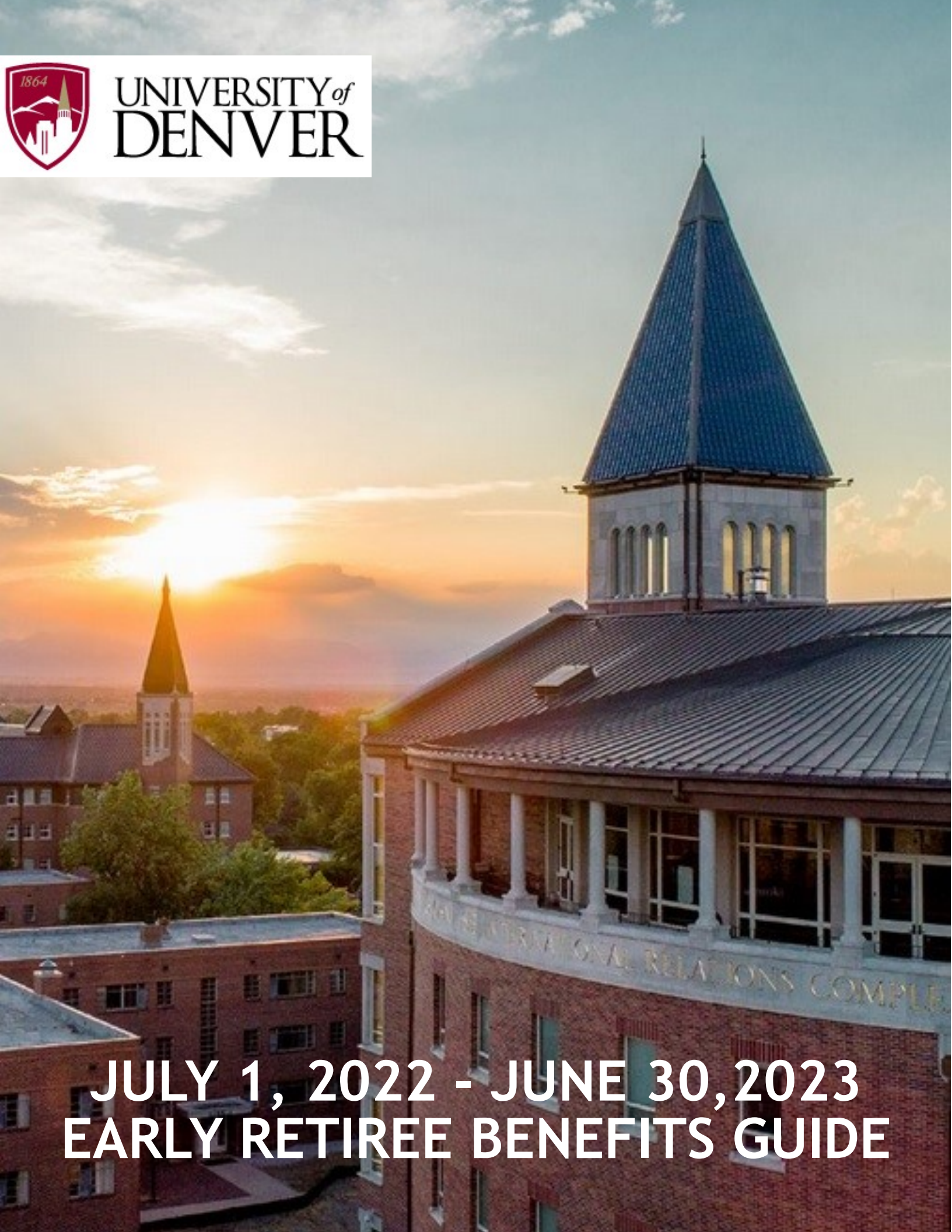

UNIVERSITY of DENVER

JULY 1, 2022 - JUNE 30, 2023
EARLY RETIREE BENEFITS GUIDE

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Eligibility Overview

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

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

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

If you have been employed with the University for 30 years or longer and/or have obtained Emeritus Status, you will be eligible to continue your group life insurance during retirement. The University will continue to pay for your Basic Life Insurance coverage and you may elect to continue to pay for any Voluntary Life Insurance coverage that you have at the time of retirement. Both of these reduce to a 65% payout at age 65 and then terminate at age 70. You may also elect to "Port" or "Convert" your Basic and/or Supplemental Life Insurance coverage within 31 days of your retirement. Please contact Shared Services at benefits@du.edu or 303-871-7420.

