UNIVERSITY of DENVER

Employee Benefits
July 1, 2021 - June 30, 2022

Benefits Overview

The University of Denver is proud to offer a comprehensive benefits package to employees holding an appointed 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.

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Eligibility

You and your dependents are eligible for The University of Denver benefits plans on the first day of the month following your date of hire into an appointed 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 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 event. If you experience a qualifying event, you must contact Shared Services within 30 days.

Qualifying Events

You may make a change in your coverage during the plan year 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 events listed below, provided you apply for the change in coverage within 30 days of the qualifying event:

- Marriage, divorce, or legal separation
- Birth, or adoption of a child
- Death of your spouse or covered dependent
- Covered dependent no longer qualifies as an eligible dependent
- Qualified Medical Child Support Order
- Significant cost or coverage changes

For a complete listing of qualified changes in status, contact Shared Services at 303-871-7420 or benefits@du.edu. Changes to your benefits must be made within 30 days of the event and must be consistent with your change in status.

Payroll 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 by personal check to Shared Services. For more information, please contact Shared Services 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: New Year's Day, Martin Luther King, Jr. Day, Memorial Day, Juneteenth (June 19), Independence Day, Labor Day, Thanksgiving Day, Thanksgiving Holiday, Winter Break (the last 5 week days of the calendar year).

Paid Vacation & Sick Leave

Appointed, non-faculty employees receive accrued paid time off. Please contact Shared Services at 303-871-7420 or benefits@du.edu for further details. Union employees, please refer to the union contract.

Paid Parental Leave

The University offers one academic term of paid parental leave for faculty members and 10 weeks of paid parental leave for staff. Staff parental leave is paid at a percentage of your salary based on your years of service. This enables a mother or father to take time off for birth, adoption, or foster placement of a child. Contact Shared Services at 303-871-7420 or visit https://www.du.edu/human-resources/hrpartners/leaves.html for details. Whenever possible, faculty and staff intending to take a leave should inform their dean, chair, supervisor, or department head no later than three months prior to the proposed beginning of leave. If this is not possible because of pre-term delivery, sudden availability of adoption placement, or other unpredictable changes in family status, leave will still be granted.

Other Forms of Leave

University policies provide for other kinds of leave, such as bereavement, jury duty, sabbaticals, military etc. Contact Shared Services at 303-871-7420 or benefits@du.edu for additional information.

What's New

Effective July 1, 2021, health benefits will transition from Kaiser to Cigna. 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.

To ease the transition to Cigna, below are a few action items to complete before 7/1/2021:

- Apply for Transition of Care if you are currently receiving ongoing treatment for an acute condition from a provider who will not be part of your new Cigna network. Please see page 9 for more details.
- Request a 60-90 day prescription refill for your daily/maintenance medications.
- If your medication requires prior authorization, supporting documentation will need to be shared with your new Cigna in-network provider.
- Deductible & Out-of-Pocket amounts met from 1/1/2021 to 6/30/2021 will be credited. This can take a few months, but you can speed up the process by submitting your last Explanation of Benefits (EOB).
- Contact your One Guide concierge service for assistance, details on these programs are located on pages 8 and 9.

Additionally the University is enhancing many other benefits to provide you and your family with the additional financial protection you may need for unexpected expenses.

- Basic Life & AD&D: increase in benefit amount from 1x salary to $50,000 to 1x salary to $100,000. Currently, AD&D coverage is only up to $10,000.
- Voluntary Life: guarantee issue amount for employees is increasing from $100,000 to the lesser of 5x salary or $200,000. Current amounts will rollover, and you can elect up to the guarantee issue without evidence of insurability.
- Short-Term Disability: benefit maximum increased from $600 per week to $1,500 per week.
- Long-Term Disability: benefit maximum increased from $10,000 per month to $12,500 per month.
- New Benefit Offerings: Voluntary Accident & Voluntary Critical Illness.

2021 Open Enrollment

May 10th - May 28th

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 Cigna program offerings. You will have access to in-network benefits from health care providers and facilities. The University of Denver offers you a choice of 2 plans through Cigna: 1 Copay plan and 1 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 deductible and coinsurance for higher cost and lesser utilized services.
- Copays do not apply toward your deductible but do apply towards your annual out-of-pocket maximum.
  - Once you reach your deductible 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 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 18.
- 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 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.

