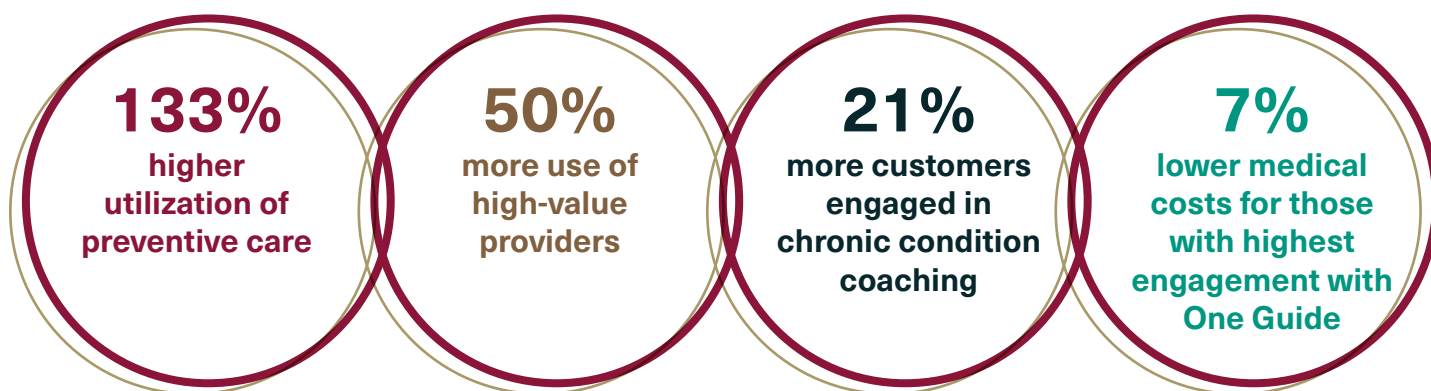
Cigna One Guide

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

Start using Cigna One Guide by app, chat or phone.

Download the myCigna app or call the phone number on the back of your ID card to talk with your personal guide.

You can reach out to Cigna's 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.



Cigna MotivateMe

The University of Denver wants to help you get healthy and stay healthy. So when you get involved in wellness goals sponsored by the University, you can easily earn rewards*, including money. And the more you do, the more you earn.

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

Getting started is easy

Visit myCigna.com and select "Wellness" or "View my incentives" to:

- Find detailed instructions on how to get started
- View a list of eligible goals and matching rewards
- Check and track your completed goals and earned rewards
- The rewards you earn will be automatically applied toward a debit or gift card

The rest is up to you

For more information or help setting up your account, visit 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.

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 weekend 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 | ■ Constipation | ■ Infections | ■ Shingles |
| ■ Allergies | ■ Diarrhea | ■ Joint aches | ■ Sinus infection |
| ■ Asthma | ■ Earaches | ■ Pink eye | ■ Skin infection |
| ■ Bronchitis | ■ Fever | ■ Rash | ■ Sore throats |
| ■ Cold and Flu | ■ Headaches | ■ Respiratory infection | ■ 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 | ■ Eating disorders | ■ Panic disorders | ■ Trauma/PTSD |
| ■ Bipolar disorders | ■ Grief/Loss | ■ Parenting issues | ■ Women's issues |
| ■ Child/Adolescent issues | ■ Marriage and Relationship issues | ■ Postpartum depression | |
| ■ Depression | ■ Men's issues | ■ Stress | |

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

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.

Delta Dental

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 | | | | | | |
| Oral exam, cleanings, sealants, x-rays | Covered at 100% | Covered at 100%* | Covered at 100% | Covered at 100%* | See Fee Schedule | |
| 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.

| Summary of Covered Benefits | Base Plan | | Enhanced Plan | |
|---|---|--|--|--|
| | 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

Health Savings Accounts (HSA)



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 either the Cigna 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 2023 calendar year.

| | IRS 2023 Maximum Contribution |
|-----------|---|
| Self Only | \$3,850 |
| Family | \$7,750 |
| Catch-Up | Age 55+ may contribute an additional \$1,000* |

*Employees age 55 or older anytime in 2023, 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.



Benefit Advocate Center

Overview

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

Overview

At no cost to you, the University of Denver is pleased to announce a new, 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?