Cigna Medical Network Options

LocalPlus Provider Network

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

The LocalPlus provider network has roughly 5,000 primary care physicians and over 14,000 specialists in the Denver metro area alone.

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

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

- The LocalPlus network is available in the following Colorado Counties*: Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Eagle, Jefferson, La Plata, Larimer, Mesa, Montezuma, Routt, Summit, Weld
- The LocalPlus network includes the following major provider groups*: Boulder 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 LocalPlus network includes the following major Hospitals* and Hospital Systems:
    - Front Range: Boulder Community Health, Centura Health***, Children's Hospital Colorado, Craig Hospital, Denver Health Medical Center, HealthONE, National Jewish Health, SCL Health System, UCHealth
    - Mountain (Eagle, Routt and Summit counties): Centura 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 the Cigna OneGuide team by using the number on the back of your ID card or 1-800-Cigna24 (1-800-244-6224) or visit Cigna.com.

* Listing is not all-inclusive. For a complete listing, contact your Cigna representative or visit Cigna.com.
** Colorado Health 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 LocalPlus service area, you have access to the Cigna Open Access Plus provider network. The OAP Network contains participating physicians nationwide. To find out if your doctor is a participating provider in the network, please visit Cigna's website, cigna.com.

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

Which Plan Is Best For You?

The Copay plan:

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

The High Deductible Health Plan (HDHP):

- Tax-qualified plan for a Health Savings Account (HSA). With an HSA you are able to set aside pre-tax funds into an account to be used for qualified medical expenses. For more information on how your HSA works, please see the HSA section of this booklet starting on page 16.
- You pay the full Cigna-negotiated cost for medical services and prescription drugs until you meet your annual deductible (with the exception of preventive care which is covered at 100%).
- There are no copays with the exception of prescription drugs (once your deductible has been met).
- After the deductible is met, you and the plan share the costs (80% paid by the plan and 20% paid by you) until you reach the annual out-of-pocket maximum.
- If you reach your out-of-pocket maximum, all services are paid at 100% for the remainder of the calendar year.

Both Plans:

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

Cigna Copay Plan vs. High Deductible Health Plan

Both the Copay and HDHP plans use the Cigna LocalPlus and Open Access Plus (OAP) network which means that the doctors and hospitals that are in-network under the Copay plan will also be in-network with the HDHP option. Both options cover 100% of the cost for preventive care services like annual physicals and routine immunizations.

The way you plan for care is different with each plan. Below is a chart highlighting the key differences in the plans:

	Copay Plan	HDHP Plan
Per-Paycheck Cost for Coverage	Higher	Lower
Calendar Year Deductible	Lower	Higher
Calendar Year Out-of-pocket Maximum	Lower	Higher
Using the Plan	Pay more with each paycheck and less when you need care	Pay less with each paycheck and more when you need care
Savings/Spending Account Options	Not Applicable	Health Savings Account (HSA)

**Please see the example on page 8 for further clarification on the differences between the Copay plan and the High Deductible Health Plan.

