

# Employee Choice *Flexible Benefit Plan*

## 2009/2010 Plan Year

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Aims Community College • Arapahoe Community College •  
College Assist • CollegenInvest • Colorado Commission on  
Higher Education • Colorado Community College System •  
Colorado Northwestern Community College • Community College of  
Aurora • Community College of Denver • Front Range Community  
College • Lamar Community College • Morgan Community  
College • Northeastern Junior College • Otero Junior College •  
Pikes Peak Community College • Pueblo Community College •  
Red Rocks Community College • Trinidad State Junior College

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### **IMPORTANT**

INFORMATION INCLUDED INSIDE ABOUT

- 1) MEDICARE PART D - NOTICE OF CREDITABLE COVERAGE; AND
- 2) CONTINUATION RIGHTS UNDER COBRA

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# Employee Choice Flexible Benefit Plan



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**If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 16 through 17 for more details.**

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## Carrier Phone/Contact References

### Health Insurance

Anthem Blue Cross and Blue Shield - All Plans  
Local ..... 1-877-811-3106  
Statewide ..... 1-877-811-3106  
Anthem Alliance Behavioral Health. 1-800-424-4014  
Website..... [www.anthem.com](http://www.anthem.com)

### Kaiser Permanente HMO

Customer Service .....303-338-3800  
Ambulance Service.....303-861-3434  
Appointment & Advice 24-hours a day  
Family Practice .....303-338-4545  
Internal Medicine .....303-338-4545  
Pediatrics .....303-388-4545  
OB/GYN.....303-338-4545  
Claims.....303-338-3600  
Outside of 303 Area Code  
Appointment & Advice ..... 1-800-218-1059  
Website..... [www.kp.org](http://www.kp.org)

### Dental Insurance

Mutual of Omaha/DentaBenefits..... 1-866-454-3190  
Website..... [www.dentabenefits.com](http://www.dentabenefits.com)

### Vision Care

VSP ..... 1-800-877-7195  
Website ..... [www.vsp.com](http://www.vsp.com)

### Basic Life/AD&D & Dependent Term Life

UNUM Life Insurance  
Website..... [www.unum.com](http://www.unum.com)

### Voluntary Employee & Dependent Term Life/AD&D

Colorado PERA (through UNUM Life Insurance)  
Website..... [www.unum.com](http://www.unum.com)

### Voluntary Accidental Death & Dismemberment

Mutual of Omaha ..... 1-800-524-2324  
Website..... [www.mutualofomaha.com](http://www.mutualofomaha.com)

### Business Travel Accident Insurance

Prudential Insurance  
Website..... [www.prudential.com](http://www.prudential.com)

### Flexible Benefit Plan

PayFlex Systems .....1-800-284-4885  
Claims Fax..... 1-402-231-4310  
Website..... [www.mypayflex.com](http://www.mypayflex.com)

### COBRA

HealthSmart Benefit Solutions  
Statewide ..... 1-800-423-4445

### Disability Insurance

Short-Term/Retirement Disability Program  
PERA ..... 303-832-9550  
Statewide ..... 1-800-759-7372  
Website ..... [www.copera.org](http://www.copera.org)

### Long Term Disability Insurance

UNUM Life Insurance  
Website ..... [www.unum.com](http://www.unum.com)

### Voluntary Supplemental Retirement Plans

PERA 401(k) ..... 303-832-9550  
Statewide ..... 1-800-759-7372  
Website ..... [www.copera.org](http://www.copera.org)

### MetLife Resources 403(b)

Local ..... 303-758-7800  
Statewide ..... 1-800-758-3231  
Website ..... [www.AV.metlife.com](http://www.AV.metlife.com) or [www.metlife.com](http://www.metlife.com)

TIAA-CREF 403(b)..... 1-800-842-2776  
Website ..... [www.tiaa-cref.org](http://www.tiaa-cref.org)

### VALIC Financial Advisors, Inc. 403(b)

Aims Community College .....970-590-0470  
Arapahoe Community College.....303-746-5844  
Colorado Commission on Higher Ed. ....303-517-1955

Colorado Community College System...720-962-8014  
Colorado NW Community College.....970-623-6986  
Community College of Aurora .....720-394-8027  
Community College of Denver.....303-517-1955  
Front Range Community College ..... 720-331-8740

970-231-4803  
Lamar Community College .....719-252-8944  
Morgan Community College .....970-521-7800  
Northeastern Junior College.....970-521-7800  
Otero Junior College .....719-252-8944  
Pikes Peak Community College .....719-388-1429  
Pueblo Community College .....719-252-8944  
Red Rocks Community College.....303-912-5634  
Trinidad State Junior College .....719-252-8944  
Colorado Assist .....303-517-1955  
College Invest.....303-517-1955  
Website ..... [www.aigretirement.com](http://www.aigretirement.com)

State of Colorado Deferred Comp. 457  
Contact Great-West..1-800-838-0457, select option 2  
Website ..... [www.colorado457.com](http://www.colorado457.com)

## Group Insurance Plan Number References

### Health Insurance

#### Anthem Blue Cross and Blue Shield

HMO, Point-of-Service and BluePreferred:

Aims Community College.....	C12055
Arapahoe Community College .....	C12056
COBRA .....	C12071
Colo. Comm. on Higher Education.....	C12057
Colo. Northwestern Community College .....	C12072
College Assist .....	C12058
CollegelInvest .....	C12059
Community College of Aurora .....	C12060
Colorado Community College System .....	C12054
Community College of Denver .....	C12061
Front Range Community College.....	C12062
Lamar Community College.....	C12063
Morgan Community College.....	C12064
Northeastern Junior College .....	C12065
Otero Junior College .....	C12066
Pikes Peak Community College.....	C12067
Pueblo Community College.....	C12068
Red Rocks Community College .....	C12069
Trinidad State Junior College.....	C12070
Prescription Drug .....	610575

#### Kaiser Permanente HMO

Arapahoe Community College .....	489-03
COBRA .....	489-14
Colo. Comm. On Higher Education.....	489-04
College Assist .....	489-13
CollegelInvest .....	489-12
Community College of Aurora. ....	489-08
Colorado Community College System .....	489-01
Community College of Denver .....	489-06
Front Range Community College.....	489-02
Morgan Community College.....	489-07
Northeastern Junior College .....	489-16
Pikes Peak Community College.....	489-10
Red Rocks Community College .....	489-05
Trinidad State Junior College.....	489-17

### Dental Insurance

DentaBenefits (United Concordia)

Claims/Benefits

Option I.....	A00220004
Option II.....	A00220005

### Vision Care

VSP .....	12066182
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### Basic & Dependent Term Life

UNUM Life Insurance .....	364016
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### Voluntary Employee & Dependent Term Life

Colorado PERA (UNUM Life Insurance) .....	595121
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### Voluntary Accidental Death & Dismemberment

Mutual of Omaha.....	T66BA-P-51585
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### Business Travel Accident Insurance

Prudential .....	42637
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### Long Term Disability

PERA Disability Program .....	633387
UNUM Life Insurance .....	364016

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## Human Resources/Benefits Office Contacts

### **Aims Community College**

5401 W. 20<sup>th</sup> St.  
Greeley, CO 80634  
**Phone: 970-339-6434**  
1-800-301-5388  
Fax: 970-506-6953

### **Arapahoe Community College**

5900 S. Santa Fe Drive  
Littleton, CO 80160  
**Phone: 303-797-5715**  
Fax: 303-797-5938

### **College Assist**

1560 Broadway, Suite 1700  
Denver, CO 80202  
**Phone: 720-264-8575**  
Fax: 303-866-4266

### **Collegelvest**

1560 Broadway, Suite 1700  
Denver, CO 80202  
**Phone: 720-264-8575**  
Fax: 303-866-4266

### **Colorado Commission on Higher Education**

1560 Broadway, Suite 1600  
Denver, CO 80202  
**Phone: 720-264-8575**  
Fax: 303-866-4266

### **Colorado Community College System**

9101 E. Lowry Blvd  
Denver, CO 80230  
**Phone: 303-595-1589**  
Fax: 303-620-4030

### **Colorado Northwestern Community College**

500 Kennedy Drive  
Rangely, CO 81648  
**Phone: 970-675-3353**  
Fax: 970-675-8654

### **Community College of Aurora**

16000 E. Centretch Parkway  
Aurora, CO 80011-9036  
**Phone: 303-360-4823**  
Fax: 303-360-4772

### **Community College of Denver**

1201-5<sup>th</sup> Street, Suite 310  
Campus Box 240, P.O. Box 173363  
Denver, CO 80217-3363  
**Phone: 303-352-3004**  
Fax: 303-352-3029

### **Front Range Community College-Boulder County Campus**

2190 Miller Drive  
Longmont, CO 80501  
**Phone: 303-678-3708**  
Fax: 303-678-3709

### **Front Range Community College-Larimer**

4616 S. Shields  
Ft. Collins, CO 80526  
**Phone: 970-204-8106**  
Fax: 970-204-8303

### **Front Range Community College-Westminster**

3645 W. 112<sup>th</sup> Avenue  
Westminster, CO 80031  
**Phone: 303-404-5307**  
Fax: 303-438-9077

### **Lamar Community College**

2401 S. Main St.  
Lamar, CO 81052  
**Phone: 719-336-1572**  
Fax: 719-336-5626

### **Morgan Community College**

920 Barlow Road  
Fort Morgan, CO 80701  
**Phone: 970-542-3130**  
Fax: 970-867-3083

### **Northeastern Junior College**

100 College Avenue  
Sterling, CO 80751  
**Phone: 970-521-6661**  
Fax: 970-521-6678

### **Otero Junior College**

1802 Colorado Avenue  
La Junta, CO 81050  
**Phone: 719-384-6824**  
Fax: 719-384-6947

### **Pikes Peak Community College**

5675 S. Academy Blvd., Box C-4  
Colorado Springs, CO 80906  
**Phone: 719-502-2005**  
Fax: 719-502-2601

### **Pueblo Community College**

900 W. Orman Ave.  
Pueblo, CO 81004  
**Phone: 719-549-3475**  
Fax: 719-549-3127

### **Red Rocks Community College**

13300 W. 6<sup>th</sup> Ave.  
Lakewood, CO 80228-1255  
**Phone: 303-914-6297**  
Fax: 303-914-6800

### **Trinidad State Junior College**

600 Prospect St.  
Trinidad, CO 81082  
**Phone: 719-846-5534**  
Fax: 719-846-5064

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# Benefit Eligibility and Enrollment

## Introduction

The State Board for Community Colleges and Occupational Education (SBCCOE) is pleased to announce your benefit choices for the 2009-2010 Plan Year. This information is provided to answer your benefit questions and to be a resource to you. The SBCCOE Employee Choice Flexible Benefit Plans are fully insured and benefits are provided under fully insured master contracts with several insurance companies. Entitlement and eligibility for benefits is governed by the terms of each insurance contract and certificate of insurance issued to you by an insurance company. **In the event of a conflict between the provisions of this summary and the insurance contract or certificate, the terms of the certificate and insurance contract shall take precedence over this booklet and shall prevail in settling any disputes or claims that may arise.** Each certificate of insurance coverage contains a separate definition of eligible dependent. Your eligible dependents must also satisfy any requirements contained in the certificate of insurance coverage from the insurance company providing benefits under the plan.

You can access any of our service provider websites by visiting our web address at [www.cccs.edu/HR/Admin.html](http://www.cccs.edu/HR/Admin.html). Click on the Flexible Benefits link on the Human Resources Home Page. The 2009-2010 benefit book and links will be active by open enrollment. During open enrollment you can review current physician and prescription listings online by visiting the provider websites.

It is our hope that this overview will help you better design a personalized benefit plan that effectively meets your individual needs. If you have questions or concerns, phone numbers and websites are included for your convenience.

## Employee Eligibility

You are eligible to participate in this plan on the day you officially commence work as long as:

- (a) you are a regular employee of the policyholder; and
- (b) you are and continue to be actively employed\*.

\* "Actively employed" means working the required number of hours per week or teaching on a half time or more regular contract basis. The weekly hour requirements are defined as working at least 50% of contract with a minimum of 20 hours per week for all locations except for Aims Community College, which has a minimum requirement of 35 hours per week.

## Dependent Eligibility

"Dependent" means an employee's:

- (a) legal spouse (includes common-law);
- (b) an employee's unmarried child(ren) who are financially dependent upon the employee for more than half of his/her own support and maintenance
  - (i) until the end of the month of their 25th birthday, or
  - (ii) of any age who are medically certified by a physician as disabled;
- (c) a grandchild of an employee or employee's spouse if the employee or employee's spouse is the grandchild's court-appointed permanent guardian or has adopted the grandchild;
- (d) child(ren) for whom the employee is required to provide health benefits pursuant to a court order or qualified medical child support order; and/or
- (e) any dependent which is required by state insurance law to be covered or offered coverage under any insurance contract issued to the Trust for the SBCCOE Employee Benefit Plan.

Dependents must also satisfy the requirements of the Internal Revenue Code to qualify as tax dependents of the employee for, as applicable, medical, dental and vision plan purposes, and satisfy the eligibility requirements for coverage under the SBCCOE Employee Benefit Plan.

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# Benefit Eligibility and Enrollment

Effective July 1, 2009, for purposes of medical, dental, vision, basic life and voluntary accidental death and dismemberment benefits (hereinafter collectively referred to as "Benefits"), including any COBRA rights related to such Benefits, a dependent shall also include an employee's domestic partner as described in paragraph 1 below and the child(ren) of an employee's domestic partner as described in paragraph 2 below.

1. An employee's domestic partner is an adult of the same or opposite gender as the employee, whose personal relationship with the employee meets the criteria established by the Trust Committee for domestic partnership. The employee must follow the procedures established by the Trust with regard to the enrollment and termination of a domestic partner, including the completion of an Affidavit for Domestic Partnership. A domestic partner is not a legal spouse of an employee under Colorado law pursuant to C.R.S. 14-2-104.
2. The natural or adopted child(ren) of a domestic partner who is not related by blood, adoption or court order to the employee, is a child(ren) who satisfies the following:
  - (i) is a member of the employee's household or a full-time student; and
  - (ii) otherwise meets the definition of dependent child(ren) under paragraph A(b)(i) or (ii) above.

Dependents must also satisfy the requirements of the Internal Revenue Code to qualify as tax dependents of either the domestic partner or the employee for medical, dental and vision plan purposes and satisfy the eligibility requirements for coverage under a Benefit Plan. A dependent shall also include any dependent which is required by state insurance law to be covered or offered coverage under any insurance contract issued to the Trust for the SBCCOE Employee Benefit Plan. The employee must follow the procedures established by the Trust Committee with regard to enrollment and termination of coverage for the child(ren) of a domestic partner.

For the purposes of the certificates of insurance evidencing medical, dental, vision, basic life and voluntary accidental death and dismemberment coverage, any reference to the term "spouse" shall also include a domestic partner.

*NOTE: If you do not enroll your dependents within thirty-one (31) days of when you first become eligible or within thirty-one (31) days of a status change, then you cannot enroll dependents until the next regularly scheduled open enrollment period.*

## Benefit Election

The medical, dental and basic life insurance plans are not linked. Employees may elect to participate in one or more of the benefit plans offered. A benefit allowance/subsidy will be provided only if you elect to enroll in any of the health, dental and/or life insurance options. **Your benefit election cannot be changed during the plan year unless you experience an eligible status change and submit appropriate paperwork within thirty-one (31) days of the change.**

## Benefit Coverage Effective Dates

### Employee

Benefit coverage becomes effective on July 1<sup>st</sup> or on the day you officially begin active employment. If you are not actively at work on the date coverage would normally begin, then it is not effective until you complete one full day of active employment.

### Spouse and Dependents

Your spouse and dependents will be covered on your effective date or can be enrolled during open enrollment each year. If dependents are enrolled at a later date, due to an eligible event, then coverage will begin on the date of the qualifying event. Newborns are covered from date of birth as long as you enroll them within thirty-one (31) days of the birth.