Medical Plan Provider Networks

Local Plus Provider Network

If you live in the Local Plus service area, you will have access to Cigna's Local Plus provider network. The Local Plus 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 Local Plus 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 Local Plus 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.

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

- The Local Plus 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 Local Plus network includes the following major provider groups*: Boulder Medical Center, Boulder Valley Care Network, Colorado Care Partners, Colorado Health Neighborhoods**, New West Physicians, Optum Medical Group, PHP Prime, Primary Care Partners, UCHealth Integrated Network
- The Local Plus 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 Health St. Anthony Summit Medical Center, Vail Valley Medical Center
  - West (La Plata, Mesa and Montezuma counties): Animas Surgical Hospital, Centura Health Mercy Regional Medical Center, Southwest Memorial Hospital, St. Mary's Medical Center

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

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

Summary of Covered Benefits	Copay Plan In-Network Benefits	HDHP Plan In-Network Benefits
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 ded.
Primary Care Office Visit	$25 copay	20% after ded.
Specialist Office Visit	$40 copay	20% after ded.
Preventive Care	**100% covered**	**100% covered**
DIAGNOSTIC TESTING/ IMAGING		
Diagnostic Lab and X-ray	Based on place of service	20% after ded.
Advanced Imaging (MRI, CT/PET Scan)	$100 copay	20% after ded.
HOSPITAL SERVICES		
Emergency Room	20% after ded.	20% after ded.
Urgent Care	$50 copay	20% after ded.
Inpatient	20% after ded.	20% after ded.
Outpatient Surgery	20% after ded.	20% after ded.
Chiropractic Care (80 days per calendar year combined with cognitive, occupational, physical, pulmonary & speech therapy)	$25 copay	20% after ded.
PRESCRIPTION DRUGS		
Retail - 30-day supply Tier 1 Tier 2 Tier 3 Specialty	 $15 copay $30 copay $60 copay 20% up to $75	Plan deductible then, $15 copay $30 copay $60 copay 20% up to $75
Mail Order - 90-day supply Tier 1 Tier 2 Tier 3	 $30 copay $60 copay $120 copay	Plan deductible then, $30 copay $60 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.

Transition & Continuity of Care

What is Transition of Care?

With Transition of Care, you may be able to continue to receive services for specified medical and behavioral conditions with health care providers who are not in the Cigna network at in-network coverage levels. This care is for a defined period of time until the safe transfer of care to an in-network provider or facility can be arranged. You must apply for Transition of Care at enrollment, or when there is a change in your medical plan. **You must apply no later than 30 days after the effective date of your coverage.**

What is Continuity of Care?

With Continuity of Care, you may be able to receive services at in-network coverage levels for specified medical and behavioral conditions when your health care provider leaves your plan's network and the immediate transfer of your care to another health care provider would be inappropriate and/or unsafe. This care is for a defined period of time. **You must apply for Continuity of Care within 30 days of your health care provider's termination date.** This is the date that he or she is leaving your plan's network.

How they both work:

You must already be under treatment for the condition identified on the Transition of Care/ Continuity of Care request form.

If the request is approved for medical or behavioral conditions:

- You will receive the in-network level of coverage for treatment of the specific condition by the health care provider for a defined period of time, as determined by Cigna.
- Transition of Care/Continuity of Care applies only to the treatment of the medical or behavioral condition specified and the health care provider identified on the request form. All other conditions must be cared for by an in-network health care provider for you to receive in-network coverage.

The availability of Transition of Care/Continuity of Care:

- Does not guarantee that a treatment is medically necessary.
- Does not constitute precertification of medical services to be provided.
- Depending on the actual request, a medical necessity determination and formal precertification may still be required for a service to be covered.

To complete the Transition/Continuity of Care form please call the phone number on the back of your ID card.