Cigna Medical Plan Options

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

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

Cigna Copay Plan vs. High Deductible Health Plan Examples

	Copay Plan	HDHP Plan
Example of Employee Only Coverage		
Claim 1—Member goes for their preventive care, annual physical, including routine lab (blood work to check cholesterol levels and routine exam), utilizing an in-network provider—Total cost = $150		
Member Pays	$0, covered at 100%	$0, covered at 100%
Member's Remaining Balance Deductible Out-of-Pocket Max	 $0 $2,000	 $1,500 $3,000
Claim 2—Member goes to an in-network pharmacy and fills their 30 day prescription for a tier 2 drug—Total cost = $200		
Member Pays	$30 copay	$200 deductible
Member's Remaining Balance Deductible Out-of-Pocket Max	 $0 $1,970	 $1,300 $2,800
Claim 3—Member is hospitalized at an in-network facility for 2 days—Total cost = $6,000		
Member Pays	$0 deductible $1,200 coinsurance	$1,300 deductible $1,200 coinsurance
Member's Remaining Balance Deductible Out-of-Pocket Max	 $0 $770	 $0 $300
Example of Employee + Family Coverage		
Claim 1—Member and their 3 dependents goes for their preventive care, annual physicals, including age appropriate routine lab and immunizations, utilizing an in-network provider—Total cost = $600		
Member Family Pays	$0, covered at 100%	$0, covered at 100%
Member's Family Remaining Balance Deductible Out-of-Pocket Max	 $0 Ind. / $0 Fam. $2,000 Ind. / $4,500 Fam.	 $3,000 Fam. $6,000 Fam.
Claim 2—Member's spouse/partner goes to an in-network pharmacy and fills their 30 day prescription for a tier 2 drug, 4 months—Total cost = $800		
Member Family Pays	$120 copay ($30/month)	$800 deductible ($200/month)
Member's Family Remaining Balance Deductible Out-of-Pocket Max	 $0 Ind. / $0 Fam. $1,880 Ind. / $4,380 Fam.	 $2,200 Fam. $5,200 Fam.
Claim 3—Member's child (dependent) has an emergency room an in-network facility—Total cost = $3,000		
Member Family Pays	$0 deductible $600 coinsurance	$2,200 deductible $800 coinsurance
Member's Family Remaining Balance Deductible Out-of-Pocket Max	 $0 Ind. / $0 Fam. $1,400 Ind./ $3,780 Fam.	 $0 Fam. $2,200 Fam.

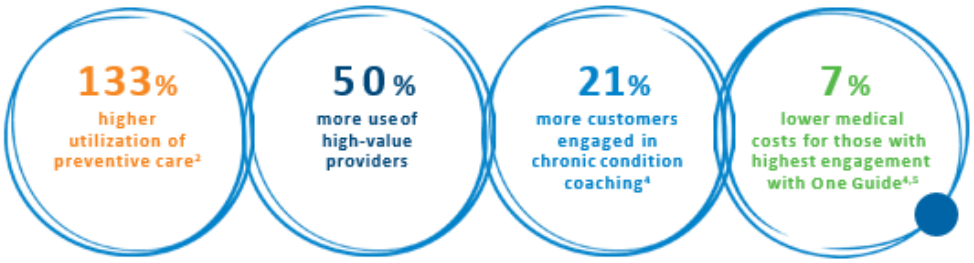
Cigna One Guide

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.

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

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

You can reach out to Cigna's pre-enrollment line at 888.806.5042

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

myCigna App

Manage Your Health through myCigna

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

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

Download the myCigna® app today.

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

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

Cigna MotivateMe

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

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

Getting started is easy

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

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

The rest is up to you

For more information or help setting up your account visit **myCigna.com** or call **800-244-6224**. You can also find information by downloading the myCigna Mobile App for your mobile device.**

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

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

Virtual Care Options

TeleHealth

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 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.

Kaiser Medical Plan Options

Kaiser Permanente HMO & HDHP Plans

With Kaiser Permanente (KP) you will find high quality care and coverage in one place. With these 2 options, you must visit an in-network provider allowing for lower out-of-pocket costs. There are no out-of-network benefits, except in the case of a true emergency.