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# Benefit Eligibility and Enrollment

## Transfers

If you are currently enrolled in the SBCCOE Employee Choice Flexible Benefit Plan, you will keep the same coverage when you are transferred to another participating location. However, if your current health insurance plan is not available at your new location you can select coverage with another plan.

## Before And After-Tax Options

The premium for health, dental, vision and basic term life insurance (up to \$50,000 death benefit) can be paid on a before-tax basis. When you pay premiums with before-tax dollars, you reduce the cost of the premium by 25% or more. This savings is the result of reduced PERA contributions, Medicare, Federal and State withholding taxes. Premiums paid with before-tax dollars are not allowed as deductions on your tax return.

Deductibles, copayments and non-covered expenses can be budgeted and paid tax-free through your Health Care Spending Account. Dependent care expenses necessary for your employment can be paid tax-free through the Dependent Care Spending Account (see Flexible Spending Accounts Information).

**If you are planning to retire within the next four contract years, we recommend you elect an after-tax premium payment and that you waive participation in the spending account to ensure your highest possible PERA retirement benefit. PERA retirement benefits are based on your highest paid three years of employment. However, if you retire on or after January 1, 2009, and your pay increase in any of these years exceeds 15%, an adjustment may be made to your highest average salary. A base year salary (your 4th highest salary year) will be used to determine the starting point of the annual salary increase limit, but is not used as one of the three annual salaries in your HAS calculation. Contact PERA for additional information.**

## Leave of Absence

You can continue insurance coverage while on an Approved Leave of Absence, including but not limited to:

- Short-Term Disability and Long-Term Disability
- Workers Compensation Leave
- Family and Medical Leave (FMLA)
- Military Leave under the Uniformed Services Employment & Reemployment Rights Act (USERRA)

You will continue to pay your share of the premium, and your agency will continue to pay its appropriate share. Contact your Human Resources Office for details as some exceptions may apply.

## Domestic Partner Benefits

Effective July 1, 2009, the State Board for Community College and Occupational Education Employee Benefit Trust (the "SBCCOE Trust") modified the definition of "Dependent" to include domestic partners of covered employees. This means that domestic partners are eligible for group medical, dental, vision, basic life and voluntary accidental death and dismemberment benefits offered by member colleges/agencies.

A domestic partner is an adult who shares a committed relationship with a member college/agency's eligible employee of the same or opposite gender, evidenced by an Affidavit of Domestic Partnership filed by the employee with their respective college/agency human resources office.

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# Benefit Eligibility and Enrollment

Affidavit of Domestic Partnership: The Affidavit of Domestic Partnership contains an affirmation by the employee and the domestic partner of the following:

- they are both at least eighteen (18) years of age and are mentally competent to contract;
- neither is legally married to another person, nor is either a member of another domestic partnership;
- they are sole domestic partners and have been living together as domestic partners in a shared residence for at least twelve (12) consecutive months preceding the date of the Affidavit, and they intend to remain sole domestic partners indefinitely;
- they are not related by blood closer than permitted by state law for marriage in the State of Colorado;
- they are jointly responsible for each other's common welfare as evidenced through two (2) of the following: a joint deed, joint mortgage, joint lease, joint credit card, joint bank account, previous designation of domestic partner as beneficiary for a life insurance or retirement contract, designation of domestic partner as primary beneficiary in the employee's will, joint designation of durable powers of attorney authorizing each of them to act on behalf of the other (such joint designation to constitute but one form of documentation), jointly named on auto, renter's or homeowner's insurance policy, and have attached copies of at least two of these documents to the Affidavit;
- they understand and agree that if insurance benefits are fraudulently obtained or provided as a result of their declarations contained in the Affidavit, they will be jointly liable for any benefits received through insurance procured under the Affidavit, including attorneys' fees that may apply. In addition, the employee may be subject to disciplinary action, up to and including termination of employment;
- it has been at least twelve (12) months since a previous Statement of Termination of Domestic Partnership from either individual has been filed (if applicable); and
- they understand that a domestic partner enrolled as a dependent ceases to be an eligible member on the first day of the month following the termination of such domestic partnership and that the employee agrees to submit a Statement of Termination of Domestic Partnership form and an Enrollment Application/Change Form within thirty-one (31) days of the termination of the domestic partnership.

The affidavit must be signed by both partners and witnessed by a notary public.

## Legal Concerns

The Affidavit of Domestic Partnership required to register a domestic partner includes an attestation of the relationship. Due to the legal obligations that may be created between the employee and the domestic partner by submitting such an affidavit, both parties are advised to consult an attorney for advice.

## Eligibility for Coverage

Domestic partners and their eligible dependents will be eligible for medical, dental, vision, basic life and voluntary accidental death and dismemberment insurance in the same manner as for an employee's spouse and other dependent child(ren). In order to be eligible for coverage, "eligible dependent child(ren)" of domestic partners must:

- be the natural or adopted child(ren) of the domestic partner;
- be members of the employee's household or a full-time student; and
- otherwise meet the definition of eligible dependent child(ren) under the SBCCOE Trust and its group medical, dental, vision, basic life and voluntary accidental death and dismemberment plans.

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# Benefit Eligibility and Enrollment

## Enrollment Procedure

Enrolling a domestic partner is subject to the same limitations that apply to a spouse or child(ren). Enrollment is limited to:

- within thirty-one (31) days of being hired into a benefits eligible appointed position;
- during an annual open enrollment period for benefits effective the following July 1st;
- within thirty-one (31) days of all IRS-defined change of status (e.g., birth/adoption of child(ren) or loss of a partner's coverage through his or her employer); or
- within thirty-one (31) days of meeting the criteria to establish a domestic partnership as defined by the SBCCOE Trust.

**The employee must file an Affidavit of Domestic Partnership to enroll a domestic partner and the domestic partner's child(ren).**

## Termination of Domestic Partnership

In the event a domestic partnership ends, the employee is required to file a Statement of Termination of Domestic Partnership form within thirty-one (31) days of the termination of the domestic partnership. If there is any change in status of the criteria set forth in the Affidavit of Domestic Partnership that would terminate the domestic partnership, the employee must similarly complete a Statement of Termination of Domestic Partnership and return it to the college/agency human resources office within thirty-one (31) days of the change.

Medical, dental, vision, basic life and voluntary accidental death and dismemberment benefits for the domestic partner and their eligible child(ren), if any, will be discontinued on the first day of the month following the date of termination of the domestic partnership. The respective employer will provide any applicable notice of rights to continue benefit coverage to the former domestic partner.

The employee must also mail a copy of the Statement of Termination of Domestic Partnership to the former domestic partner within ten (10) days of completing the Statement. Once a Statement of Termination of Domestic Partnership has been submitted, the employee may not establish another domestic partnership until twelve (12) months after the termination of the previous domestic partnership.

## Employee Liability

If the employee fails to file a Statement of Termination of Domestic Partnership on a timely basis, or otherwise supplies any false or misleading statements in order to obtain domestic partner benefits to which the employee is not otherwise entitled, the employee shall be liable to the SBCCOE Trust or his or her college/agency for all resulting monetary damages, costs and attorneys' fees which result from such actions. In addition, the employee may be subject to disciplinary action, up to and including termination of employment.

## Flex Plans

If the domestic partner and his/her child(ren) are the employee's tax dependent(s) for medical, dental and vision plan purposes and the employee has completed a Certification of Tax-Qualified Dependents, then the employee may receive reimbursements of the domestic partner's expenses from the employee's flexible spending account. If the domestic partner and his/her child(ren) are **not** the employee's tax dependents, their expenses are not eligible for reimbursement from the employee's flexible spending account.

Benefits relating to the domestic partner and his/her child(ren) under dependent care assistance flexible spending accounts will depend on how the domestic partner and/or his or her child(ren) fit within the guidelines established by the tax code for these benefits.

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# Benefit Eligibility and Enrollment

## COBRA

Continuation of medical, dental and vision care coverage is allowed under the same terms that would apply to an employee's spouse and child(ren). A registered domestic partner and/or child(ren) of the domestic partner enrolled in medical, dental and vision plans have sixty (60) days from the date eligibility for coverage ends to enroll in COBRA coverage.

## Tax Effect

IRS regulations require the employer to tax the employee for the excess of the fair market value of coverage provided to the domestic partner and his/her child(ren) over the amount the employee pays, if any, for the coverage. In general, an employee's premiums for coverage of a domestic partner or dependent of a domestic partner are paid on an after-tax basis. There is an exception to this rule if the domestic partner and his/her child(ren) are tax dependents for medical, dental and vision plan purposes. Please review the document entitled "Important Tax Information for Domestic Partner Medical, Dental and Vision Benefits," and complete the Certification of Tax-Qualified Dependents, if appropriate.

## Benefit Availability

Although the SBCCOE Trust and the member schools intend to offer domestic partnership benefits for medical, dental, vision, basic life and voluntary accidental death and dismemberment insurance indefinitely, such benefits are dependent, in part, on their availability in the group health insurance market. As always, the SBCCOE Trust and its member colleges/agencies reserve the right to amend, suspend or terminate its benefit plans at any time in accordance with the Trust Agreement.

## Legislative Updates

### Children's Health Insurance Program Reauthorization Act of 2009

The SBCCOE group health 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:

- Termination of Medicaid or CHIP Coverage - if the employee or dependent is covered under a Medicaid plan or under a State child health plan (SCHIP) and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility; or
- Eligibility for Employment Assistance Under Medicaid or CHIP - if the employee or dependent becomes eligible for premium assistance under Medicaid or SCHIP, including under any waiver or demonstration project conducted under or in relation to such a plan (usually a program where the state assists employed individuals with premium payment assistance for their employer's group medical, dental and vision plans rather than direct enrollment in a state Medicaid program).

To be eligible for this special enrollment opportunity you must request coverage under the group medical, dental and vision plans within sixty (60) days after the date the employee or dependent becomes eligible for premium assistance under Medicaid or SCHIP or the date you or your dependent's Medicaid or state-sponsored CHIP coverage ends.

### The American Recovery and Reinvestment Act of 2009 – COBRA Premium Assistance Subsidy

This new legislation includes a premium assistance program to help eligible individuals involuntarily terminated between September 1, 2008 and December 31, 2009, afford COBRA premiums. Individuals involuntarily terminated between September 1, 2008, and December 31, 2009, who are not Medicare eligible or eligible for any other group medical, dental and vision plan and meet the income threshold, will be eligible for the COBRA premium assistance subsidy. This also includes dependents that make an independent election as a result of the employee's involuntary employment termination.

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# Benefit Eligibility and Enrollment

## Genetic Information Nondiscrimination Act (GINA)

Congress passed the Genetic Information Nondiscrimination Act (GINA) establishing a national and uniform standard to fully protect workers from genetic discrimination. In addition to prohibitions on discrimination in employment practices, GINA prohibits group health insurers and group health plans from adjusting premiums or contributions based on genetic information. Also, GINA amended the HIPAA privacy rules to include genetic information in the definition of protected health information. The effective date of this act is July 1, 2009.

## Status Change Definitions

If you have elected to pay for premiums with after-tax dollars, you may drop coverage at any time. However, any change in your pre-tax election must be consistent with and required by the Status Change that occurred and must be requested within thirty-one (31) days of the event. A status change includes the following:

1. change in employee's marital status: marriage, domestic partnership, divorce, annulment, termination of domestic partnership, legal separation or death of a spouse/domestic partner;
2. change in number of tax-eligible dependents: birth, adoption, placement for adoption, court ordered change in legal custody status or Qualified Medical Child Support (QMCSO) or death of a dependent;
3. change in employment status: transition from full-time to part-time, part-time to full-time, strike or lockout by an employee, employee's spouse or eligible dependent;
4. commencement of/or return from Family and Medical Leave (FMLA) or other approved unpaid leave of absence by an employee, employee's spouse/domestic partner or eligible dependent;
5. commencement or termination of employment by an employee, employee's spouse/domestic partner or eligible dependent;
6. attainment or loss of dependent eligibility as defined by the Plan; i.e., exceeding the Plan's established age limitations, marriage or eligibility for coverage under another health plan would all qualify as an eligible change in status event;
7. entitlement to/or loss of Medicaid or Medicare coverage by an employee, employee's spouse/ domestic partner or eligible dependent (see Legislative Updates for additional information);
8. residence and/or work site change: a required change in place of residence and/or work site of an employee, employee's spouse/domestic partner or eligible dependent (i.e., a move outside a health plan's service area would qualify as a change in status event);
9. an employee may make a prospective election change during the plan year if the change corresponds with an open enrollment period change made by the employee's spouse/domestic partner or qualified dependent, provided the election change is consistent with the changes under the other group plan; or
10. significant change in available benefits and/or their cost; i.e., if a fully insured health plan imposed a change in benefit coverage levels or increases premiums substantially, this would qualify as a change in status event; however, an employer's change in contribution amounts would not apply.  
*NOTE: This does not allow election changes in the Health Care Flexible Spending Account.*

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# Benefit Eligibility and Enrollment

## Special Enrollment Under Health Insurance Portability & Accountability Act (HIPAA)

HIPAA provides two special enrollment periods for medical and dental coverage when requested within thirty-one (31) days of an eligible event.

### 1. Mid-year loss of COBRA or other coverage

To qualify, the employee, spouse or dependent must have lost medical and/or dental coverage because:

- a) coverage was provided under COBRA and the COBRA period ended;
- b) coverage was non-COBRA and terminated due to a loss of eligibility (examples: divorce, death, termination of employment, etc.); or
- c) coverage was non-COBRA and the employer contributions for the coverage terminated (complete cessation of employer contributions is required to trigger this eligible event, not just a reduction in contributions).

### 2. Acquisition of new spouse or dependent

When an employee becomes married or acquires a new dependent by birth, adoption or placement for adoption, the employee may add the new spouse or dependent to the benefit coverage within thirty-one (31) days of the eligible event. New benefit coverage can only be added for the new spouse or dependent and does not apply to other family members.

## Termination of Eligibility

Eligibility to participate in the plans under the SBCCOE Employee Choice Flexible Benefit Plan shall terminate on the earliest of the following dates:

- the last day of the month in which an employee terminates employment for any reason including death and retirement;
- the last day of the month in which an employee ceases to satisfy the definition of an eligible employee either because of a change in status or a reduction in the scheduled work hours per week falls below the minimum number of hours required for coverage;
- the last day of the month for which contributions are paid in a timely manner;
- the date any benefit plan is terminated or amended to terminate benefits for any class of participants;
- the effective date an employee elects to waive coverage under any benefit plan;
- the date a participant enters the armed forces of any country on active full-time duty except as covered under USERRA;
- the date any certificate of insurance coverage issued under any benefit plan is terminated or amended to terminate coverage for any participant; or
- the date a participant falsifies or misuses documents or information relating to coverage or services under any benefit plan or any certificate.

Dependent coverage terminates on the earliest of the date coverage would otherwise terminate above, and the following:

- the last day of the month in which a dependent child(ren) becomes an employee of any employer, and becomes benefit eligible;
- the date a dependent enters the armed forces of any country on active full-time duty; the last day of the month in which the dependent ceases to satisfy the definition of a dependent under the SBCCOE Employee Choice Flexible Benefit Plan; or
- the last day of the month a dependent child(ren) marries.

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# Benefit Eligibility and Enrollment

## The Uniformed Services Employment and Reemployment Rights Act (USERRA)

USERRA provides for, among other employment rights and benefits, continuation of health care coverage to a covered employee and covered dependents, during a period of active service or training with any of the Uniformed Services. The Act provides that a covered employee may elect to continue such coverages in effect at the time the employee is called to active service.