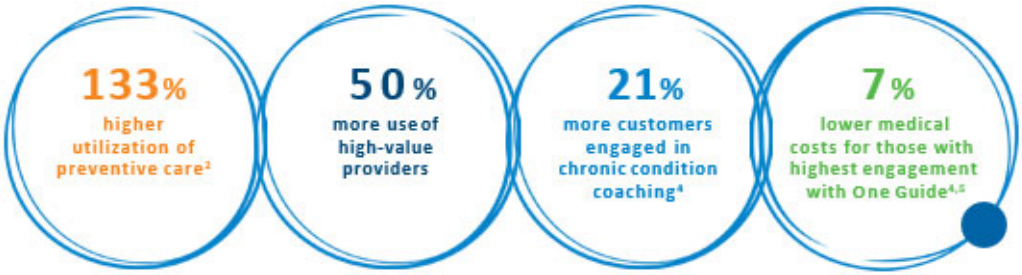
Cigna One Guide®

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 on July 1, 2021 - 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.
Before July 1, 2021 you can reach out to Cigna's pre-enrollment line at 888.806.5042.

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 plan.

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

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

Services for the whole family

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

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

Employee or family member calls a toll-free number dedicated to Cigna customers.

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.

Manage Your Health through myCigna

Your online account will be available after July 1, 2021, or 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.

Download the myCigna® app today.

myCigna

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.

DispatchHealth

Bringing back the house call. DispatchHealth offers on-demand medical care in the comfort of your home, work, or place of need.
Mobile medical teams arrive equipped with the latest technology and tools to treat minor or severe injuries and illnesses. DispatchHealth is available for the same cost of an urgent care visit.

Virtual Care Options

TeleHealth

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
- 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.MDLIVEforCigna.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 to help ensure you get the support that works best for you.

- 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.

- Up to three free sessions with a licensed clinician in our employee assistance program 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.

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

- 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.

- 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.

www.meruhealth.com/cigna

Meru Health
The New Standard of Mental Healthcare

- 12-week app-based counseling program
- Daily support from licensed clinicians and anonymous peers to treat

- 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.

www.talkspace.com/cigna

talkspace

Care Options

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 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

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 3 dental plans, 2 with Delta Dental and 1 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 2 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 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

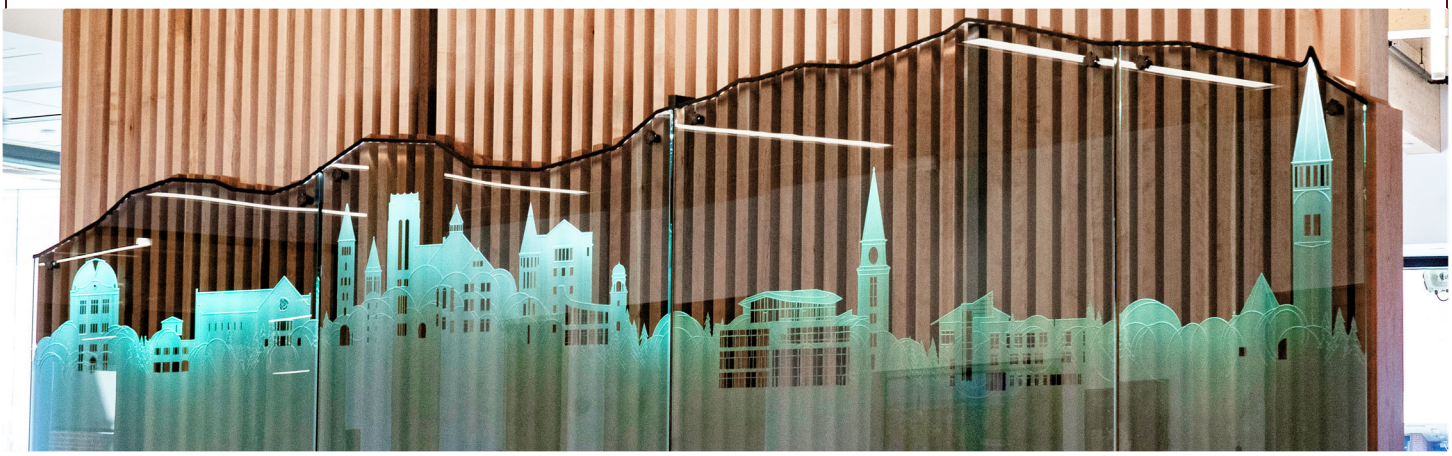
*Balance-billing applies if you see an out-of-network provider. The amount you may owe is the difference between the provider's billed charges and the payment received by Delta Dental based off of their "Maximum Allowable Charge" schedule.
** Those who do not enroll in the dental plan when initially 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