Summary of Covered Benefits	HMO Plan KP Providers	HDHP-HSA Plan KP Providers
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	100% covered	100% covered
Primary Care Office Visit	$25 copay	20% after deductible
Specialist Office Visit	$40 copay	20% after deductible
Preventive Care	**100% covered**	**100% covered**
DIAGNOSTIC TESTING/ IMAGING		
Diagnostic Lab and X-ray	100% covered	20% after deductible
Advanced Imaging (MRI, CT/PET Scan)	$100 copay per procedure	20% after deductible
HOSPITAL SERVICES		
Emergency Room	20% coinsurance	20% after deductible
Urgent Care	$50 copay	20% after deductible
Inpatient	20% coinsurance	20% after deductible
Outpatient Surgery	KP Facility: 10% coinsurance All Other Facilities: 20% coinsurance	Ambulatory Surgical Center: 10% after deductible Outpatient Hospital: 20% after deductible
Chiropractic Care (up to 20 visits per calendar year)	$25 copay	20% after ded.
PRESCRIPTION DRUGS		
Retail - 30-day supply Tier 1 Tier 2 Tier 3 Specialty	 $15 copay $30 copay $50 copay $75 copay	Plan ded. then: $15 copay $30 copay $50 copay $75 copay
Mail Order - Tier 1/2/3/Specialty (90-day supply)	$30/$60/$100/$75	$30/$60/$100/$75
Pediatric Vision Exam	$25 copay	20% after ded.

*If you have other family members on the plan, the overall family deductible & out-of-pocket maximum must be met before the plan begins to pay.

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

Kaiser In-Person Care Options

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

- Primary care: regular visits to your doctor for preventive screenings and checkups.
- Specialty care: services from doctors with training in specific areas of care, such as obstetrics-gynecology, dermatology, cardiology, mental health, and more.
- After-hours care
- Pharmacy
- Lab
- Radiology services
- Mental health services
- Vision and audiology services

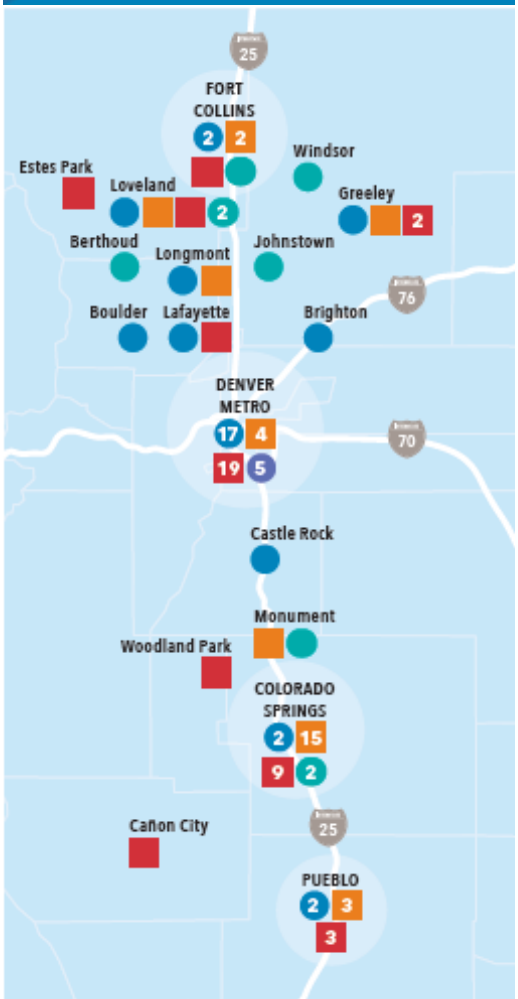
Find doctors and locations across Colorado. There are 1,200+ Kaiser Permanente physicians, and 15,000+ network providers at locations across Colorado.