The maximum period of coverage for the employee and the covered employee's dependents under such an election shall be the lesser of:

- the twenty-four (24) month period beginning on the date the person's absence begins; or
- the period beginning on the date the covered employee's absence begins and ending on the day after the date on which the covered employee fails to apply for or return to a position of employment as follows:
  - ◆ for service of less than thirty-one (31) days, no later than the beginning of the first full regularly scheduled work period on the first full calendar day following the completion of the period of service and the expiration of eight (8) hours after a period allowing for the safe transportation from the place of service to the covered employee's residence or as soon as reasonably possible after such eight hour period;
  - ◆ for service of more than thirty-one (31) days but less than one hundred eighty one (181) days, no later than fourteen (14) days after the completion of the period of service or as soon as reasonably possible after such period;
  - ◆ for service of more than one hundred eighty (180) days, no later than ninety (90) days after the completion of the period of service; or
  - ◆ for a covered employee who is hospitalized or convalescing from an illness or injury incurred in or aggravated during the performance of service in the Uniformed Services, at the end of the period that is necessary for the covered employee to recover from such illness or injury. Such period of recovery may not exceed two (2) years.

A covered employee who elects to continue health plan coverage under the plan during a period of active service in the Uniformed Services may be required to pay not more than 102% of the full premium under the plan associated with such coverage for the employer's other employees, except that in the case of a covered employee who performs service in the Uniformed Services for less than thirty-one (31) days, such covered employee may not be required to pay more than the employee share, if any, for such coverage. Continuation coverage cannot be discontinued merely because activated military personnel receive health coverage as active duty members of the Uniformed Services, and their family members are eligible to receive coverage under the Department of Defense's managed health care program, TRICARE.

In the case of a covered employee whose coverage under a health plan was terminated by reason of services in the Uniformed Services, the pre-existing exclusion and waiting period may not be imposed in connection with the reinstatement of such coverage upon reemployment under this Act. This applies to the covered employee who is reemployed and any dependent whose coverage is reinstated. The waiver of the pre-existing exclusion shall not apply to illness or injury which occurred or was aggravated during performance of service in the Uniformed Services.

"Uniformed Services" shall include full time and reserve components of the United States Army, Navy, Air Force, Marines, Coast Guard, Army National Guard, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

If you are a covered employee called to a period of active service in the Uniformed Service, you should check with the Plan Administrator for a more complete explanation of your rights and obligations under USERRA. In the event of a conflict between this provision and USERRA, the provisions of USERRA, as interpreted by the SBCCOE, shall take precedence.

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# Benefit Eligibility and Enrollment

## COBRA Eligibility

You and your covered dependents have the right to continue group health coverage (medical, dental, vision, and Health Care Flexible Spending Account) if employment is terminated. Special rules apply to the Health Care Spending Account (see Flexible Benefit Plan Chapter, Health Care Spending Account Termination Section for details). For additional information, see page 44.

## Assignment and Payment of Benefits

No benefit payable under the SBCCOE Employee Choice Flexible Benefit Plan can be assigned, transferred or subject to any lien, garnishment, pledge or bankruptcy. However, a participant may assign benefits payable under this plan to a provider or hospital pursuant to the terms of the certificate. Ultimately, it is the participant's responsibility to pay any hospital or provider. If the benefit payment is made directly to a participant, for whatever reason, such payment shall completely discharge all liability of the SBCCOE Employee Choice Flexible Benefit Plan, the SBCCOE and the colleges/agencies.

If any benefit under the SBCCOE Employee Choice Flexible Benefit Plan is erroneously paid to a participant, the participant must refund any overpayment. The refund may be payment or reduction of future benefits otherwise payable under the SBCCOE Employee Choice Flexible Benefit Plan.

## Right to Information and Fraudulent Claims

The SBCCOE has the right to request information from any participant to verify his/her eligibility and entitlement to benefits under the SBCCOE Employee Choice Flexible Benefit Plan. If a participant falsifies any document in support of a claim or coverage under the SBCCOE Employee Choice Flexible Benefit Plan, the SBCCOE may, without the consent of any person, terminate coverage and refuse to honor any claims under the plan for the participant and dependent.

## Third Party Reimbursement and Subrogation

If you or a covered dependent receive benefits under the SBCCOE Employee Choice Flexible Benefit Plan for injury, sickness or disability that was caused by a third party, and you have a right to receive a payment from the third party, then the SBCCOE Employee Choice Flexible Benefit Plan has the right to recover payments for the benefits paid. If you recover any amount for covered expenses from a third party, the amount of benefits paid by the SBCCOE Employee Choice Flexible Benefit Plan will be reduced by the amount you recovered.

In making a claim for benefits from the SBCCOE Employee Choice Flexible Benefit Plan, you and your covered dependents agree that the SBCCOE will be subrogated to any recovery, or right of recovery, you or your dependent has against any third party, and that the SBCCOE will be reimbursed and will recover 100% of any amount paid by the SBCCOE Employee Choice Flexible Benefit Plan or amounts which the SBCCOE Employee Choice Flexible Benefit Plan is otherwise obligated to pay. You also agree that you will not take any action that would prejudice the SBCCOE Employee Choice Flexible Benefit Plan's subrogation rights and will cooperate in doing what is reasonably necessary to assist the SBCCOE Employee Choice Flexible Benefit Plan in any recovery. The SBCCOE has a right to pursue all legal and equitable remedies to recover, without deduction for attorney's fees and costs or other expenses you incur, and without regard to whether you or a covered dependent is fully compensated by the recovery or made whole. The SBCCOE Employee Choice Flexible Benefit Plan's right of recovery and reimbursement is a first priority and first lien against any settlement, judgment, award or other payment obtained by you or your dependents, for recovery of amounts paid by the SBCCOE Employee Choice Flexible Benefit Plan.

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# Benefit Eligibility and Enrollment

## Women's Health and Cancer Rights Act

All health plans offered through the SBCCOE Employee Choice Flexible Benefit Plan provide coverage for certain reconstructive services under the Women's Health and Cancer Right Act. 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 related to physical complications during all stages of mastectomy, including lymph edemas.

Refer to your plan certificate of coverage for specific information. The plans may apply deductibles and copays consistent with other coverage provided.

## HIPAA Privacy

The SBCCOE Employee Choice Flexible Benefit Plan will not use or further disclose Protected Health Information (PHI) in a manner that would violate the requirements of state or federal law or regulation. The SBCCOE Employee Choice Flexible Benefit Plan will use PHI to the extent of and in accordance with the uses and disclosures permitted by HIPAA.

## Amendment or Termination of SBCCOE Employee Choice Flexible Benefit Plan

The State Board for Community Colleges and Occupational Education has the right to amend or terminate the benefit plan at any time. The benefit plan may be amended or terminated by a written instrument duly signed and adopted by the SBCCOE or any of its delegates. The President of the Colorado Community College System or his/her designee may sign insurance contracts for this benefit plan on behalf of the SBCCOE, including amendments to those contracts, and may adopt (by a written instrument) amendments to the benefit plan that he or she considers to be administrative in nature or advisable to comply with applicable law.

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# Medicare Part D Notice of Creditable Coverage

## Important Information about the SBCCOE Employee Choice Flexible Benefit Plan and Your Prescription Drug Coverage and Medicare Part D

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 SBCCOE Employee Choice Flexible Benefit Plan and your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to enroll in a Medicare drug plan. If you are considering enrolling in a Medicare drug plan, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plan offering Medicare prescription drug coverage in your area. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

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 through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription 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. On behalf of the SBCCOE Employee Choice Flexible Benefit Plan, Anthem Blue Cross and Blue Shield and Kaiser Permanente have determined that the prescription drug coverage offered by the SBCCOE Employee Choice Flexible Benefit Plan is expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.

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**Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay extra if you later decide to enroll in a Medicare prescription drug plan.**

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15<sup>th</sup> through December 31<sup>st</sup>. However, if individuals lose their current creditable coverage, through no fault of their own, they will also be eligible for a two (2) month Special Enrollment Period to sign up for a Medicare prescription drug plan.

**If you do decide to enroll in a Medicare prescription drug plan and drop your Anthem Blue Cross and Blue Shield or Kaiser Permanente health coverage, be aware that you and your dependents may not be able to re-enroll in this coverage until the next open enrollment.**

You should also know that if you drop or lose your coverage with Anthem Blue Cross and Blue Shield or Kaiser Permanente and don't enroll in a Medicare prescription drug plan within sixty-three (63) continuous days after your current coverage ends, you may pay a higher premium (a penalty) to enroll in a Medicare prescription drug plan later. If you go sixty-three (63) days or longer without creditable prescription drug coverage, your monthly premium may go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen (19) months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

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# Medicare Part D Notice of Creditable Coverage

For more information about this notice or your current prescription drug coverage contact your agency/campus Human Resource (HR) Office for further information. **NOTE: You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage changes. You also may request a copy from your agency/campus Human Resource Office or download a copy from the <http://www.cccs.edu/HR/Admin.html#ExemptBenefitMaterials>.**

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. If you or any of your dependents are Medicare eligible, you’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. You can also get more information about Medicare prescription drug plans from these resources:

- Visit [www.medicare.gov](http://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see 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

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date:	April 21, 2009
Name of College/Agency:	Contact your college/agency human resources office (See Contact List page 4)

**Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare, which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.**

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# Health Insurance

We are pleased to offer you four health insurance plans, **Anthem Blue Cross and Blue Shield triple option plan and Kaiser Permanente**. These choices are open to all benefit-eligible employees and their dependents based on their place of residence. Please review the following information on the various health insurance plans carefully before you make your selection.

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## Anthem Blue Cross Blue Shield of Colorado

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The Anthem Blue Cross Blue Shield triple option plans are available for enrollment at all locations. Options available include:

- HMO Colorado (HMO) Plan
- HMO Colorado Point-of-Service (POS) Plan
- BluePreferred Provider Organization (PPO) Plan

Part of **Anthem Blue Cross and Blue Shield's** mission is to provide useful tools that help improve the lives of their members and assist them in making informed decisions about their health. The following programs are included with your health coverage:

- **MyAnthem™** takes the hassle out of your health care. Get the information you need online through the secure **MyAnthem™** site at [www.anthem.com](http://www.anthem.com), Colorado, MyAnthem login. Use **MyAnthem™** to:
  - ◆ Find a doctor or hospital
  - ◆ Order a new ID card or print a temporary ID card
  - ◆ View your benefits or check on a claim
  - ◆ Change your address or primary care physician
  - ◆ See if your medication is on the Anthem formulary
  - ◆ **Visit MyHealth@Anthem®**, powered by **WebMD®**, for personalized health information, surveys and calculators
  - ◆ Save money on health-related products and services with **SpecialOffers@Anthem<sup>SM</sup>**
  - ◆ Get help making medical choices with decision-support tools
- **ConditionCare** offers valuable tools and information that could make a real difference if you or one of your dependents have *diabetes, coronary artery disease (CAD), heart failure (HF), chronic obstructive pulmonary disease (COPD) or asthma*. **ConditionCare** programs that help manage these conditions include:
  - ◆ 24-hour, toll-free access to registered nurses to answer your questions and provide you with support and education on how to better manage your condition
  - ◆ Specially designed condition-specific care diaries, self-monitoring charts, self-care tips and other easy-to-use empowerment materials.

**For information about Anthem's ConditionCare programs, call toll-free 877-236-7486 or go to [www.anthem.com](http://www.anthem.com), Colorado, 360° Health-Health Solutions Made Simple, Health Management. Various conditions are listed for your information.**

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# Health Insurance

- **Future Moms** program helps you and your doctor work together to have a healthy pregnancy and a healthy new baby. Remember, your doctor is your best source of information about your pregnancy and your health, and Future Moms is here to help along the way. At such an important time in your life, you'll have access to extra pre- and post-natal confidential support and education any time of the day or night! Even with terrific care from your doctor, you may have questions that come up between visits. Nurses are available for you to talk with around the clock. You may also benefit from:
  - ♦ maternity care materials including *Your Pregnancy Week By Week*, which is a helpful prenatal care book;
  - ♦ a confidential questionnaire to evaluate your risk for premature delivery; and/or
  - ♦ useful tools to help you, your doctor and your **Future Moms** nurse track your pregnancy and identify possible risks.

**To reach Future Moms, call toll-free 866-664-5404 or go to [www.anthem.com](http://www.anthem.com), Colorado, 360° Health-Health Solutions Made Simple, Health Guidance, Future Moms.**

- **24/7 NurseLine** assists you in making more informed health care decisions via confidential, one-on-one conversations with a registered nurse, any time of the day or night. Whenever you call, you can easily access a library of audio tapes on a range of topics related to your health care. Or, if you prefer, you can talk to a nurse about hundreds of health issues ranging from asthma to zinc, like: *Coughs* ▪ *Abdominal Pain* ▪ *Weight Loss* ▪ *Colds* ▪ *Children's Health* ▪ *Sexually Transmitted Diseases* ▪ *Fever* ▪ *Food & Diet* ▪ *Headache* ▪ *Smoking* ▪ *Women's Health* . . . *and much more!* Bilingual nurses, the Language Line and TTY/TDD relay services for the hearing impaired are also available.

**For confidential health information from a registered nurse 24-hours a day, 365 days a year, call 1-800-337-4770 or go to [www.anthem.com](http://www.anthem.com), Colorado, 360° Health-Health Solutions Made Simple, Health Guidance, 24/7 NurseLine.** In a medical emergency, call 911 or your local emergency service number.

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# Health Insurance

## HMO Colorado Plan

Under the HMO Colorado Plan, you must select a Primary Care Physician (PCP) for each covered family member. A member may self-refer to any specialist. Emergency care and urgent-after-hours care can be facilitated by any provider. There are no deductibles and most office visits require only a \$20 copay for PCP visits and a \$40 copay for specialist visits. Inpatient hospital treatment requires a \$700 per admission copay. Prescription copays are based on a formulary and mail order services are available (see Colorado Health Plan Description Form at the end of this chapter).

## HMO Colorado Point-of-Service Plan

The HMO Point-of-Service (POS) Plan includes both HMO Colorado in-network and out-of-network benefits. The POS Plan provides more flexibility in provider care. A member has the option for both in-network and out-of-network benefits based on the provider rendering the service.

Under the POS Plan you must select a Primary Care Physician (PCP) for each covered family member in order to be eligible for in-network benefits. A member may self-refer to any in-network specialist to receive in-network benefits.

Services rendered by a non-HMO provider are processed out-of-network and subject to the appropriate deductible and coinsurance. For services under this portion of the plan, the member is not required to get a PCP referral for services. A member can receive covered services from any provider whether or not they are within the HMO network of providers. However, out-of-pocket expenses are higher when you use an out-of-network provider. Many of these services require prior authorization before services are rendered.

In-network copays are \$25 per PCP office visit, \$50 per specialist office visit and \$500 copay per day inpatient hospital admission up to a maximum copay of \$1,000 per admission. Prescriptions are based on a formulary and mail order services are available (see the Colorado Health Plan Description Form for details).

## BluePreferred Provider Organization Plan

The BluePreferred is your Preferred Provider Organization (PPO) Plan. To obtain a higher level of benefits you can select a PPO Provider within the network of PRIME doctors (in-network) or you can choose to go outside the network and see any doctor of your choice.

If you live in a rural area and there are no in-network providers within a certain radius, you may call customer service to obtain preauthorization to use out-of-network providers and receive benefits at in-network levels (if applicable). This only applies when using providers within your area.

You can select in-network physicians who provide care at predetermined rates, which saves you money on coinsurance charges, or you can select the physician of your choice outside of the network.

**However, out-of-pocket expenses may be significantly higher if you select an out-of-network provider.**

If you use an in-network provider most office visits have a \$30 copay and inpatient hospital admissions are subject to a \$1,500 individual deductible (maximum \$4,500 family deductible), plus an additional 20% coinsurance on most services. If you use an out-of-network provider, a \$3,000 individual deductible (maximum \$9,000 family deductible) applies per plan year with an additional 40% coinsurance on most services. Prescriptions are based on a formulary and a mail order service is available (see the Colorado Health Plan Description Form for details).