Early Retiree Premium Contributions

Medical

| | University of Denver's Contribution | Cigna Copay Plan LocalPlus | | Cigna HDHP Plan LocalPlus | |
|---------------------------|-------------------------------------|----------------------------|------------|---------------------------|------------|
| | | Retiree's Contribution | Total Cost | Retiree's Contribution | Total Cost |
| Retiree Only | \$60.00 | \$691.97 | \$751.97 | \$521.73 | \$581.73 |
| Spouse/ Partner Only | N/A | \$751.97 | \$751.97 | \$581.73 | \$581.73 |
| Retiree & Spouse/ Partner | \$60.00 | \$1,438.59 | \$1,498.59 | \$1,098.63 | \$1,158.63 |
| Retiree & Child(ren) | \$60.00 | \$1,289.23 | \$1,349.23 | \$983.21 | \$1,043.21 |
| Family | \$60.00 | \$2,035.99 | \$2,095.99 | \$1,560.00 | \$1,620.00 |

| | University of Denver's Contribution | Cigna Copay Plan OAP | | Cigna HDHP Plan OAP | |
|---------------------------|-------------------------------------|------------------------|------------|------------------------|------------|
| | | Retiree's Contribution | Total Cost | Retiree's Contribution | Total Cost |
| Retiree Only | \$60.00 | \$801.27 | \$861.27 | \$634.06 | \$694.06 |
| Spouse/ Partner Only | N/A | \$861.27 | \$861.27 | \$694.06 | \$694.06 |
| Retiree & Spouse/ Partner | \$60.00 | \$1,663.36 | \$1,723.36 | \$1,329.07 | \$1,389.07 |
| Retiree & Child(ren) | \$60.00 | \$1,491.29 | \$1,551.29 | \$1,190.18 | \$1,250.18 |
| Family | \$60.00 | \$2,353.44 | \$2,413.44 | \$1,885.14 | \$1,945.14 |

Dental and Vision

| Retiree's Cost | Dental | | | Vision | |
|-----------------------------|---------------------|-------------------------|------------------------|-----------|---------------|
| | Delta Base PPO Plan | Delta Enhanced PPO Plan | Beta Health Alpha Plan | Base Plan | Enhanced Plan |
| Retiree/Spouse/Partner Only | \$29.92 | \$49.94 | \$10.75 | \$6.34 | \$8.85 |
| Retiree & Spouse/Partner | \$58.97 | \$98.45 | \$20.25 | \$12.07 | \$16.81 |
| Retiree & Child(ren) | \$70.95 | \$118.40 | \$23.25 | \$12.71 | \$17.72 |
| Family | \$110.74 | \$184.55 | \$29.75 | \$18.69 | \$26.03 |



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 (BAC) | | | |
| 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 |
| VIRTUAL CARE | | | |
| MDLive | 888.726.3171 | www.MDLIVEforCigna.com | 3344360 |
| 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 | | | |
| Rocky Mountain Reserve | 888.722.1223 | www.rockymountainreserve.com | N/A |
| RETIREE BILLING ADMINISTRATION | | | |
| Benistar | 800.236.4782 | www.benistar.com | N/A |



Legal Notices

For Plan Year: July 1, 2023 – June 30, 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](tel: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: Copay Plan (Individual: 20% coinsurance and \$0 deductible; Family: 20% coinsurance and \$0 deductible)

Plan 2: HDHP Plan (Individual: 20% coinsurance and \$1,500 deductible; Family: 20% coinsurance and \$3,000 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 balance 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 never 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, 2023. Contact your state for more information on eligibility.

| | |
|--|--|
| ALABAMA – Medicaid http://myalhipp.com 855.692.5447 | 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 |
| 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 | FLORIDA – Medicaid www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html 877.357.3268 |
| ARKANSAS – Medicaid http://myarhipp.com 855.MyARHIPP (855.692.7447) | 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 |
| 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 | |

Legal Notices

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: 800.766.9012

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP):
<https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>
855.459.6328 | KIHIPPPROGRAM@ky.gov
KCHIP: <https://kidshealth.ky.gov/Pages/index.aspx> |
877.524.4718
Medicaid: <https://chfs.ky.gov>

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/ofa/applications-forms>
800.977.6740 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

<https://www.mass.gov/masshealth/pa>
800.862.4840 | TTY: 617.886.8102

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: HSHIPPProgram@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://medicaid.ncdhhs.gov/>
919.855.4100

NORTH DAKOTA – Medicaid

<http://www.nd.gov/dhs/services/medicalserv/medicaid>
844.854.4825

OKLAHOMA – Medicaid and CHIP

<http://www.insureoklahoma.org>
888.365.3742

OREGON – Medicaid

<http://healthcare.oregon.gov/Pages/index.aspx>
<http://www.oregonhealthcare.gov/index-es.html>
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)

Legal Notices

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

VERMONT – Medicaid

<http://www.greenmountaincare.org>
Health Insurance Premium Payment (HIPP) Program |
Department of Vermont Health Access
800.250.8427

VIRGINIA – Medicaid and CHIP

<https://www.coverva.org/en/famis-select>
<https://www.coverva.org/hipp/>
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, 2023, 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.

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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.

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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.

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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, 2023
Name of Entity/Sender: University of Denver
Contact: Human Resources
Address: 2199 S. University Blvd.
Denver, Colorado 80208
United States
Phone Number: 303.871.7420

Legal Notices

Marketplace Notice

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

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. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

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 meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax 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 meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources at benefits@du.edu or **303.871.7420**.

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.

¹An 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.

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.

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?

No

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 standard¹ 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.

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?

¹An 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).

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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