- Denver/Boulder
- Northern Colorado: Fort Collins, Greeley, Loveland
- Southern Colorado: Colorado Springs, Monument & Pueblo

For a full list of providers included in your plan, visit kp.org/locations or call:

- Denver/Boulder: 303-338-3800
- Northern Colorado: 1-844-201-5824
- Southern Colorado: 1-888-681-7878
- TTY 711

Are you planning on moving? If you are planning on moving, please contact Shared Services at 303-871-7420 or benefits@du.edu to verify you are still within the Kaiser Permanente service area. If you are no longer in the Kaiser Permanente service area there are other options available to you.



- Kaiser Permanente medical offices
- Affiliated Providers with Extended Hours
- Urgent care facility
- Emergency care facility[1]
- Behavioral health offices (network providers available in Northern and Southern Colorado).
- [1] Numbers indicate multiple locations in a city or metropolitan area.

Kaiser In-Person Care Options (cont'd)

Manage Your Health with www.kp.org

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

1. Visit www.kp.org/register using your computer (not a mobile device)
2. Follow the instructions. You will need your medical record number on your ID card.
3. Start managing care for you and your family - find a doctor, schedule an appointment, transition your prescriptions and more.

Kaiser Permanente Mobile Access

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

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

You can get the care that's right for you by choosing from a number of options that meet your needs and lifestyle. Visit www.kp.org for more information.

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

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

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

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

IN-PERSON
Same-day or next-day appointments are often available.

Call 303-338-4545 (TTY 711)

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

Manage Your Health Care Costs Online

* Pay your medical bills at www.kp.org/paymedicalbills
* Get a personalized cost estimate at www.kp.org/costestimates. Use this tool to find out what you can expect to pay out-of-pocket for exams, tests, and other services.
* Go paperless at www.kp.org/gopaperless and receive medical bills and other documents online. You will get an email alert each time a bill is ready.

Need help paying for care?

Payment plans and financial assistance are available. Call Financial Counseling at 303-338-3025 or 1-877-803-1929 (TTY: 711), Mon-Fri from 8am to 6pm.

Kaiser In-Person Care Options (cont'd)

MENTAL HEALTH AND WELLNESS

Get the emotional support you need—whenever you need it

Text with a coach using the Ginger app

Through Kaiser Permanente, you may use the Ginger App. The Ginger app offers 1-on-1 support for many common challenges—from anxiety, stress, grief, and low mood to issues with work, relationships, and more. Ginger's highly trained emotional support coaches are ready to help 24/7. Kaiser Permanente members can use the app for 90 days per year at no cost.

What can you do with Ginger?

- Text with your coach on the Ginger app now or schedule a time to connect later.
- Discuss goals, share challenges, and create an action plan with your coach.
- Get personalized, interactive skill-building tools from your coach from a library of more than 200 activities on the app.
- View recaps from each texting session and track your process.
- Work with your coach to adjust your action plan if needed to better help you reach your goals.

AmWell with Kaiser Permanente

Schedule video visits with AmWell

Your mental health is important to us and AmWell through Kaiser Permanente allows you to get the care you need. Through AmWell, you can schedule video visits 7 days a week with affiliated, licensed psychologists or therapists to discuss . Visits are typically 45 minutes and allow flexibility to include multi-way videos for couples and families. Members can visit kp.org/getcare for more information on how to schedule an appointment.

Health Savings Accounts

Administered by Rocky Mountain Reserve

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

Are you eligible for an HSA?

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

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

High Deductible Health Plans and HSA

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

How does an HSA work?

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

How much can you contribute to your HSA?

Any contributions made by all parties can not exceed the IRS annual HSA limit. Below are the IRS limit amounts for the 2022 calendar year.

	IRS 2022 Maximum Contribution
Self Only	$3,650
Family	$7,300
Catch-Up	Age 55+ may contribute an additional $1,000*

*Employees age 55 or older anytime in 2022, who are not enrolled in Medicare, may contribute an additional $1,000 to their HSA account. Spouse/Partners who are 55 or older and covered under the employee's medical insurance through the University of Denver may also make a catch-up contribution into a separate HSA account in their own name. If you enroll in Medicare mid-year, your catch-up contribution should be prorated.