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# Health Insurance

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## Kaiser Permanente

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Kaiser Permanente HMO Plan 220 is available to all locations in the Denver, Boulder and Longmont service areas. There are no deductibles or coinsurance. Primary care office visits are \$20 copay per visit, and specialty care office visits are \$40 copay per office visit. Hospitalization is subject to a \$500 per admission copay, and outpatient ambulatory surgery is subject to a \$250 copay. The prescription drug copay is \$15 generic / \$30 brand per prescription for up to a thirty (30) day supply. Kaiser Permanente utilizes its own prescription drug formulary, and for mail order service a ninety (90) day supply is available. There are twenty (20) full-service medical offices with more than seven hundred forty (740) physicians available to you. All locations include doctors, x-rays, lab services and pharmacies (see the Colorado Health Plan Description Form for further details). If you become ill or are injured when traveling outside the service areas, you are covered for emergency or urgent care.

With Kaiser Permanente, you get what you need to take charge of your health, and it's right at your fingertips, 24 hours a day, 7 days a week. The following programs and services are available with your Kaiser Permanente membership:

- Healthy lifestyle programs are available online at [www.kp.org/healthylifestyles](http://www.kp.org/healthylifestyles). Access this site to:
  - ♦ Take an inventory of your health with HealthMedia Succeed®
  - ♦ Reach your weight loss goals with HealthMedia Balance®
  - ♦ Reduce and manage your stress with HealthMedia Relax®
  - ♦ Make smart food choices with HealthMedia Nourish®
  - ♦ Stop smoking for good with HealthMedia Breathe®

- My Health Manager online allows you to access your secure medical record, order prescription refills, request routine doctor's appointments and find doctors and medical offices near you – 24/7. Once you register at [www.kp.org](http://www.kp.org), you'll be able to:

- ♦ E-mail your doctor's office
- ♦ View your allergies and recent immunization history
- ♦ See a list of your ongoing health conditions
- ♦ Review past office visit information
- ♦ Review most lab test results
- ♦ View your eligibility and benefit information
- ♦ Check or cancel future appointments

To register, all you have to do is fill out the online registration form. We'll mail your password to your home in seven to ten days. Also, be sure to activate your access within three days of password receipt. You can change your password at anytime.

- Featured health topics on health, medications, treatment options and practical steps for preventing or managing conditions are available at [www.kp.org/featuredhealthtopics](http://www.kp.org/featuredhealthtopics).
- Complementary health discounts on services like massage therapy, acupuncture and chiropractic, free shipping for online vitamin and herbal supplement purchases, and preferred rates on select fitness club memberships are found at [www.kp.org/healthyroads](http://www.kp.org/healthyroads).
- Online health calculators to help you find your healthy weight, see if you're getting enough calcium, learn how to avoid asthma triggers and more are offered at [www.kp.org/calculators](http://www.kp.org/calculators).
- Get up and get moving offers you a healthy discount on 10,000 Steps®, an easy-to-use online walking program. Using a pedometer, count your steps each day and then track your progress online. Visit [www.kp.org/10000steps](http://www.kp.org/10000steps) today and start walking your way to better health.
- Weight Watchers® allows you to take control of your weight and live healthier. Discounts range from 12%-23% off regular program rates including Weight Watchers Community Meetings, Weight Watchers at Home, and Weight Watchers Online. To learn more, call 1-888-639-3300 or visit [www.kp.org/weightwatchers](http://www.kp.org/weightwatchers).

## Colorado Health Plan Description Form

### PART A: TYPE OF COVERAGE:

Anthem Blue Cross and Blue Shield		
	HMO Plan No. 20-7-15/40/60	Point-of-Service No. 25-5-15/40/60-P500
1. Type of Plan	Health Maintenance Organization (HMO)	Point-of-Service (POS)
2. Out-of-Network Care Covered? <sup>1</sup>	Only for Emergency and Urgent Care	Yes, but patient pays more for out-of-network care
3. Areas of Colorado where plan is available	Plan is available throughout Colorado	Plan is available throughout Colorado

### PART B: SUMMARY OF BENEFITS

**Important Note:** This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Coinsurance and copayment options reflect the amount the covered person will pay.

	HMO In-Network only (Out-of-Network care is not covered except as noted)	Point-of-Service	
		In-Network	Out-of-Network
4. Deductible Type <sup>2</sup>	Not Applicable	Not Applicable	Benefit Year
4a. Annual Deductible <sup>2a</sup> a) Individual <sup>2b</sup> b) Family <sup>2b</sup>	No Deductibles	No Deductibles	\$500 \$1,000 aggregate
5. Out-of-pocket annual maximum <sup>2,3</sup> a) Individual  b) Family  c) Is deductible included in the out-of-pocket maximum?	\$2,000. Copays for office visits, durable medical equipment, emergency room, urgent care, MRI/CT, mental health and prescription drug do not apply to this out-of-pocket maximum.  \$4,000 aggregate. Copays for office visits, durable medical equipment, emergency room, urgent care, MRI/CT, mental health and prescription drug do not apply to this out-of-pocket maximum.  Not Applicable	\$2,000. Copays for office visits, durable medical equipment, emergency room, urgent care, MRI/CT, mental health and prescription drug do not apply to this out-of-pocket maximum.  \$4,000 aggregate. Copays for office visits, durable medical equipment, emergency room, urgent care, MRI/CT, mental health and prescription drug do not apply to this out-of-pocket maximum.  Not Applicable	\$2,500 + deductible  \$5,000 + deductible  No
6. Lifetime or Benefit Maximum Paid by the Plan for all care	No lifetime maximum Infertility Diagnosis-\$2,000 Bariatric Surgery-\$15,000	No lifetime maximum Infertility Diagnosis-\$2,000 Bariatric Surgery-\$15,000	\$1,000,000 per member Infertility Diagnosis-\$2,000 Bariatric Surgery-\$1,500
7A. Covered Providers	HMO Colorado Managed Care Network. See online provider directory for complete list of current providers.	HMO Colorado Managed Care Network. See online provider directory for complete list of current providers.	All providers licensed or certified to provide covered benefits.
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my Primary Care Physician?	Yes	Yes	Yes

## Colorado Health Plan Description Form

### PART A: TYPE OF COVERAGE:

Anthem Blue Cross and Blue Shield	Kaiser Foundation Health Plan of Colorado
<b>BluePreferred Option M 30/1500/80% Rx 15/40/60</b>	<b>HMO Plan No. 220</b>
Preferred provider organization (PPO)	Health Maintenance Organization (HMO)
Yes, but patient pays more for out-of-network care	Only for Emergency Care
Plan is available throughout Colorado	Plan is available if you reside in the following areas: Denver, Broomfield and Boulder Counties and portions of Adams, Arapahoe, Clear Creek, Douglas, Elbert, Gilpin, Jefferson, Larimer, Park and Weld Counties.

### PART B: SUMMARY OF BENEFITS

**Important Note:** This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Coinsurance and copay options reflect the amount the covered person will pay.

BluePreferred		Kaiser
In-Network	Out-of-Network	In-Network only (Out-of-Network care is not covered except as noted)
Benefit Year	Benefit Year	Not Applicable
\$1,500 \$4,500 aggregate	\$3,000 \$9,000 aggregate	No Deductibles No Deductibles
\$3,000 + deductible (\$4,500) and copays. Copays for office visits and prescription drugs do not apply to this out-of-pocket maximum.	\$6,000 + deductible (\$9,000)	\$2,000/Individual Copays for office visits and prescription drugs do not apply to this out-of-pocket maximum.
\$6,000 aggregate + deductible (\$10,500) and copays. Copays for office visits and prescription drugs do not apply to this out-of-pocket maximum.	\$12,000 aggregate + deductible (\$21,000).	\$4,500/Family Copays for office visits and prescription drugs do not apply to this out-of-pocket maximum.
No	No	Not Applicable
\$2,000,000 per member (combined in and out-of-network) Infertility Diagnosis-\$2,000 Bariatric Surgery-\$15,000	\$2,000,000 per member (combined in- and out-of-network) Infertility Diagnosis-\$2,000 Bariatric Surgery-\$1,500	No Lifetime Maximum
Anthem Blue Cross Blue Shield PPO Provider Network. See online provider directory for complete list.	All providers licensed or certified to provide covered benefits.	Colorado Permanente Medical Group, P.C. See online provider directory for complete list
Yes	Yes	Not applicable. This is not a network plan

## Colorado Health Plan Description Form

### PART B: SUMMARY OF BENEFITS

	HMO In-Network only (Out-of-Network care is not covered except as noted)	Point-of-Service	
		In-Network	Out-of-Network
<b>8. Medical office visits<sup>4</sup></b>	\$20 copay per visit for PCP \$40 copay per visit for specialist	\$25 copay per visit for PCP \$50 copay per visit for specialist	30% after deductible 30% after deductible
<b>9. Preventive Care</b>			
<b>a) Children's services</b>	\$20 copay per visit for PCP \$40 copay per visit for specialist	\$25 copay per visit for PCP \$50 copay per visit for specialist	30% not subject to deductible for children up to age 13; not covered after age 13
<b>b) Adults' services (includes mammograms, gynecological, colonoscopy and prostate screenings)</b>	\$20 copay per visit for PCP \$40 copay per visit for specialist \$100 copay for routine colonoscopy (no age or frequency limits)	\$25 copay per visit for PCP \$50 copay per visit for specialist \$100 copay for routine colonoscopy (no age or frequency limits)	30% on annual gynecological exam. 30% on colonoscopy (no age or frequency limits); not subject to deductible. All other preventive care is not covered.
<b>10. Maternity</b>			
<b>a) Prenatal Care</b>	\$40 copay for first prenatal care visit ; no copay thereafter	\$50 copay for first prenatal care visit; no copay thereafter	30% after deductible
<b>b) Delivery &amp; inpatient well baby care<sup>5</sup></b>	\$700 copay per admission	\$500 copay per day up to a maximum of \$1000 per admission	30% after deductible
<b>11. Prescription Drugs Level of coverage and restrictions<sup>6</sup></b>			
<b>a) Inpatient</b>	Included with inpatient hospital copay (see line 12)	Included with inpatient hospital copay (see line 12)	30% after deductible
<b>b) Outpatient</b>	Tier 1 \$15 copay; Tier 2 \$40 copay; Tier 3 \$60 copay per prescription at a participating retail or specialty pharmacy—up to 30-day supply. Diabetic supplies will be covered under Tier 1 \$15 copay.	Tier 1 \$15 copay; Tier 2 \$40 copay; Tier 3 \$60 copay per prescription at a participating retail or specialty pharmacy—up to 30-day supply. Diabetic supplies will be covered under Tier 1 \$15 copay.	Not covered
<b>c) Prescription Mail Service</b>	Tier 1 \$15 copay; Tier 2 \$80 copay; Tier 3 \$120 copay per prescription at a partici- pating retail pharmacy—up to a 90-day supply. Diabetic supplies will be covered under Tier 1 \$15 copay.  Benefits are limited to a Tier 1 drug unless a Tier 1 drug is not available. Member pays appropriate copay plus difference in price of Tier 1 and Tiers 2 or 3. For drugs on our approved list, contact Customer Service at 1-877-811-3106.	Tier 1 \$15 copay; Tier 2 \$80 copay; Tier 3 \$120 copay per prescription at a partici- pating retail pharmacy—up to a 90-day supply. Diabetic supplies will be covered under Tier 1 \$15 copay.  Benefits are limited to a Tier 1 drug unless a Tier 1 drug is not available. Member pays appropriate copay plus difference in price of Tier 1 and Tiers 2 and 3. For drugs on our approved list, contact Customer Service at 1-877-811-3106.	Not covered

**Colorado Health Plan Description Form**

**PART B: SUMMARY OF BENEFITS**

BluePreferred		Kaiser
In-Network	Out-of-Network	In-Network only (Out-of-Network care is not covered except as noted)
\$30 copay per office visit + 20% after deductible for all other services (e. g. laboratory & x-ray services)	40%, after deductible	\$20 copay per visit \$40 copay per visit specialty care
\$30 copay per office visit + 20% (not subject to deductible) for all other services (e. g. laboratory & x-ray services) includes immunizations (up to age 13)	40%, not subject to deductible includes immunizations (up to age 13)	\$20 copay per visit
\$30 copay per office visit + 20% after deductible for all other services (e. g. laboratory & x-ray services). In addition, mammogram and prostate screening are covered and not subject to the deductible or coinsurance. \$100 copay for routine colonoscopy (No age or frequency limits)	Not covered except for mammogram and prostate screening, not subject to deductible and coinsurance up to maximum benefit allowance. 40% benefit on colonoscopy (no age or frequency limits) and not subject to deductible.	\$20 copay per visit \$70 copay for routine diagnostic colonoscopy
\$30 copay for first prenatal care visit plus 20% after deductible for all other services (e.g., laboratory and x-ray); no copay thereafter	40% after deductible	\$20 copay per visit
20% after deductible	40% after deductible	\$500 copay per admission
20% after deductible	40% after deductible	\$500 copay per admission
Tier 1 \$15 copay; Tier 2 \$40 copay; Tier 3 \$60 copay per prescription at a participating retail or specialty pharmacy—up to a 30-day supply. Diabetic supplies will be covered under Tier 1 \$15 copay.	Not covered	\$15 generic/\$30 brand for up to a 30-day supply.
Tier 1 \$15 copay; Tier 2 \$80 copay; Tier 3 \$120 copay per prescription at a participating retail pharmacy—up to a 90-day supply. Diabetic supplies will be covered under Tier 1 \$15 copay.	Not covered	\$30 generic/\$60 brand for up to a 90-day supply.
Benefits are limited to a Tier 1 drug unless a Tier 1 drug is not available. Members pay appropriate copay plus difference in price of Tier 1 and Tiers 2 or 3. For drugs on approved list, contact Customer Service at 1-877-811-3106.	Not covered	For drugs on our approved list, please contact your Medical Office Pharmacist

**Colorado Health Plan Description Form**

**PART B: SUMMARY OF BENEFITS**

	<b>HMO In-Network only Out-of-Network care is not covered except as noted)</b>	<b>Point-of-Service</b>	
		<b>In-Network</b>	<b>Out-of-Network</b>
<b>d) Specialty Drugs</b>	Subject to Tier 1 \$15 copay; Tier 2 \$40 copay; Tier 3 \$60 copay per prescription. Specialty Drugs are only available for up to a 30-day supply through PrecisionRX by mail only—not available through retail pharmacy.	Subject to Tier 1 \$15 copay; Tier 2 \$40 copay; Tier 3 \$60 copay per prescription. Specialty Drugs are only available for up to a 30-day supply through PrecisionRX by mail only—not available through retail pharmacy.	Not covered
<b>12. Inpatient Hospital</b>	\$700 copay per admission	\$500 copay per day up to a maximum of \$1,000 per admission	30% after deductible
<b>13. Outpatient Ambulatory Surgery</b>	\$325 copay per procedure	\$400 copay per procedure	30% after deductible
<b>14. Laboratory and X-ray</b>	\$100 copay for MRI / MRA / CT & PET scans; No copay (100% covered) most lab & x-ray services	\$100 copay for MRI / MRA / CT & PET scans; No copay (100% covered) most lab & x-ray services;	30% after deductible
<b>15. Emergency Care<sup>7, 8</sup></b>	\$150 copay per emergency room visit (waived if admitted to hospital) in or out-of-network	\$200 copay per emergency room visit (waived if admitted to hospital)	\$200 copay per emergency room visit (waived if admitted to hospital)
<b>16. Ambulance</b>	\$50 copay per trip (waived if admitted)	\$50 copay per trip (waived if admitted)	\$50 copay per trip (waived if admitted)
<b>17. Urgent, non-routine, after hours care</b>	\$40 copay per urgent care visit (Urgent care may be received from your PCP or from an urgent care center)	\$50 copay per urgent care visit (Urgent care may be received from your PCP or from an urgent care center)	30% after deductible
<b>18. Biologically-based Mental Illness Care<sup>9</sup></b>	Coverage is no less extensive than the coverage provided for any other physical illness.	Coverage is no less extensive than the coverage provided for any other physical illness.	Coverage is no less extensive than the coverage provided for any other physical illness.
<b>19. Other Mental Health Care</b>			
<b>a) Inpatient care</b>	50% of billed charges (limited to 45 full or 90 partial days per contract year for other mental health care, except as listed below).*	50% of billed charges (limited to 45 full or 90 partial days per contract year for other mental health care, except as listed below).*	Not covered
<b>b) Outpatient care</b>	\$20 copay. Limited to 20 visits.	\$25 copay. Limited to 20 visits.	Not covered

\* For other mental disorders of post-traumatic stress disorder, dysthymia, cyclothymia, social phobia, agoraphobia with panic disorder and general anxiety disorder, coverage is no less extensive than the coverage provided for any other physical illness. Anorexia nervosa and bulimia nervosa, to the extent those diagnoses are treated on an outpatient, day treatment, and inpatient basis (residential treatment is excluded), are covered no less extensively than the coverage provided for any other illness.