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	
	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 in-network discounts	40% off complete pair of prescription eyeglasses, 20% off non-prescription sunglasses, 20% off remaining balance beyond plan coverage			

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



Monthly Employee 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

	Copay Plan		HDHP-HSA Plan*	
	University of Denver Contributes	Employee	University of Denver Contributes	Employee
Employee Only	$526.54	$89.03	$522.39	$0.00
Employee & Spouse	$855.85	$370.87	$881.52	$158.94
Employee & Child(ren)	$771.85	$332.70	$791.46	$145.42
Family	$1,132.57	$583.23	$1,174.91	$279.96

*If you enroll in the HDHP and open a health savings account (HSA) through Rocky Mountain Reserve the

Dental

	Delta Base PPO Plan	Delta Enhanced PPO Plan	Beta Health Alpha Plan
Employee Only	$28.95	$48.32	$10.22
Employee & Spouse**	$57.05	$95.25	$20.24
Employee & Child(ren)	$68.64	$114.55	$24.92
Family**	$107.14	$178.85	$29.86

Vision

	Base Plan	Enhanced Plan
Employee Only	$6.34	$8.85
Employee & Spouse**	$12.07	$16.81
Employee & Child(ren)	$12.71	$17.72
Family**	$18.69	$26.03

Health Savings Account (HSA)

What is a Health Savings Account (HSA)?

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.

High Deductible Health Plans and HSA

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

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's Healthcare FSA.

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 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 2021 calendar year.

	IRS 2021 Maximum	The University of Denver	Employees Maximum
Self Only	$3,600	$331.68 ($27.64 per month)	$3,268.32
Family	$7,200		$6,868.32
Catch-Up	Age 55+ may contribute an additional $1,000*		

*Employees age 55 or older anytime in 2021, who are not enrolled in Medicare, may contribute an additional $1,000 to their HSA account. Spouses 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

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 2021, the contribution limit is $2,750.

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 2021, the contribution limit is $2,750.

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. **For 2021 only, per the American Rescue Plan Act (ARPA) employees are allowed to contribute up to $10,500 married and filing jointly or single as head of household or $5,250 if married and filing separately, to their DCAP until December 31, 2021.**

Starting January 1, 2022 contributions revert back to the standard IRS limit of $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 FSA debit card or submit a claim form for reimbursement.
4. **Per the Consolidated Appropriations Act, 2021 (CAA), for plan years ending in 2020 & 2021 unused health and dependent care flexible spending account balances to carry over to the next plan year with no maximum.**

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	Copay	HDHP	All employees
2021 Contribution limits	$3,600 Individual $7,200 Family $1,000 Catch-up	$2,750		Up to $10,500, see page 19 for details
Who can contribute?	Employer, employee, spouse, family members**	Employee		Employee
Rollover	100%	Unlimited, see page 20 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 and covered children over age 19 must contribute to their own individually-owned HSA account

Life & Disability 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.

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 basic weekly salary
- Benefit Maximum: Up to $1,500 per week
- Benefit Period: Up to 11 weeks

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 basic monthly salary
- Benefit Maximum: $12,500 per month
- Benefit Duration: the greater of your social security normal retirement age or 4 years

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

Voluntary Life and Accidental Death & Dismemberment

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 are guaranteed coverage as outlined below without answering medical questions if you enroll when you are first eligible, or during this open enrollment only. 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

- 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

- Increments of $5,000 to $500,000
  - 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 $75,000
  - 15% of the employee covered amount if you do not have spouse covered under this policy.
  - 10% of the employee covered amount if you have spouse covered under this policy.