Dental Plan Options

Insured by Delta Dental and Beta Health

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

Delta Dental

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

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

Beta Health

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

Summary of Covered Benefits	Delta Base PPO Plan		Delta Enhanced PPO Plan		Beta Health Alpha Plan
	PPO	Premier or Out-of-Network	PPO	Premier or Out-of-Network	
Annual Deductible (single/family)	$50/up to $150		$50/up to $150		N/A
Annual Benefit Maximum	$1,000 per member		$1,500 per member		Unlimited
Preventive Dental Services Oral exam, cleanings, sealants, x-rays	Covered at 100%	Covered at 100%*	Covered at 100%	Covered at 100%*	See Fee Schedule
Basic Dental Services Fillings, simple extractions, oral surgery, endodontics, periodontics	20% after ded.	20% after ded.*	20% after ded.	20% after ded.*	
Major Dental Services Crowns, dentures, bridges, implants	50% after ded.	50% after ded.*	50% after ded.	50% after ded.*	
Orthodontia Services Adult & children	Not Covered		50% to a $1,500 lifetime maximum per member		
Late Enrollee 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

Insured by EyeMed

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

Summary of Covered Benefits	Base Plan		Enhanced Plan	
	In-Network	Out-of-Network Reimbursement	In-Network	Out-of-Network Reimbursement
Eye Exam	Under age 19: Twice every plan year; Age 19+: Once every plan year			
	$10 copay	Up to $45	Plan pays 100%	Up to $45
Lenses	Under age 19: Twice every plan year; Age 19+: Once every plan year			
Single Vision Bifocal Trifocal	$25 copay	Up to $35 Up to $50 Up to $65	$10 copay	Up to $35 Up to $50 Up to $65
Frames*	Once every two plan years		Once every plan year	
	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 Medically Necessary	Up to $130 allowance; then 15% off balance Covered in full	Up to $104 Up to $210	Up to $150 allowance; then 15% off balance Covered in full	Up to $120 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			

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

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

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

Early Retiree Premium Contributions

Medical

	University of Denver 's Contribution	Cigna Copay Plan - LocalPlus		Cigna HDHP Plan—LocalPlus		Kaiser HMO Plan	
		Retiree's Contribution	Total Cost	Retiree's Contribution	Total Cost	Retiree's Contribution	Total Cost
Retiree Only	$60.00	$633.38	$693.38	$476.40	$536.40	$915.77	$975.77
Spouse/ Partner Only	N/A	$693.38	$693.38	$536.40	$536.40	$975.77	$975.77
Retiree & Spouse/ Partner	$60.00	$1,321.78	$1,381.78	$1,008.36	$1,068.36	$2,286.62	$2,346.62
Retiree & Child(ren)	$60.00	$1,184.16	$1,244.16	$902.00	$962.00	$2,051.95	$2,111.95
Family	$60.00	$1,872.68	$1,932.68	$1,433.88	$1,493.88	$3,225.31	$3,285.31
	University of Denver 's Contribution	Cigna Copay Plan—OAP		Cigna HDHP Plan—OAP		Kaiser HDHP Plan	
		Retiree's Contribution	Total Cost	Retiree's Contribution	Total Cost	Retiree's Contribution	Total Cost
Retiree Only	$60.00	$734.05	$794.05	$579.88	$639.88	$708.58	$768.58
Spouse/ Partner Only	N/A	$794.05	$794.05	$639.88	$639.88	$768.58	$768.58
Retiree & Spouse/ Partner	$60.00	$1,528.87	$1,588.87	$1,220.63	$1,280.63	$1,788.36	$1,848.36
Retiree & Child(ren)	$60.00	$1,370.10	$1,430.10	$1,092.59	$1,152.59	$1,603.51	$1,663.51
Family	$60.00	$2,164.92	$2,224.92	$1,733.18	$1,793.18	$2,527.73	$2,587.73