## Colorado Health Plan Description Form

### PART B: SUMMARY OF BENEFITS

BluePreferred		Kaiser
In-Network	Out-of-Network	In-Network only (Out-of-Network care is not covered except as noted)
Subject to Tier 1 \$15 copay; Tier 2 \$40 copay; Tier 3 \$60 copay per prescription. Specialty Drugs are only available for up to a 30-day supply through PrecisionRX by mail only—not available through retail pharmacy.	Not covered	\$15 generic/\$30 brand for up to a 30-day supply.  \$30 generic/\$60 brand for up to a 90-day supply.  Certain drugs are limited to a 30-day supply.
20% after deductible	40% after deductible	\$500 copay per admission
20% after deductible	40% after deductible	\$250 copay per visit
20% after deductible	40% after deductible	\$100 copay for MRI / CT / PET scan & Nuclear Medicine Studies; Therapeutic X-ray - \$40 copay per visit; Diagnostic Lab and X-ray - no copay (100% covered)
20% after deductible per emergency room visit	20% after in-network deductible per emergency room visit	\$100 copay per visit at a Kaiser Permanente designated facility or non-Plan emergency room, waived if admitted as an inpatient. Payment of non-Plan emergency claims is limited to usual, reasonable and customary charges.
<b>Ground &amp; Air:</b> 20% after deductible	<b>Ground &amp; Air:</b> 20% after in-network deductible	20% of charges up to a maximum of \$500 per trip
\$60 copay per visit + 20% after deductible for all other services (e. g. laboratory & x-ray services)	40% after deductible	\$100 copay per visit at a Kaiser Permanente designated emergency room or a non-Plan emergency room, outside the Service Area
Coverage is no less extensive than the coverage provided for any other physical illness.	Coverage is no less extensive than the coverage provided for any other physical illness.	Coverage is no less extensive than the coverage provided for any other physical illness.
50% after deductible (limited to 45 full or 90 partial days per contract year for other mental health care, except as listed below)*.	Not covered	A maximum of 45 days per contract year subject to a \$500 copay per admission.*
50% after deductible (limited to 30 visits with no less than \$1,000 in benefits per contract year for other mental health care, except as listed below).	Not covered	A maximum of 20 visits per year; \$20 copay per visit. Two group visits count as one individual visit.

\* For other mental disorders of post-traumatic stress disorder, dysthymia, cyclothymia, social phobia, agoraphobia with panic disorder and general anxiety disorder, coverage is no less extensive than the coverage provided for any other physical illness. Anorexia nervosa and bulimia nervosa, to the extent those diagnoses are treated on an outpatient, day treatment, and inpatient basis (residential treatment is excluded), are covered no less extensively than the coverage provided for any other illness.

## Colorado Health Plan Description Form

### PART B: SUMMARY OF BENEFITS

	HMO In-Network only (Out-of-Network care is not covered except as noted)	Point-of-Service	
		In-Network	Out-of-Network
<b>20. Alcohol &amp; Substance Abuse</b>	Coverage is no less extensive than the coverage provided for any other physical illness.	Coverage is no less extensive than the coverage provided for any other physical illness.	Coverage is no less extensive than the coverage provided for any other physical illness.
<b>21. Physical, Occupational, &amp; Speech Therapy</b>			
<b>a) Inpatient care</b>	\$700 copay per admission (limited to 30 days per injury or illness)	\$500 copay per day up to a maximum of \$1,000 per admission (limited to 30 days per injury or illness)	30% after deductible (limited to 30 days per injury or illness)
<b>b) Outpatient care</b>	\$20 copay per visit for PCP \$40 copay per visit for specialist Occupational, physical and speech therapies will be covered separately, and members will be allowed 20 visits for each type of therapy per benefit period	\$25 copay per visit for PCP \$50 copay per visit for specialist. Occupational, physical and speech therapies will be covered separately, and members will be allowed 20 visits for each type of therapy per benefit period	30% after deductible Occupational, physical and speech therapies will be covered separately, and members will be allowed 20 visits for each type of therapy per benefit period
<b>22. Durable Medical Equipment</b>	No copay (100% covered), limited to \$1,000 per contract year, combined with oxygen (line 23) except for prosthetic devices which are not subject to the maximum payment, but do reduce the maximum \$1,000 benefit.	No copay (100% covered), limited to \$1,000 per contract year, combined with oxygen (line 23) except for prosthetic devices which are not subject to the maximum payment, but do reduce the maximum \$1,000 benefit.	30% after deductible; limited to \$1,000 per contract year, combined with oxygen (line 23) except for prosthetic devices which are not subject to the maximum payment but do reduce the maximum \$1,000 benefit
<b>23. Oxygen</b>	No copay (100% covered, with benefits limited to \$1,000 payment per contract year, combined with Durable Medical Equipment (see line 22)	No copay (100% covered) with benefits limited to \$1,000 payment per contract year, combined with Durable Medical Equipment (see line 22) and combined in- and out-of-network	30% after deductible; with benefits limited to \$1,000 payment per contract year, combined with Durable Medical Equipment (line 22) and combined in- and out-of-network
<b>24. Organ Transplants</b>	\$1 million limit per transplant	\$1 million limit per transplant	Not covered
<b>a) Major Organ Transplants</b>			
<b>- Inpatient</b>	\$700 copay per admission	\$500 copay per day up to a maximum of \$1,000 per admission	Covered as in-network when pre-authorized and delivered in an HMO Colorado organ transplant facility
<b>- Outpatient</b>	\$20 copay per PCP visit \$40 copay per specialist visit	\$25 copay per PCP visit \$50 copay per specialist visit	
<b>b) Other Transplants</b>			
<b>- Inpatient</b>	\$700 copay per admission	\$500 copay per day up to a maximum of \$1,000 per admission	30% after deductible
<b>- Outpatient</b>	\$20 copay per PCP visit \$40 copay per specialist visit	\$25 copay per PCP visit \$50 copay per specialist visit	30% after deductible

**Colorado Health Plan Description Form**

**PART B: SUMMARY OF BENEFITS**

BluePreferred		Kaiser
In-Network	Out-of-Network	In-Network only (Out-of-Network care is not covered except as noted)
Coverage is no less extensive than the coverage provided for any other physical illness.	Coverage is no less extensive than the coverage provided for any other physical illness.	Coverage is no less extensive than the coverage provided for any other physical illness.
20% after deductible limited to 30 non-acute inpatient days per contract year in- and out-of-network combined  20% after deductible Occupational, physical and speech therapies will be covered separately, and members will be allowed 20 visits for each type of therapy per benefit period	40% after deductible limited to 30 non-acute inpatient days per contract year in- and out-of-network combined  40% after deductible Occupational, physical and speech therapies will be covered separately, and members will be allowed 20 visits for each type of therapy per benefit period	\$500 copay per admission for conditions subject to significant improvement within two months*  \$20 copay per visit for up to 20 visits per therapy per year.  Therapy for congenital defects and birth abnormalities is covered for children age 3 to age 6.
20% after deductible; limited to \$1,000 per contract year, combined with oxygen (line 23) except for prosthetic devices which are not subject to the maximum payment, but do reduce the maximum \$1,000 benefit.	Not covered	<b>Inpatient:</b> \$500 copay per admission  <b>Outpatient:</b> 20% coinsurance within the Service Area \$2,000 annual benefit maximum See policy for types and circumstances of coverage
20% after deductible limited to \$1,000 per contract year, combined with Durable Medical Equipment (line 22)	Not covered	<b>Inpatient:</b> \$500 copay per admission  <b>Outpatient:</b> 20% coinsurance within the Service Area/up to \$2,000 Maximum Benefit per Calendar Year.
\$1 million limit per transplant	Not covered	\$1 million lifetime maximum
20% after deductible	Not covered	\$500 copay per admission-no waiting period. Covered transplants are limited to kidney, kidney/pancreas, heart, heart-lung, lung, some bone marrow, cornea and liver, small bowel and small bowel/liver
20% after deductible	Not covered	
20% after deductible	Not covered	Not covered
20% after deductible	Not covered	Not covered

## Colorado Health Plan Description Form

### PART B: SUMMARY OF BENEFITS

	HMO In-Network only (Out-of-Network care is not covered except as noted)	Point-of-Service	
		In-Network	Out-of-Network
<b>25. Home Health Care</b>	No copay (100% covered) limited to 100 visits	No copay (100% covered) limited to 100 visits (combined in- and out-of-network visits)	30% after deductible limited to 100 visits (combined in- and out-of-network visits)
<b>26. Hospice Care</b>			
<b>a) Inpatient</b>	No copay (100% ) covered	No copay (100% ) covered	30% after deductible
<b>b) Outpatient</b>	No copay (100% ) covered	No copay (100% ) covered	30% after deductible
<b>27. Skilled Nursing Facility Care</b>	No copay (100% covered), limited to 100 days per contract year	No copay (100% covered), limited to 100 days per contract year combined with out-of-network	30% after deductible, limited to 100 days per contract year combined with in-network
<b>28. Dental Care</b>	Not covered; limited benefits available for accident related dental injuries. See policy for details.	Not covered; limited benefits available for accident related dental injuries. See policy for details.	Not covered; limited benefits available for accident related dental injuries. See policy for details.
<b>29. Vision Care</b>	\$15 copay per visit (limited to one routine refraction exam every 12 months)	\$20 copay per visit (limited to one routine refraction exam every 12 months)	Covered up to \$35
<b>30. Chiropractic Care</b>	\$20 copay per visit (limited to 20 visits per contract year) <b>The contracted provider must obtain an authorization for services from Landmark at 1-800-638-4557.</b>	\$25 copay per visit (limited to 20 visits per contract year combined with Out-of-network benefits) <b>The contracted provider must obtain an authorization for services from Landmark at 1-800-638-4557.</b>	30% after deductible (limited to 20 visits per contract year combined with in-network benefits)
<b>31. Significant Additional Covered Services</b>	When a member desires another professional opinion, they may obtain a second surgical opinion.  Hearing aid services are covered for members up to their eighteenth (18th) birthday. See plan certificate for details.	When a member desires another professional opinion, they may obtain a second surgical opinion.  Hearing aid services are covered for members up to their eighteenth (18th) birthday. See plan certificate for details.	For services covered under this rider, a member is not required to get a PCP referral, which is required under the regular BlueAdvantage HMO Plan coverage.  A member may also choose to receive covered services from a provider who is not in the HMOC network. When a member desires another opinion, they may obtain a second surgical opinion.  Hearing aid services are covered for members up to their eighteenth (18th) birthday. See plan certificate for details.

## Colorado Health Plan Description Form

### PART B: SUMMARY OF BENEFITS

BluePreferred		Kaiser
In-Network	Out-of-Network	In-Network only (Out-of-Network care is not covered except as noted)
20% after deductible; limited to 60 visits per contract year	Not covered	No copay (100% covered) for prescribed medically necessary home health services. Not covered outside the Service Area.
20% after deductible	40% after deductible	No copay (100% covered) for home-based hospice care. Not covered outside the Service Area
20% after deductible	40% after deductible	No copay (100% covered) for home-based hospice care. Not covered outside the Service Area
20% after deductible (limited to 100 days per contract year in- and out-of-network combined)	40% after deductible (limited to 100 days per contract year in- and out-of-network combined)	No copay, (100% covered) up to 100 days; for prescribed skilled nursing facility services at approved skilled nursing facilities. Not covered outside the Service Area.
Not covered; limited benefits available for accident related dental injuries. See policy for details.	Not covered; limited benefits available for accident related dental injuries. See policy for details.	Not covered.
100% after \$25 copay per visit (limited to one routine refraction exam every 12 months)	Covered up to \$35	\$20 copay per visit for vision exam Hardware not covered
100% after \$30 copay per visit plus 20% after deductible for all other services (e.g., laboratory and x-ray) (limited to 12 visits per contract year combined with acupuncture care (line 31)	Not covered	No chiropractic benefits are available
Acupuncture care - 100% after \$30 copay per visit plus 20% after deductible for all other services (e.g., laboratory and x-ray) (limited to 12 visits per contract year combined with chiropractic care (line 30)  When a member desires another professional opinion, they may obtain a second surgical opinion	When a member desires another professional opinion, they may obtain a second surgical opinion	Travel Clinic for pre-travel health risk assessments, immunizations and prescriptions; Mail-order Pharmacy; post-mastectomy breast reconstruction including services to attain breast symmetry, prostheses and services due to complications; Health education classes including Smoking Cessation, Stress Management, Women's Health and Diet and Nutrition
Hearing aid services are covered for members up to their eighteenth (18th) birthday. See plan certificate for details.	Hearing aid services are covered for members up to their eighteenth (18th) birthday. See plan certificate for details.	Hearing aid services are covered for members up to their eighteenth (18th) birthday. See plan certificate for details.

## Colorado Health Plan Description Form

### PART C: LIMITATIONS AND EXCLUSIONS

	<b>HMO In-Network only (Out-of-Network care is not covered except as noted)</b>	<b>Point-of-Service In-Network and Out-of-Network</b>
<b>32. Period during which pre-existing conditions are not covered.<sup>10</sup></b>	Not applicable; plan does not impose limitation periods for pre-existing conditions.	Not applicable; plan does not impose limitation periods for pre-existing conditions.
<b>33. Exclusionary Riders. Can an individual's specific, pre-existing condition be entirely excluded from the policy?</b>	No	No
<b>34. How does the policy define a "pre-existing condition"?</b>	Not applicable plan does not exclude coverage for pre-existing conditions	Not applicable plan does not exclude coverage for pre-existing conditions
<b>35. What treatments and conditions are excluded under the policy?</b>	Exclusions vary by policy. List of exclusions is available immediately upon request from your carrier, agent, or plan sponsor (e.g., employer). Review them to see if a service or treatment you may need is excluded from the policy.	