Voluntary Long Term Care Insurance

Long term care is the assistance a person may need with the basic activities of daily living – eating, bathing, dressing, transferring, toileting, and continence. It can also include supervision needed to protect a person's health and safety. The need for long term care may develop from things such as an accident, illness, stroke, advanced age or other chronic condition such as Alzheimer's, dementia or Parkinson's disease. Long term care consists mainly of personal care rather than medical care, which is typically covered by a health plan. Long Term Care insurance is available through LifeSource. To obtain your personalized quote please call or visit the website listed in the contact section of this guide.

Voluntary Accident & Critical Illness

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.

Employee Only	$9.92
Employee & Spouse	$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

Benefit Amounts for Critical Illness:

- Employee: $10,000, $20,000 or $30,000; Guarantee issue: $30,000
- Spouse: 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.

Monthly Rates Per $10,000 & Based on	Employee Only	Employee & Spouse	Employee & Child(ren)	Family
0-29	$2.49	$3.98	$3.71	$5.22
30-39	$4.42	$6.94	$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

403(b) Retirement Plan

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 2021 is $19,500. 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 2021 is $6,500.

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.

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 Shared Services 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., MT.
- Want to speak with an advisor at no extra cost? Call 800-732-8353, weekdays 8 a.m. to 8 p.m., ET, 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

Back-up Care & Family Support

The University of Denver and Bright Horizons have partnered to help you better manage your many work, family, and personal responsibilities. As a valued employee you have access to two programs: *Bright Horizons Back-Up Care*™ and *Bright Horizons Additional Family Supports*™.

Bright Horizons Back-Up Care™ provides access to back-up care for your children, adult, and elderly family members during a lapse or breakdown in normal care arrangements. Employees have access to **3** annual days of back-up care at subsidized rates. Center-based care is $20 per child/day or $35 per family/day. In-home care for children and adults is $8 per hour (4 hour minimum required).

Examples of when you can use back-up child care include:

- You have a new baby and need care while you transition back to a normal work schedule or in between child care arrangements
- Your child's school or center is closed for breaks, teacher in-service days, or inclement weather
- You need in-home child care for evening and weekend hours

Examples of when you can use back-up adult and elder care include:

- Your parent's regular in-home care provider is out sick or on vacation
- Your teenage/adult child is mildly ill and you want someone with him/her while you are at work
- Your parents or grandparents live out of state and need assistance
- Your spouse or partner (or other adult family member) is recovering from an illness or injury and needs assistance

Through *Bright Horizons Additional Family Supports*™, your employer provides you with resources to help you secure your own regular, ongoing family care, including:

- Preferred Enrollment at select Bright Horizons child care centers
- Discounted tuition for full-time care at select partner centers in our child care network
- Online, self-serve, and self-pay resources to search for and connect with:
  - Babysitters and nannies for regular and weekend care (including children with special needs) and adult and elder companion caregivers — available through Sittercity
  - Pet sitters, dog walkers, groomers, and more — available through Sittercity
  - Elder care resources, planning, and referrals — available through Years Ahead
  - Tutoring, test prep, and homework help — available through Tutoring and Test Prep
  - Housekeepers — available through Sittercity

Visit https://clients.brighthorizons.com/DU

Employer Username: DU | **Password:** Benefits4You

Download the App: Search "back-up care" in the App Store or Google Play

Questions? Call 877-BH-CARES (242-2737)

Employee Assistance Program (EAP)

The University of Denver provides an EAP through SupportLinc to all employees at **no cost to you**. 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 spouse and immediate family members 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.

Visit the portal at :

www.supportlinc.com

user name: universityofdenver

Tuition Waiver

The Tuition Waiver program is designed to enable benefited employees, their spouses, 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 benefitted 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 & SPOUSE

Employee's Work Schedule	Employee Eligibility per Academic Period	Plan Year Credit Maximum* Summer through Spring	Spouse's Eligibility per Academic Period
Full-time (.93-1.0 FTE)	2 classes (9 credit max)	20 credits	5 credits
3/4-time (.75-.92 FTE)	2 classes (7 credit max)	16 credits	4 credits
1/2-time (.50-.74 FTE)	2 classes (5 credit max)	12 credits	3 credits
Retiree	5 credits	N/A	5 credits
* 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.			
Employee's Work Schedule	**Fall Period**	**Winter Period**	**Spring 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 with Tenure or Less than 5 Years of Service: Undergraduate/Graduate	Employees with Tenure or Less than 5 Years of Service Undergraduate/Graduate
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/index.html or contact Shared Services 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 the purchase of DU Athletic event tickets 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 the DU Transportation Center at 303-871-7433 or Shared Services at 303-871-7420 or benefits@du.edu.