Dental & Vision

	Dental			Vision	
Retiree's Cost	Delta Base PPO Plan	Delta Enhanced PPO Plan	Beta Health Alpha Plan	Base Plan	Enhanced Plan
Retiree/Spouse/Partner Only	$28.95	$48.32	$10.22	$6.34	$8.85
Retiree & Spouse/Partner	$57.05	$95.25	$20.24	$12.07	$16.81
Retiree & Child(ren)	$68.64	$114.55	$24.92	$12.71	$17.72
Family	$107.14	$178.85	$29.86	$18.69	$26.03

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	800-244-6224	N/A	3344360
Virtual Care MDLive	888-726-3171	www.MDLIVEforCigna.com	3344360
Medical Kaiser Permanente	800-632-9700	mykp.org/du	00214
Health Savings Account Rocky Mountain Reserve	888-722-1223	www.rockymountainreserve.com	N/A
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

LEGAL NOTICES

For Plan Year: July 1, 2022—June 30, 2023

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

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

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

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

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

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

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

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

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

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

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Shared Services at 303-871-7420 or benefits@du.edu.

Important Warning

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

HIPAA Notice of Privacy Practices Reminder

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

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Shared Services at 303-871-7420 or benefits@du.edu.

Women's Health & Cancer Rights Act

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

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

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

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

Plan 2: Cigna HDHP Plan (Individual: 20% coinsurance and $1,500 deductible; Family: 20% coinsurance and $3,000 deductible)

Plan 3: KP HMO Plan (Individual: 20% coinsurance and $0 deductible; Family: 20% coinsurance and $0 deductible)

Plan 4: KP HDHP Plan (Individual: 20% coinsurance and $1,500 deductible; Family: 20% coinsurance and $3,000 deductible)

If you would like more information on WHCRA benefits, please call your Shared Services at 303-871-7420 or benefits@du.edu.

Newborns' and Mothers' Health Protection Act

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

Uniformed Services Employment & Reemployment Rights Act (USERRA)

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

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

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

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

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

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

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

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

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

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

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

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

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

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

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

Your health plan generally must:

- Cover emergency services without requiring you to get approval for services in advance (prior authorization).
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact 800-985-3059.

Visit www.cms.gov/nosurprises/consumer for more information about your rights under federal law.

Visit www.doi.colorado.gov for more information about your rights under Colorado laws.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid	CALIFORNIA –Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.goc/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
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	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
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA- Medicaid	MAINE-Medicaid
A HIPP Website: https://medicaid.georgia.gov/health insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/ programs/third-party-liability/childrens-health-insurance -program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Enrollment Website: https://www.maine.gov/dhhs/ofi/ applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https:// www.maine.gov/dhhs/ofi/applications-forms Phone: (800) 977-6740 TTY: Maine relay 711
INDIANA – Medicaid	Massachusetts-Medicaid and CHIP
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-(877) 438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-(800) 457-4584	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840
IOWA – Medicaid and CHIP (Hawki)	MINNESOTA- Medicaid
Medicaid Website: http://dhs.iowa.gov/ime/members Medicaid Phone: 1-(800) 338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-(800) 257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/ medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://mn.gov/dhs/people-we-serve/seniors/ health-care/health-care-programs/programs-and-services/ other-insurance.jsp Phone: (800) 657-3739
KANSAS – Medicaid	MISSOURI – Medicaid
Website: https://www.kancare.ks.gov/ Phone: (800) 792-4884	Website: http://www.dss.mo.gov/mhd/participants/ pages/hipp.htm Phone: (573) 751-2005
KENTUCKY- Medicaid	MONTANA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/ Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/ index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://dphhs.mt.gov/ MontanaHealthcarePrograms/HIPP Phone: 1-(800) 694-3084
LOUISIANA - Medicaid	NEBRASKA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178