### Part D: USING THE PLAN

	<b>HMO In-Network Only</b>	<b>Point-of-Service</b>	
		<b>In-Network</b>	<b>Out-of-Network</b>
<b>36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care or all cases?</b>	No	No	Yes. The member is responsible for obtaining pre-certification, unless the provider participates with Anthem.
<b>37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?</b>	Yes, the physician who schedules the procedure or hospital care is responsible for obtaining the prior authorization.	Yes, the physician who schedules the procedure or hospital care is responsible for obtaining the prior authorization.	Yes. The member is responsible for obtaining pre-certification, unless the provider participates with Anthem.
<b>38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?</b>	No	No	Yes, if the provider does not participate with Anthem
<b>39. What is the main customer service number?</b>	1-877-811-3106	1-877-811-3106	
<b>40. Whom do I write/call if I have a complaint or want to file a grievance?<sup>11</sup></b>	HMO Colorado Complaints and Appeals 700 Broadway Denver, CO 80273 303-831-2020 or 1-800-782-4723	HMO Colorado Complaints and Appeals 700 Broadway Denver, CO 80273 303-831-2020 or 1-800-782-4723	
<b>41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?</b>	Write to: Colorado Division of Insurance, ICARE Section, 1560 Broadway, Suite 850 Denver, CO 80202	Write to: Colorado Division of Insurance, ICARE Section, 1560 Broadway, Suite 850 Denver, CO 80202	

## Colorado Health Plan Description Form

### PART C: LIMITATIONS AND EXCLUSIONS

BluePreferred In-Network and Out-of-Network	Kaiser
	In-Network only (Out-of-Network care is not covered except as noted)
6 months for pre-existing conditions for late enrollees; may not apply if proof of credible coverage is provided. Late enrollees may only apply with an eligible status change or during open enrollment. See policy for details.	Not applicable. Plan does not impose limitation periods for pre-existing conditions.
No	No
A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the last 6 months immediately preceding the date of enrollment or, if earlier, the first day of the waiting period; except that pre-existing condition exclusions may not be imposed on a newly adopted child, a child placed for adoption, a newborn, other special enrollees, or for pregnancy.	Not applicable. Plan does not exclude coverage for pre-existing conditions
Exclusions vary by policy. List of exclusions is available immediately upon request from your carrier, agent, or plan sponsor (e.g., employer). Review them to see if a service or treatment you may need is excluded from the policy.	

### Part D: USING THE PLAN

BluePreferred		Kaiser
In-Network	Out-of-Network	In-Network only
No	Yes. The member is responsible for obtaining pre-certification unless the provider participates with Anthem	Yes
Yes	Yes. The member is responsible for obtaining pre-certification unless the provider participates with Anthem	Yes
No	Yes, if the provider does not participate with Anthem Blue Cross and Blue Shield	No
1-877-811-3106		303-338-3800
Anthem Blue Cross and Blue Shield Complaints and Appeals 700 Broadway Denver, CO 80273 303-831-2900 or 1-800-331-6170		Customer Service Center 2500 S. Havana Street Aurora, CO 80014 303-338-3800
Write to: Colorado Division of Insurance, ICARE Section, 1560 Broadway, Suite 850 Denver, CO 80202		Write to: Colorado Division of Insurance, ICARE Section, 1560 Broadway, Suite 850 Denver, CO 80202

## Colorado Health Plan Description Form

### PART D: USING THE PLAN

	HMO In-Network Only	Point-of-Service		BluePreferred		Kaiser
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only
<b>42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.</b>	Policy form #'s 98200 Group - All sizes	Policy form #'s 98200 / 96055 Group - All sizes		Policy form #'s 98491_MNO Group - All sizes		Policy form SA210-DEN (11-99), Large Group
<b>43. Does the plan have a binding arbitration clause?</b>	Yes	Yes		Yes		Yes
<b>44. What is the cost of the plan?</b>	Contact your agent, this insurance company, or your employer, as appropriate, to find out the premium for this plan. In some cases, plan costs are included with this form.					

#### Endnotes:

<sup>1</sup> "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network (i.e., go in-network) than if you don't (i.e., go out-of-network).

<sup>2</sup> "Deductible Type" indicates whether the deductible period is "Calendar Year" (January 1 through December 31) or "Benefit Year" (i.e., based on a benefit year beginning on the policy's anniversary date) or if the deductible is based on other requirements such as a "Per Accident or Injury" or "Per Confinement".

<sup>2a</sup> "Deductible" means the amount you will have to pay for allowable covered expenses under a health plan during a specified time period (e.g., a calendar year or benefit year) before the carrier will cover those expenses. The specific expenses that are subject to deductible may vary by policy. Expenses that are subject to deductible should be noted in boxes 8 through 31.

<sup>2b</sup> "Individual" means the deductible amount you and each individual covered by a non-HSA qualified policy will have to pay for the allowable covered expenses before the carrier will cover those expenses. "Single" means the deductible amount you will have to pay for allowable covered expenses under an HSA-qualified health plan when you are the only individual covered by the plan.

<sup>2c</sup> "Family" is the maximum deductible amount that is required to be met for all family members covered by a non-HSA qualified policy and it may be an aggregated amount (e.g. \$3,000 per family), or specified as the number of individual deductibles that must be met (e.g. "3 deductibles per family"). "Non-single" is the deductible amount that must be met by one or more family members covered by a HSA-qualified plan before any covered expenses are paid.

<sup>3</sup> "Out-of-pocket maximum" Means the maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductible or copayments, depending on the contract for that plan. The specific deductibles or copayments included in the out-of-pocket maximum may vary by policy. Expenses that are applied toward the out-of-pocket maximum should be noted in boxes 8 through 31.

<sup>4</sup> Medical office visits include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically-based mental illness.

<sup>5</sup> Well baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. The hospital copayment applies to mother and well-baby together; there are not separate copayments.

<sup>6</sup> Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.

<sup>7</sup> "Emergency care" means all services delivered in an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed.

<sup>8</sup> Nonemergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to an emergency room by his/her carrier or primary care physician. If emergency departments are used by the plan for non-emergency after-hours care, then urgent care copayments apply.

<sup>9</sup> "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

<sup>10</sup> "Waiver of pre-existing condition exclusions." State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.

<sup>11</sup> "Grievances." Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

# Dental Insurance

## DentaBenefits (United Concordia)

DentaBenefits is a specially designed line of dental products that brings together two industry leaders, Mutual of Omaha and United Concordia. United Concordia's Advantage Plus is the dental provider network. To help ensure optimum dental health for all employees, two dental plan options are available. Option I has an in- and out-of-network benefit schedule and provides orthodontic treatment. Option II provides the same reimbursement amount to all providers. No orthodontic treatment is available in this plan.

You may select Option I or II under the plan regardless of the level of benefit selected for health insurance. The deductible and coinsurance varies by plan. Pre-authorization on major services is recommended. Please review the benefit options listed below carefully before making a selection.

### Definitions of Benefit Classes

#### Preventive Benefits:

Routine oral exams (2 per year)  
 Routine prophylaxis (cleanings—2 per year)  
 Fluoride treatment  
 Dental x-rays  
 Dental sealants [for child(ren) under age 17 only]

#### Basic Benefits:

Extractions  
 Oral Surgery  
 Fillings  
 Anesthesia  
 Endodontics  
 Emergency treatment  
 Periodontics

#### Major Benefits:

Crowns  
 Dentures  
 Bridges  
 Implants

#### Orthodontic Benefits:

Orthodontic treatment

BENEFITS	OPTION I		OPTION II
	In-Network	Out-of-Network	
Annual Deductible	\$50 individual / \$150 family		\$50 individual / \$150 family
Preventive	100% no ded	80% no ded	50% no deductible
Basic	80% after ded	60% after ded	50% after deductible
Major	50% after ded	40% after ded	50% after deductible
Orthodontics	50% no ded	50% no ded	Not covered
Ortho Maximum	\$2,000 lifetime maximum		N/A
Dental Maximum	\$2,000 per plan year maximum		\$1,000 per plan year maximum

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# Vision Care

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## Vision Service Plan (VSP)

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VSP is offered on a voluntary basis to provide a high level of eye care for you and your family. Employees choosing to participate in the plan can use the services of a VSP doctor or may choose to see an out-of-network provider. Benefit schedules will be different based on your choice as outlined below.

### Maximum Benefits

Participants in VSP are eligible for the following services every 12 months from the last date of service.

	VSP Doctor	Out-of-Network Provider
<b>One Eye Exam *</b>	\$15 copay	Reimbursed up to \$35
<b>One Pair Eyeglasses</b>		
Single vision lenses	Covered in full after \$15 copay	Reimbursed up to \$25
Lined Bifocal lenses	Covered in full after \$15 copay	Reimbursed up to \$50
Lined Trifocal lenses	Covered in full after \$15 copay	Reimbursed up to \$55
Progressive lenses	30% discount on cost exceeding plan benefit	Reimbursed up to \$55
<b>Frame Selection</b>	Covered up to \$120 retail allowance	Reimbursed up to \$45
	<b>OR</b>	
<b>Contact Lens Care</b>	Reimbursed up to \$120 in lieu of lenses and frames	Reimbursed up to \$110 in lieu of lenses & frames

\* Diabetic Eyecare Program—\$5.00 copayment for follow-up exam relating to Type 1 diabetes.

### Laser VisionCare Program

Potential candidates for laser vision correction surgery can learn about this procedure and be evaluated by a VSP doctor. LASIK, PRK and Custom LASIK procedures are available. VSP has arranged for its members to receive these procedures at a discounted fee. To learn more visit our website at [www.vsp.com](http://www.vsp.com) or call 888-354-4434.

### Value Added Discounts

**Contact Lenses**—\$120 allowance for contacts and the contact lens exam (fitting and evaluation). New and current soft contact lens wearers may qualify for a program that includes a contact lens evaluation and initial supply of lenses. VSP offers a 15% savings off the doctors contact lens exam, fitting and evaluation if needed.

**Prescription Glasses**—Polycarbonate lenses for dependent child(ren) are covered in full. VSP offers average savings of 30-40% when you purchase lens extras such as tints, coats and progressive lenses. Additional prescription glasses or sunglasses (including lens options) will be discounted 30% if purchased on the same day as your examination or 20% discount if purchased from any VSP doctor within 12 months of the examination.

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# Basic Term Life Insurance / Accidental Death and Dismemberment

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## UNUM Life Insurance

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Basic Term Life Insurance is available to all benefit-eligible active and retired employees. The amount of life insurance benefit for active employees is calculated on the annual base contract.

Under the Basic Term Life Insurance Plan, you may elect your annual contract (rounded up to the next highest \$1,000) with a minimum of \$50,000 in death benefit. The first \$50,000 in death benefit can be paid with before-tax dollars.

### Guaranteed Issue

New employees who enroll in the UNUM Basic Term Life Insurance/AD&D within thirty-one (31) days of their date of hire are guaranteed issue up to the maximum benefit allowed (see Maximum Benefit section) without evidence of insurability. **Guaranteed issue is only available when the employee initially becomes eligible for insurance benefits.** Thereafter, you can change your coverage only during open enrollment or within thirty-one (31) days of a change in status. Coverage can be changed by one level without evidence of insurability. However, if you apply to increase your coverage more than one level, evidence of insurability will be required. If you are not approved for the increase in your coverage, you will only be eligible to increase one level at open enrollment.

### Maximum Benefit

The maximum Basic Term Life Insurance Plan election is your annual contract times three (rounded up to the next highest \$1,000), but not to exceed a maximum of \$300,000 in death benefit. Upon retirement, the maximum benefit level will be reduced to two times your annual contract.

### Benefit Reduction

At age 65, life insurance benefits reduce to 65% of the amount elected. On your 70th birthday benefits will become 50% of the original value or \$10,000, whichever is less. These restrictions apply to active and retired employees.

### Terminal Illness Accelerated Benefit

If you are diagnosed with a terminal medical condition with an anticipated life expectancy of 12 months or less, you may receive 50% of your life insurance benefit prior to your death. Any advance payment will be deducted from the benefits payable at the time of your death.

### Accidental Death & Dismemberment Benefits

When a serious accident occurs, compensation for the accident is provided as part of the life insurance benefit at no additional expense to the employee.

If you are accidentally injured and that injury is independent of sickness or other causes, the policy pays a benefit. Loss must occur within 365 days of the injury and must be a permanent loss. Read your certificate for details.

### Total Disability Life Insurance Continuance

If you become totally disabled, your coverage may continue without payment of premiums if certain requirements are met (see certificate for details):

- the disability began while you were insured under this provision;
- the disability began prior to age 60; and
- proof of the disability is provided no later than the ninth (9th) to the twelfth (12th) month of the disability.

*NOTE: You must be totally disabled from any occupation or activity for a minimum of nine (9) months to be considered for the waiver of premium. Application forms will be sent upon request.*

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# Basic Dependent Term Life Insurance

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## UNUM Life Insurance

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Dependent Term Life Insurance is available to all dependents of benefit-eligible active and retired employees.

### Dependent Benefit

There are two levels of death benefit amounts available for your spouse/domestic partner and child(ren):

#### Level 1

Spouse/domestic partner.....	\$5,000
Child(ren), 14 days to less than 6 months .....	\$1,000
Child(ren), 6 months but less than 25 years.....	\$5,000

#### Level 2

Spouse/domestic partner.....	\$10,000
Child(ren), 14 days to less than 6 months .....	\$1,000
Child(ren), 6 months but less than 25 years.....	\$10,000

### Guaranteed Issue

When dependents first become eligible and are enrolled in the UNUM Basic Dependent Term Life Insurance plan within thirty-one (31) days of their eligibility, you may apply for either Level 1 or Level 2 of dependent coverage without evidence of insurability. **Guaranteed issue is only available when the dependent initially becomes eligible for insurance benefits.** Thereafter, you can change their coverage only during open enrollment or within thirty-one (31) days of a change in status. Coverage can be changed by one level without evidence of insurability. However, if you apply to increase their coverage by more than one level, evidence of insurability will be required. If you are not approved for the increase in your coverage, they will automatically remain at the same level they had prior to applying for the increase.

### Benefit Payments

The benefit amount is always paid to the employee or retiree who elected the coverage for the dependents. The payment is made in a lump sum.

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# Voluntary Group Life / Accidental Death & Dismemberment

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## Colorado PERA (through UNUM)

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All active and retired members of PERA and inactive members who maintain their PERA account may elect to purchase additional group life insurance through this program. When the employee participates in the plan, their spouse and dependent child(ren) are automatically covered. Domestic partners are not eligible for coverage under the provisions of this plan. However, child(ren) of domestic partners are covered as long as they are living with the PERA member in a regular parent/child(ren) relationship and dependent on the member for their main support.

### Guaranteed Issue

New employees who are enrolled in PERA may purchase this plan on their date of hire for guaranteed issue of up to four (4) units of Life/AD&D benefits for themselves, their spouse and their dependent child(ren) during the initial open enrollment. **Guaranteed issue is only available when the employee initially becomes eligible for insurance benefits or at open enrollment each year if actively covered under the plan and wanting to increase the units of coverage (maximum of 4 units).** The Voluntary Group Life benefit is purchased in units of Life/AD&D insurance and the coverage amounts are based on age. No more than four (4) units of Life/AD&D can be purchased.

### Evidence of Insurability

Employees, their spouse and/or child(ren) currently enrolled in this plan do not need to complete a new enrollment form unless they wish to change their coverage. Completion of a new enrollment application, including the health questionnaire, is required for existing participants wanting to increase coverage amounts outside of open enrollment.

### Premium Rate Changes

Premiums are based on the number of units purchased and the coverage amount is age rated based on five-year increments. When you reach the next age bracket, your benefit amount will be reduced based on the number of units purchased.

### Effective Dates

The employee's coverage becomes effective the first day of the month following the first premium payment and/or if required, underwriting approval, provided the employee is actively working.

The dependent's coverage begins the day the employee's coverage becomes effective. However, if the dependent is confined to an institution or at home for medical treatment on the effective date, the effective date will be the day following the doctor's authorization for release from confinement.

### Terminal Illness Accelerated Benefits

A covered individual can receive up to 50% (to a maximum of \$121,000) of the life insurance benefit in a lump sum prior to death. This is available when the policyholder has a terminal illness that is a certifiable medical condition causing a life expectancy of less than twelve months.

### Portability and Conversion Options

Upon termination of employment and receiving a lump-sum payment of the complete PERA member account, the employee and/or spouse and dependents may elect to continue coverage under the Voluntary Group Life plan at the same group rate as long as there is no medical condition which has a material effect on life expectancy. In this situation, application for conversion to a whole life policy is available.

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# Voluntary Accidental Death & Dismemberment

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## Mutual of Omaha

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This is a voluntary accident plan for you and your family. It provides benefits for loss of life, limbs or sight resulting from an accident occurring on or off the job while you or the dependent are covered under the plan. Payments are made regardless of any other insurance.