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

LEGAL NOTICES

For Plan Year: July 1, 2021 - June 30, 2022

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 Privacy Notice**
- **Women's Health and 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"**
- **Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)**
- **Pregnant Workers Fairness Act C.R.S. § 24-34-402.3**
- **Model COBRA Continuation Coverage General Notice Instructions**
- **Medicare Part D**
- **Marketplace Notice**

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

Shared Services

University of Denver

2601 East Colorado Avenue Denver, CO 80208

Phone: 303.871.7420

Fax: 303.871.6339

Email: benefits@du.edu

HIPAA Special Enrollment Rights

Loss of Other Coverage — If you are declining or have declined enrollment for yourself and/or your dependents (including your spouse) because of other health insurance coverage or group health plan coverage, you may in the future be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage or if the employer stops contributing towards you or your dependent's coverage. To be eligible for this special enrollment opportunity, you must request enrollment within 30 days after your other coverage ends or after the employer stops contributing towards the other non-COBRA coverage.

New Dependent as a Result of 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/or your dependents.

To be eligible for this special enrollment opportunity, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Medicaid Coverage— The University of Denver Health and Welfare Plan will allow an employee or dependent who is eligible, but not enrolled for coverage, to enroll for coverage if either of the following events occur:

1. **TERMINATION OF MEDICAID OR CHIP COVERAGE — If** the employee or dependent is covered under a Medicaid plan or under a State child health plan and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility.
2. **ELIGIBILITY FOR PREMIUM ASSISTANCE UNDER MEDICAID OR CHIP —If** the employee or dependent becomes eligible for premium assistance under Medicaid or CHIP, including under any waiver or demonstration project conducted under or in relation to such a plan. This is usually a program where the state assists employed individuals with premium payment assistance for their employer's group health plan rather than provide direct enrollment in a state Medicaid program.

To be eligible for this special enrollment opportunity you must request coverage under the group health plan within 60 days after the date the employee or dependent becomes eligible for premium assistance under Medicaid or CHIP or the date you or your dependent's Medicaid or state-sponsored CHIP coverage ends.

HIPAA Privacy Notice

HIPAA requires the University of Denver to notify you that a privacy notice is available by obtaining a copy from the Shared Services Center. Please contact Shared Services if you have any questions .

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act requires group health plans that provide coverage for mastectomy to provide coverage for certain reconstructive services. This law also requires that written notice of the availability of the coverage be delivered to all plan participants upon enrollment and annually thereafter. This language serves to fulfill that requirement for this year. These services include:

- Reconstruction of the breast upon which the mastectomy has been performed;
- Surgery/reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment for physical complications during all stages of mastectomy, including lymphedemas.

In addition, the plan may not:

- Interfere with a participant's rights under the plan to avoid these requirements; or
- Offer inducements to the healthcare provider, or assess penalties against the provider, in an attempt to interfere with the requirements of the law.

However, the plan may apply deductibles, coinsurance, and copays consistent with other coverage provided by the Plan.

Newborns' and Mothers' Health Protection Act

Federal law (Newborns' and Mothers' Health Protection Act of 1996) prohibits the plan from limiting a mother's or newborn's length of stay to less than 48 hours for a normal delivery or 96 hours for a cesarean delivery or from requiring the provider to obtain pre-authorization for a stay of 48 hours or 96 hours, as appropriate. However, federal law generally does not prohibit the attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours for normal delivery or 96 hours for cesarean delivery.

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.

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, 2021. You should contact your State for further information on eligibility.