NEVADA – Medicaid	SOUTH CAROLINA – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-(800) 992-0900	Website: http://www.scdhhs.gov Phone: 1-(888) 549-0820
NEW HAMPSHIRE – Medicaid	SOUTH DAKOTA - 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	Website: http://dss.sd.gov Phone: 1-(888) 828-0059
NEW JERSEY – Medicaid and CHIP	TEXAS – Medicaid
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:1-(800) 701-0710	Website: http://gethipptexas.com/ Phone: 1-(800) 440-0493
NEW YORK – Medicaid	UTAH – Medicaid and CHIP
Website: http://www.health.ny.gov/health_care/medicaid/ Phone: (800) 541-2831	Medicaid Website: http://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-(877) 543-7669
NORTH CAROLINA – Medicaid	VERMONT - Medicaid
Website: http://medicaid.ncdhhs.gov/ Phone: (919) 855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-(800) 250-8427
NORTH DAKOTA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-(844) 854-4825	Website: https://www.coverva.org/en/hipp https://www.coverva.org/en/famis-select Medicaid Phone: 1-(800) 432-5924 CHIP Phone: 1-(800) 432-5924
OKLAHOMA – Medicaid and CHIP	WASHINGTON – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-(888) 365-3742	Website: https://www.hca.wa.gov/ Phone: 1-(800) 562-3022
OREGON – Medicaid	WEST VIRGINIA – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-(800) 699-9075	Website: http://mywvhipp.com/ http://dhhr.wv.gov/bms/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
PENNSYLVANIA – Medicaid	WISCONSIN – Medicaid
Website: http://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-(800) 692-7462	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-(800) 362-3002
RHODE ISLAND – Medicaid and CHIP	WYOMING – Medicaid
Website: http://www.eohhs.ri.gov/ Phone: 1-(855) 697-4347, or (401) 462-0311 (Direct Rite Share Line)	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone:1-(800) 251-1269

To see if any other states have added a premium assistance program since January 31, 2022, or for more information on special enrollment rights, contact either:

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

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

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.

COBRA General Notice

Model General Notice of COBRA Continuation Coverage Rights

(For use by single-employer group health plans)

**** Continuation Coverage Rights Under COBRA****

Introduction

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

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

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse/partner'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/partner, 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/partner dies;
- Your spouse/partner's hours of employment are reduced;
- Your spouse/partner's employment ends for any reason other than his or her gross misconduct;
- Your spouse/partner becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse/partner.

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

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

When is COBRA continuation coverage available?

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

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

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

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/ partners, 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/ partner 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/partner 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/partner 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/partner'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[1] 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.

Plan contact information

University of Denver
Shared Services
2199 S. University Blvd.
Denver, Colorado 80208
United States
303-871-7420

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

Notice of Creditable Coverage

Important Notice from University of Denver

About Your Prescription Drug Coverage and Medicare

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

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

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

When Can You Join a Medicare Drug Plan?

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

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 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 October to join.

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

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

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

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

For more information about Medicare prescription drug coverage:

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

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 1-800-772-1213 (TTY 1-800-325-0778).

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

Date:	July 01, 2022
Name of Entity/Sender:	University of Denver
Contact—Position/Office:	Shared Services
Office Address:	2199 S. University Blvd. Denver, Colorado 80208 United States
Phone Number:	303-871-7420

Marketplace Notice

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[2]

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Shared Services at benefits@du.edu or 303-871-7420.

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name University of Denver		**4. Employer Identification Number (EIN)** 84-0404231
5. Employer address 2199 S. University Blvd.		**6. Employer phone number** 303-871-7420
7. City Denver	**8. State** Colorado	**9. ZIP code** 80208
10. Who can we contact about employee health coverage at this job? Shared Services		
11. Phone number (if different from above)	**12. Email address** benefits@du.edu	

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

• As your employer, we offer a health plan to:

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

☐ Some employees. Eligible employees are:

• With respect to dependents:

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

☐ We do not offer coverage.

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

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

NOTES:

NOTES:

UNIVERSITY of DENVER

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details.

The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.