New hires may enroll immediately, and coverage will begin the first day of employment, provided the employee is actively at work and has enrolled in the plan. If new hires do not enroll within thirty-one (31) days after they are eligible to enroll, they cannot enroll until the next open enrollment period, and coverage will be effective July 1.

### Maximum Benefit

You may select any amount of insurance from a minimum of \$10,000 to a maximum of \$500,000 in increments of \$10,000. An amount of insurance elected that is greater than \$250,000 may not exceed ten times your annual earnings.

You may enroll yourself and your family. Under a full family plan your spouse's/domestic partner's principal sum is 50% of yours and each child's principal sum is 20% of yours. If there are no child(ren) covered, your spouse's/domestic partner's benefit increases to 60% of yours. If there is no spouse/domestic partner covered, each child's benefit increases to 25% of yours.

Child(ren) must be unmarried and under the age of 19 or dependent upon you for financial support and under the age of 25. A newborn child(ren) is not covered before the first of the month following the child(ren)'s birth. Eligible child(ren) include stepchild(ren), foster children, child(ren) of your domestic partner and legally adopted child(ren).

### Benefit Payment

Payments are made to you, or in the event of your death, they are paid to the beneficiary named by you. If no beneficiary is named, or in the event the designated beneficiary predeceases the insured, payment for loss of life will be paid to the first of the following surviving beneficiaries of the insured's: a) lawful spouse/domestic partner; b) child or children, jointly; c) parents, jointly if both are living, or the surviving parent if only one survives; d) brothers and sisters, jointly; e) estate. Benefit amounts are paid on the amount of insurance in effect at the time of the accident.

### Exclusions

Payments will not be made on a loss that occurs more than 365 days after the accident. They will not be paid if loss is the result of any of the following:

- suicide or any attempt thereat while sane or insane;
- loss caused by act of declared or undeclared war;
- injuries received while participating in training exercises or maneuvers of an armed service while a member of an armed service;
- injuries received while traveling by air as a pilot or member of a crew (exceptions provided in the policy/certificate);
- injuries received because the insured person was under the influence of any controlled substance unless administered on the advice of a physician;
- injuries received because the insured person was intoxicated; and/or
- while traveling in any aircraft which is owned or leased by: a) the college/agency, subsidiary or affiliate of the college/agency; or b) a director, officer or employee of the college/agency, subsidiary or affiliate of the college/agency.

### Changes in the Amount of Insurance

After you become insured, you may decrease your insurance amounts at any time. Increases in coverage are only allowed during the annual open enrollment. Changes elected will become effective on July 1.

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# Business Travel Accident Insurance

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## Prudential Insurance

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Benefits are paid for an accident resulting from business travel. This includes an authorized trip while a passenger is riding in an aircraft or when boarding or alighting from such aircraft or being struck by such aircraft. A policyholder owned or leased aircraft is excluded. Approved aircraft and pilots must meet all required certifications.

An authorized trip taken anywhere in the world begins from the time you leave your residence or office, whichever occurs later, to the time you return to the residence or office, whichever occurs first. Travel to and from work, vacations and leaves of absence are not considered authorized travel. If you are a benefit-eligible active permanent employee, you are covered under this plan at no cost to you. Spouse/ domestic partner and dependent coverage is not available.

The maximum benefit is \$100,000 (subject to the aggregate limit per accident), which is the Principal Sum. The maximum aggregate benefit amount payable on behalf of all covered persons who die or suffer losses as a result of the same accident is \$1,500,000. The maximum benefit amount would be prorated among all beneficiaries or employees.

### Schedule of Benefit Amounts per Accident

Accidental Death .....	\$100,000
Both hands or feet, sight of both eyes, one hand and one foot, speech and hearing of both ears, either hand or foot and sight of one eye, quadriplegia (total paralysis of both upper & lower limbs) .....	\$100,000
Paraplegia (total paralysis of both lower limbs) .....	\$ 75,000
Hemiplegia (total paralysis of upper & lower limbs on one side of body) either hand or foot, sight of one eye, speech or hearing of both ears.....	\$ 50,000
Loss of hearing of one ear, or thumb and index finger same hand.....	\$ 25,000

### Coma Benefit

If a qualifying accident results in a comatose condition, a coma benefit is available. This benefit equals the difference between any dollars paid and the principal sum. It is paid at 1% per month for 100 months or until the individual dies, whichever is first. Any benefit remaining after the death is paid to the beneficiary named or to the estate. There is a 31-day waiting period from the time the comatose condition begins during which no benefits will be paid.

### Claim Filing

Written notice of a claim must be given within 20 days after a covered loss occurs or starts. Proper forms will then be forwarded to you for completion. In the event of a continuing loss with recurrent payments, special rules apply. Some exceptions apply; however, no claims submitted after one year of the loss will be paid.

### Benefit Payment Reductions

The full benefit amount will be paid if you are under age 70. Thereafter, reductions on your benefit amount will reduce per a set schedule.

*NOTE: This description of benefits explains only the general purpose of the insurance. Read the policy or certificate for full details. All coverage is subject to the actual provisions, terms, conditions and limitations of Master Policy 42637.*

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# Flexible Benefit Plan Before-Tax Options

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## PayFlex Systems USA, Inc.

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When you choose to enroll on a before-tax basis in the medical, dental, vision, basic life (up to \$50,000) and/or flexible spending account options, you save Public Employee's Retirement Association (PERA) contributions and Federal and State withholding taxes on every dollar redirected from salary to benefits through the program. This savings can equal 25% - 40% off the cost of the benefit items selected and is realized through reduced taxation. The savings will vary based on your own tax situation. There will be no administration fee charged to you for participation in this plan.

Before-tax benefit choices include:

- group insurance premiums for medical, vision, dental and basic term life (to \$50,000 death benefit); and
- flexible spending accounts for out-of-pocket medical, dental and vision expenses for yourself, spouse/domestic partner and dependents and dependent care expenses necessary to employment. Review "Important Tax Information for Domestic Partner Medical, Dental and Vision Benefits" to determine if your domestic partner and their children meet the eligibility requirements for this benefit. Certain over-the-counter drugs and medications may also be reimbursable.

## IRS Rules of Participation

1. You may elect to participate in one or both flexible spending accounts. Money directed into one account cannot be used for another.
2. An election is made during the open enrollment period before a plan year begins and cannot be changed until the next year. No changes are allowed during the year unless there is an eligible change of status. A Status Change is listed in the Benefit Eligibility and Enrollment Chapter. Changes of status must meet the "consistency rule" and generally result in a change in eligibility or allow a change in participant elections.
3. The expense being reimbursed with FSA funds must be incurred during the Plan year (July 1 to June 30). A 90-day runout period is allowed at the end of the plan year (through September 30) to reclaim spending account money. However, the expense being claimed must have been incurred during the plan year while you were an active participant in the plan.
4. Any money set aside in a FSA account and not used during the plan year while you are active in the plan cannot be refunded to you. Include only "predictable" expenses in the spending account (only expenses you know you will incur during the plan year). By being conservative, you can enjoy the tax advantages of the program without the risk.

## PERA Contributions

PERA contributions are not made on dollars elected for before-tax insurance premiums or spending account elections. If you are planning to retire within the next four contract years or you are in one of your highest three years of earnings under PERA, you may want to elect an after-tax payment for insurance premiums and decline participation in the flexible spending accounts. This will help ensure your highest possible PERA retirement benefit.

## Reclaiming Flexible Spending Account Dollars

PayFlex Systems USA is your Flexible Benefit Plan Administrator. You will receive an Open Enrollment Brochure during the open enrollment period with information on how to submit claims. Spending account reimbursements submitted by mail, fax or online are processed daily and mailed to your home address or sent to your assigned bank account via direct deposit.



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# Flexible Benefit Plan Before-Tax Options

## Termination

If you terminate your employment during the plan year, only medical, dental and vision expenses incurred during the time you were an active participant in the plan are eligible for reimbursement. Under COBRA if you have a balance in your account at termination, you and your eligible dependents may be eligible to elect to continue your Health Care Spending Account by agreeing to send your regular monthly contribution to PayFlex Systems USA for the remainder of the plan year. You can then access the full elected dollars for the remainder of the plan year. See your college/agency human resources office for details and exceptions.

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## Dependent Care Spending Account

Dependent care expenses necessary to your employment can be paid 100% tax-free through the Dependent Care Spending Account. A qualifying individual for dependent day care can include a qualifying child, but only up to age 13 and only for the parent with custody. A qualifying individual for dependent day care (not a child) can include a qualifying relative, but only if: 1) the individual is unable to take care of himself/herself due to disability; 2) the taxpayer/employee pays at least half of the individual's support; and 3) the individual lives with the taxpayer/employee. Consult with your tax advisor if you have a question on eligibility.

## Types of Care

Eligible dependent care expenses include in-home care, a childcare home, childcare center, pre-school center, elder care center etc. Special camps are eligible to the extent the primary purpose of such camps is custodial in nature. Ineligible expenses include payments for referral services, parenting seminars, private schooling including kindergarten, child support payments, and payments to a spouse or other dependent for the care of the child or dependent. Overnight camp is not an eligible expense.

## Dependent Care Spending Account Limits

The maximum limit is \$5,000 per year or a maximum of \$416.66 per month in tax-free care expenses per family. The minimum is \$300 for the plan year or a minimum of \$25 per month. The number of children or dependents does not affect these limits. If you are married and filing separately, you are limited to \$2,500 per spouse per year (July 1 through June 30).

You may also use a combination of the tax credit and Dependent Care Spending Account; however, the combination cannot exceed the tax credit limit and you cannot apply the same care dollars for both.

*NOTE: After your initial enrollment, if you have a change in care providers and/or the fee changes, you may adjust your election within thirty-one (31) days of the date of the change.*

## Employee Reporting Requirements

You are required to put the name, address, and Social Security or Tax ID number of the provider on your federal tax return. This reporting is required whether you take the tax credit at the end of the year or use the tax-free Dependent Care Spending Account option.

## Payments

When using the Dependent Care Spending Account, you will be reimbursed up to the amount available in your account at the time of the claim request. The total reimbursements are limited to the plan year amount elected during open enrollment or the prorated amount for allowed election changes approved during the plan year.

## Termination

If you terminate your employment during the plan year, you are no longer a participant in the plan. However, any dollars remaining in your dependent care spending account can be claimed for eligible expenses incurred anytime during the plan year. See your college/agency human resources office for details.

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# Disability Insurance

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## PERA Disability Program

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Colorado Public Employee's Retirement Association (PERA) provides members having five or more years of earned PERA service credit with a two-tier disability program. One tier is a short-term disability plan provided by Standard Insurance Company. The second tier is a PERA disability retirement benefit. Since the disability program is part of the PERA benefit structure, members are not charged a premium for this program. Standard Insurance Company is the disability program administrator.

### Short-Term Disability (STD)

The goal of the STD plan is to help you return to work to your previous job or another job as soon as it is practical. However, the employer is not obligated to hold a position open for you beyond applicable federal and state requirements. Some employers may allow their employees to go on an approved leave of absence while they receive STD payments. Other employers may terminate employment of their employees at some point after they leave work, even though they are receiving STD payments.

As soon as you believe you may qualify for STD payments, the policies regarding leaves of absence and possible opportunities to return to work at a later date should be discussed with Human Resources. If you are terminated by your employer, you may continue to be entitled to receive STD payments as long as you do not refund your PERA member contribution account, do not become eligible for PERA service retirement and meet the STD plan requirements.

The STD plan requirements include the following:

- you are not totally and permanently medically incapacitated from all regular and substantial gainful employment;
- your medical condition prevents you from performing the essential functions of your job with reasonable accommodation as required by federal law; and
- you are medically unable to earn 75% of your predisability earnings from PERA-covered employment from any job you are able to perform, given your existing education, training and experience.

### Disability Insurance

STD may provide reasonable income replacement and vocational rehabilitation after you have been unable to work for 60 days. STD lasts up to a maximum of 22 months. The maximum income replacement is 60% of your pre-disability PERA-includable salary. This is based on the 12 consecutive calendar months immediately preceding your last full day on the job prior to the 60-day waiting period. The amount paid under the STD plan may be reduced by other income.

### Disability Retirement

The goal of disability retirement is to provide you with income if you are not able to work and are not expected to recover. As soon as you believe you may qualify for disability retirement, you should discuss with your employer its policies concerning a leave of absence and retirement. To qualify for disability retirement, you must terminate employment.

For disability retirement, the requirements include the following:

- you are totally and permanently incapacitated and are not reasonably expected to recover from your disabling medical condition;
- your medical condition prevents you from engaging in any regular and substantial gainful employment; and
- you are medically unable to earn 75% of your predisability earnings from PERA-covered employment from any job for which you are or could be educated or trained.

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# Disability Insurance

The PERA disability retirement benefit is based on your highest average salary and earned, purchased and, in some circumstances, projected service credit. The monthly benefit continues as long as you continue to be totally and permanently incapacitated from regular and substantial gainful employment.

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## Long Term Disability Insurance - UNUM Life Insurance

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The Long Term Disability benefit becomes payable to you after you have been totally disabled for 60 days or at the end of your accumulated sick leave, whichever is greater.

You are disabled when UNUM determines that:

- you are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury; and
- you have a 20% or more loss in your indexed monthly earnings due to the same sickness or injury.

After 36 months of payments, you are disabled when UNUM determines that due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience. If it is determined you are eligible, you must participate in a mandatory Rehabilitation and Return to Work Assistance Program to continue to be eligible to receive disability benefits.

### Benefit Limits

The benefit amount paid is the **lesser** of 60% of your monthly earnings or 70% of your monthly earnings less other sources of income to a maximum benefit of \$10,000 per month. Earnings are based on the last day worked prior to the disability. Hourly employee wages are based on the hourly rate of pay with a minimum of 20 hours per week (Aims—employee must work a minimum of 35 hours per week). Overtime pay, commissions, bonuses or other special compensation are not included in your monthly earnings. However, contributions to your Flexible Benefit Plan or Voluntary Retirement Plans are included in your compensation.

The minimum monthly payment is the greater of \$50 or 10% of the gross monthly benefit. Other income sources may be considered during a disability period as income and can affect disability benefit payments. Read your policy for specific details.

### Maximum Benefit Limits

Benefits are potentially paid to:

- age 65, if the date of disability began prior to age 60;
- the latter of age 65 or 36 consecutive months of total disability if the date of disability began on or after age 60, but prior to age 65; or
- the earlier of age 70 or 24 consecutive months of total disability if the date of disability began on or after age 65.

### General Exclusions

This policy does not cover any disability due to:

- war, declared or undeclared, or any act of war;
- intentionally self-inflicted injuries; or
- active participation in a riot.

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# Disability Insurance

## Pre-Existing Condition Exclusion

This policy will not cover any disability caused by, contributed to or resulting from a pre-existing condition unless it begins after the first 12 months that the insured was covered under this policy.

A "pre-existing condition" means a sickness or injury for which the insured received medical treatment, consultation, care or services including diagnostic measures, or had taken prescribed drugs or medicines in the three months prior to the insured's effective date.

## Limitation of Benefits

Limitations of benefits apply if the disability is caused by a nervous/mental condition, alcohol or drug abuse. Disability benefits are limited to 24 months if you are not in a hospital or an institution licensed to provide treatment and care for the condition causing your disability. The monthly benefit will continue to be paid if you are confined in a hospital or institution past 24 months. If you are still disabled upon discharge, the benefit will be paid for up to 90 days after leaving the hospital or institution.

## Filing a Claim

If you have a claim, notify your employer immediately. You must submit written proof of your disability. Claim forms are provided through UNUM Life Insurance. You have 60 days after the beginning of the disability to file a claim. We recommend you file a claim no later than 45 days prior to the end of the elimination period. The maximum acceptance period for a claim is one year from the end of your elimination period. UNUM has the right to order an examination by a doctor of its choice.