ALABAMA – Medicaid

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

ALASKA – Medicaid

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

ARKANSAS – Medicaid

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

CALIFORNIA – Medicaid

Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 916-440-5676

COLORADO – Medicaid & CHP+

Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI):
https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: https://flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid

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

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hipp/
Phone: (877) 438-4479
All other Medicaid
Website: https://www.in.giv/medicaid/
Phone (800) 457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: http://dhs.iowa.gov/ime/members
Medicaid Phone: (800) 338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: (800) 257-8563

KANSAS – Medicaid

Website: http://www.kdheks.gov/hcf/default.htm
Phone: (800) 792-4884

KENTUCKY – Medicaid

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

LOUISIANA – Medicaid

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

MAINE – Medicaid

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

MASSACHUSETTS – Medicaid and CHIP

Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: (800) 862-4840

MINNESOTA – Medicaid

Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: (800) 657-3739

MISSOURI – Medicaid

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

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: (800) 694-3084

NEBRASKA – Medicaid

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

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: (800) 992-0900

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: (603) 271-5218
Toll free number for the HIPP program: (800) 852-3345 ext. 5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: (609) 631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: (800) 701-0710

NEW YORK – Medicaid

Website: http://www.health.ny.gov/health_care/medicaid/
Phone: (800) 541-2831

NORTH CAROLINA – Medicaid

Website: http://medicaid.ncdhhs.gov/
Phone: (919) 855-4100

NORTH DAKOTA – Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: (844) 854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: (888) 365-3742

OREGON – Medicaid

Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: (800) 699-9075

PENNSYLVANIA – Medicaid

Website: http://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: (800) 692-7462

RHODE ISLAND – Medicaid

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

SOUTH CAROLINA – Medicaid

Website: http://www.scdhhs.gov
Phone: (888) 549-0820

SOUTH DAKOTA – Medicaid

Website: http://dss.sd.gov
Phone: (888) 828-0059

TEXAS – Medicaid

Website: http://gethipptexas.com/
Phone: (800) 440-0493

UTAH – Medicaid and CHIP

Medicaid Website: http://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: (877) 543-7669

VERMONT - Medicaid
Website: http://www.greenmountaincare.org/ Phone: (800) 250-8427
VIRGINIA - Medicaid and CHIP
Website: http://www.coverva.org/hipp/ Medicaid Phone: (800) 432-5924 CHIP Phone: (855) 242-8282
WASHINGTON - Medicaid
Website: https://www.hca.wa.gov/ Phone: (800) 562-3022

WEST VIRGINIA - Medicaid
Website: http://mywvhipp.com/ Phone: (877) 598-5820
WISCONSIN - Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: (800) 362-3002
WYOMING - Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: (800) 251-1269

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

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2023)

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.

Model COBRA Continuation Coverage General Notice Instructions

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;
- 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.

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.

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 period 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.

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.

Protecting Your Health Information Privacy Rights

Denver University is committed to the privacy of your health information. The administrators of the Denver University Health 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.

Medicare Part D

Important Notice from the 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 the 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. The University of Denver has determined that the prescription drug coverage offered by the University of Denver Health and Welfare 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 through 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 during the annual enrollment period under the University of Denver Health and Welfare Plan.

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 the 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.

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 November 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 the 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, 2021
University of Denver / Shared Services
2601 East Colorado Avenue Denver, CO 80208 Phone: 303.871.7420 / Fax: 03.871.6339
Email: benefits@du.edu

Contact Information

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

Shared Services

University of Denver

2601 East Colorado Avenue Denver, CO 80208

Phone: 303.871.7420

Fax: 303.871.6339

Email: benefits@du.edu

Plan	Phone	Website/Email	Group #
Medical Cigna	800.244.6224	www.mycigna.com	3344360
Cigna One Guide® (after 7/1)	800.244.6224		3344360
Health Advocate®	866.799.2725		N/A
Dispatch Health	303-500-1518	www.dispatchhealth.com	3344360
Virtual Care	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

Plan	Phone	Website/Email	Group #
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 Vision Care	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.cigna.com/customer-forms	Life: FLX969778 AD&D: OK971218 STD: LK752793 LTD: LK966486
Voluntary Accident & Critical Illness Cigna	800.754.3207	Www.supphealthclaims.com	AI961819 CI961734
Voluntary Long-Term Care Life Source	855.889.5540	www.groupltci.com/du	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

UNIVERSITY of DENVER

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.