## Survivor Benefits

In the event of your death, after being on disability benefits a minimum of 180 consecutive days, a lump sum benefit equal to three times your gross monthly benefit will be paid to your spouse/domestic partner (if living), to your unmarried child or children up to age 25, or to your estate, if there are no eligible survivors.

# Disability Insurance

## Disability Programs Comparison Chart

	SBCCOE		PERA	
	LTD		STD	Disability Retirement
<b>Who is eligible?</b>	Benefit eligible contractual employees based on BP3-60. For LTD coverage, an employee must work at least 20 hours per week (Aims employees must work 35 hours per week).		Employees who have earned five years of PERA service credit	
<b>Does the employer pay for the program?</b>	Yes		Yes, pre-funded through monthly employer contributions to PERA	
<b>When does coverage begin?</b>	From the first day of active employment		Once an employee has earned five years of PERA service credit	
<b>How do I apply?</b>	Contact your college/agency HR Office within 31 days of absence		Contact your college/agency HR Office or PERA's Customer Service Center to request a disability program brochure (includes an application & summary plan description)	
<b>What is the waiting period?</b>	60 calendar days or exhaustion of sick leave, whichever is later		60 calendar days or exhaustion of sick leave, whichever is later	None
<b>What is the maximum benefit period?</b>	<b>Age at Disability</b>	<b>Maximum Benefit Period</b>	22 months after the 60 calendar day waiting period	Lifetime, if disability continues
	Less than 60	To age 65		
	60-64	The latter of age 65 or 36 months		
	65 and over	The earlier of age 70 or 24 months		
<b>How is the disability benefit calculated?</b>	The lesser of 60% of basic monthly earnings or 70% of basic monthly earnings less other income benefits; or the maximum monthly benefit		60% of average 12 months salary on which PERA contributions were made immediately preceding your last full day on the job prior to the 60-day waiting period	Usually, 50% of HAS; but it may be more or less depending on age & service credit
<b>What are the maximum/minimum payments?</b>	<b>\$10,000</b> per month maximum, the minimum benefit is the greater of <b>\$50</b> or <b>10%</b> of the monthly benefit before deductions for other income benefits		None	None

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# Voluntary Supplemental Retirement Plans

As an employee, you have the opportunity to direct dollars from your gross wages into your own voluntary retirement account. When choosing this option, you can defer taxes on these dollars until they are withdrawn or you can choose to make after-tax retirement contributions into a Roth 403(b) plan. A penalty tax of 10% (plus normal income tax payments) will apply for early withdrawal unless one of the following conditions applies: death, disability, separation from service during or after the year you reach age 55, reaching age 59½ and hardship. In some cases, a rollover to another tax-deferred qualified plan is allowed by the IRS.

Under the voluntary plan in 2009, you can direct up to 100% of your annual salary or \$16,500, whichever is less, per year toward your retirement. In some cases, these limits may be higher. A catch-up provision allows anyone over the age of 50 to contribute an additional \$5,500. PERA service time may be purchased with dollars from any of the following voluntary retirement plans.

## PERA's 401(k) Plan

Colorado PERA offers members a 401(k) tax-deferred plan that includes 18 diversified funds in which you may invest and allows loans against your account for any reason. Your investment choices include: Northern Trust Short Term Fund, PIMCO Low Duration Fund, Freedom Income Fund, PIMCO Total Return Fund, Freedom 2000 Fund, Freedom 2010 Fund, Dodge & Cox Balanced Fund, Freedom 2020 Fund, Freedom 2030 Fund, Freedom 2040 Fund, Vanguard Institutional Index Fund, Dodge & Cox Stock Fund, PERA Growth & Income Stock Fund, Fidelity Contrafund, Kanier Large Cap Growth Equity Fund, American Funds EuroPacific Growth Fund, Vanguard Small-Cap Index Fund and the Pax World Balanced Institutional Fund. Funds may be used to purchase service credit with PERA. For more information, visit [www.copera.org](http://www.copera.org) or call PERA at 1-800-759-7372 or 303-832-9550.

## MetLife Resources 403(b) Plan / Roth 403(b) Plan

This 403(b) program is offered and serviced by MetLife Resources Financial Service Representatives. The 403(b) is a variable annuity contract with 56 underlying funds and a fixed account option. This fund selection includes four index funds. In addition, there is the choice to use two Exchange Traded Funds (ETF) and five asset allocation portfolios at varying degrees of risk. It offers employees the flexibility and choices necessary to create and maintain a successful retirement plan.

The annuity features well-known money managers and fund choices which cover a broad range of asset classes including domestic and international stock, bond, balanced, socially responsible and money market options. There is access to well-known investment managers including: Fidelity, MFS, Templeton, Van Kampen, Dreyfus, AIM, Franklin and Lord Abbott. In addition, the 403(b) Roth is available with the same plan features.

MetLife Resources Field Service Representatives are available to meet one on one and discuss retirement needs as well as provide Personal Financial Plans to employees at no cost.

For more information or to schedule an appointment, call 303-758-7800. Visit our websites at [www.AV.metlife.com](http://www.AV.metlife.com) or [www.metlife.com](http://www.metlife.com).

## TIAA-CREF 403(b) Plan

For over 90 years, TIAA-CREF has been helping those in the academic, medical, cultural and research fields plan for and live in retirement. We do this with a full array of financial products and services to help them live to and through retirement and invest for life's other goals along the way. In keeping with our strong nonprofit heritage, we offer low fees [Morningstar Direct (February 2008) based on Morningstar expense comparisons by category], a long-term approach to investing, and a full line of financial products and services provided by consultants who never receive commissions. Instead, they are compensated primarily on how well they serve you, not what they sell you. For more information about TIAA-CREF, visit [www.tiaa-cref.org](http://www.tiaa-cref.org) or call 1-800-842-2776.

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# Voluntary Supplemental Retirement Plans

## Valic Financial Advisors, Inc. 403(b) Plan / Roth 403(b) Plan

For half a century, VALIC has been an innovator and PACEsetter through the products and services offered by our local Financial Advisors. Portfolio Director Features:

- 24 different fund managers
- No surrender charges
- No maintenance fees
- 61 variable funds, 4 fixed accounts
- Guided Portfolio Service — 3<sup>rd</sup> Party Management
- Income Lock — guaranteed income stream in retirement
- Planning — helping clients plan financially for the future
- Advice — guidance in Portfolio design and management
- Choice — variety of products and services to choose from
- Education — comprehensive education and communication services

## State of Colorado 457 Deferred Compensation Plan

The 457 Plan benefits include the following:

- ◆ No 10% early withdrawal penalty
- ◆ Variety of mutual funds to choose from
- ◆ Dedicated registered representatives to meet with
- ◆ Separate contribution limits in addition to 403(b), 401(k) and IRA limits
- ◆ No-load mutual funds
- ◆ A stable value fund that provides a fixed interest rate
- ◆ Managed Account Service, offered through AAG (Advised Assets Group <sup>sm</sup>)
- ◆ Self-Directed Brokerage Option with TD Ameritrade
- ◆ Accepts rollovers from outside retirement plans such as 401(k), 403(b), 401(a)

For more information or to schedule an appointment, please call the office at 1-800-838-0457 or visit the website at [www.colorado457.com](http://www.colorado457.com).

# Voluntary Supplemental Retirement Plans

## Tax Deferred Compensation Plans

The following chart compares the main features of the three tax-deferred savings plans as defined by the IRS. The "right" plan or plans for you will depend on your personal investment goals and objectives. For detailed information about the features of each plan, contact the providers identified in this chapter.

	Deferred Compensation 457 Plan	PERA 401(k) Plan	403(b) Tax-Deferred Annuity Program
<b>Who Can Participate</b>	Employees of the State	Any contributing PERA member	Employees of higher education institutions
<b>Employee Contributions</b>	Via payroll deductions	Via payroll deductions	Via payroll deductions
<b>Minimum</b>	\$25 per month	None	Based on option selected
<b>Maximum</b>	\$16,500 in 2009	\$16,500 in 2009 401(k) and 403(b) contributions combined cannot exceed calendar year maximum	\$16,500 in 2009 401(k) and 403(b) contributions combined cannot exceed calendar year maximum
<b>Loans to Participants</b>	One loan per account, any reason	Up to two loans at any time for any reason.	Available if plan permits. Contact your 403(b) Plan Provider
<b>Withdrawals While Working</b>	Permitted only for: <ul style="list-style-type: none"> <li>• Extreme unforeseeable financial hardships as determined under IRS guidelines. 10% tax penalty does not apply</li> <li>• To purchase PERA service credit</li> <li>• Age 70½ or older</li> </ul>	Permitted only for: <ul style="list-style-type: none"> <li>• Employees age 59½ or older*;</li> <li>• Financial hardship*</li> <li>• To purchase PERA service credit *</li> </ul> <p><i>* 10% penalty does not apply</i></p>	Permitted only for: <ul style="list-style-type: none"> <li>• Employees age 59½ or older*;</li> <li>• Financial hardship*</li> <li>• To purchase PERA service credit</li> </ul> <p><i>* 10% penalty does not apply</i></p>
<b>Catch-up Provisions</b>	Participants age 50 and over may make additional contributions of \$5,500 in each calendar year. There is also a special 457 catch-up provision which allows participants who qualify to contribute double the available limit. Please contact the administrator for specific details.	Participants age 50 and over may make additional contributions of \$5,500 in each calendar year	Participants age 50 and over may make additional contributions of \$5,500 in each calendar year
<b>When Paid</b>	Retirement, termination —no 10% tax penalty regardless of age, hardship, death (beneficiary)	Retirement, termination, hardship, death (beneficiary)	Retirement, termination, hardship, death (beneficiary)
<b>To Enroll</b>	1-800-838-0457 "select option 2" or <a href="http://www.colorado457.com">www.colorado457.com</a>	1-800-757-7372 or 303-832-9550 or <a href="http://www.copera.org">www.copera.org</a>	Contact your Plan Representative; see page 2 for listing.

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# Guide to Understanding COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 gives you and your covered dependents the right to continue group medical, dental and vision coverage and a health care spending account when coverage with the SBCCOE Benefit Plan ends.

## 1. Who Can Continue Coverage?

Qualified Beneficiaries may continue group medical, dental and vision coverage when coverage ends due to the occurrence of certain events called Qualifying Events. Qualified Beneficiaries can be an employee, an employee's spouse/domestic partner, and an employee's dependent who were covered under one of the SBCCOE's group medical, dental and vision plans the day before a Qualifying Event. Also, a Qualified Beneficiary can be a child who is born or placed for adoption with the employee during COBRA coverage.

A Qualifying Event is defined as follows:

- a) end of employment or a reduction of work hours (EXCEPTION: COBRA rights do not apply if the end of employment is due to an employee's gross misconduct);
- b) death of covered employee;
- c) divorce or legal separation of a covered employee from his/her covered spouse;
- d) covered dependent child(ren) is no longer eligible under the terms of the plan; and/or
- e) entitlement to Medicare for a covered employee (entitlement means a person becomes eligible for and enrolled in Medicare).

Qualified Beneficiaries are required to notify the Human Resources Office in writing within 60 days of the following Qualifying Events:

- a) divorce or legal separation of a covered employee from his/her covered spouse.
- b) covered dependent child(ren) are no longer eligible as of:
  - 1) the date of the covered dependent's marriage;
  - 2) the last day of the month in which a covered dependent is no longer financially dependent upon the covered employee; or
  - 3) the last day of the month in which a covered dependent reaches age 25.

## 2. What Coverage May Be Continued?

Qualified Beneficiaries may elect their COBRA coverage to continue in the medical, dental and vision plans in which they were enrolled on the day before the Qualifying Event. The group medical, dental and vision plans offered under COBRA shall remain the same as coverage provided to active SBCCOE employees and their dependents. Qualified Beneficiaries may change medical plans during the annual Open Enrollment Period. The change will become effective July 1 following the Open Enrollment.

If SBCCOE changes the coverage for active employees and their dependents, the coverage provided under COBRA will change in the same manner. If a Qualified Beneficiary moves from the service area of a medical plan, they must change medical plans. Notification must be sent to the COBRA Coordinator at HealthSmart Benefit Solutions within 30 days of the move.

## 3. How Long Can Coverage Continue?

When coverage on an active employee stops because SBCCOE employment ends or a reduction of work hours, COBRA coverage may be continued for up to 18 months [see par. 1(a)].

A disabled Qualified Beneficiary may continue COBRA coverage for a maximum of 29 months if:

- a) he/she is considered to be disabled, according to Social Security or PERA standards at the time of or within 60 days of the Qualifying Event;
- b) he/she remains disabled according to Social Security or PERA standards during the extended COBRA coverage period; and
- c) he/she notifies the COBRA Coordinator at HealthSmart Benefit Solutions of the Social Security or PERA disability determination within 60 days after it is made and before the end of the first 18 months of COBRA coverage.

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# Guide to Understanding COBRA

**NOTE:** All covered family members of a disabled Qualified Beneficiary are entitled to the 11-month extension if the disability qualifies.

If a Qualified Beneficiary is notified by Social Security or PERA that he/she is no longer considered disabled, the Qualified Beneficiary must notify the COBRA Coordinator at HealthSmart Benefit Solutions within 30 days of the notification. If a Qualified Beneficiary's medical, dental and vision coverage ends for any Qualifying Event other than termination or reduction of work hours [see paragraphs 1(b) through 1(e)], COBRA coverage becomes available to that individual for up to 36 months.

**NOTE:** The 18-month coverage period may be extended for covered dependents if another Qualifying Event occurs during the initial 18-month coverage period. For example, if a covered dependent child reaches the eligibility age limit within the first 18-month COBRA period, the dependent child may elect to continue coverage beyond 18 months. However, if multiple Qualifying Events occur, coverage may not continue beyond a total of 36 months from the date of the first Qualifying Event.

## 4. When Does COBRA Coverage End?

COBRA coverage for a Qualified Beneficiary ends on the earliest of the following dates:

- a) the last day of the month for which a premium has been paid. There is a grace period of 30 days for the regularly scheduled monthly premiums;
- b) the date the Qualified Beneficiary becomes covered as an employee or an eligible dependent under any other group health plan. (EXCEPTION: COBRA coverage will not end if the Qualified Beneficiary has a pre-existing condition that is excluded under the new plan);
- c) the date, after the date of the continuation coverage election, the Qualified Beneficiary becomes eligible for and enrolled in Medicare;
- d) the date on which the SBCCOE ceases to provide any group medical, dental and vision coverage to any employee;
- e) the last day of the first month (at least 30 days after) a Qualified Beneficiary is no longer considered to be disabled by Social Security or PERA but not before the initial 18-month COBRA period ends; or
- f) the date of the maximum COBRA continuation period (18, 29, or 36 months) ends.

## 5. When Must A Qualified Beneficiary Decide?

A Qualified Beneficiary has 60 days from the later of the following dates to elect COBRA continuation coverage;

- a) the Qualifying Event date (e.g., divorce), or
- b) the date the notice of the right to continue coverage is sent. Continuation coverage is effective from the date that coverage under the SBCCOE's Benefit Plan would otherwise end, regardless of when the decision to elect COBRA coverage is received during the 60-day election period. If continued coverage is not elected within this 60-day period, group medical, dental and vision coverage will end along with the right to continue coverage under COBRA.

## 6. How Much Will It Cost?

Because Qualified Beneficiaries must pay premiums directly to HealthSmart Benefit Solutions, all COBRA premium payments are made on an after-tax basis. The monthly COBRA premium is the total monthly premium for coverage under the SBCCOE's Benefit Plan plus a 2% administrative fee. If the premium for group coverage under the SBCCOE Benefit Plan changes, the monthly premium for continuation coverage under COBRA will change in the same manner.

The monthly premium for continuation of the health care spending account is based on the annual amount you choose to contribute to the account and the number of months remaining under COBRA coverage during the period for which the employee made the election. SBCCOE may charge additional administrative fees for continued participation.

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# Guide to Understanding COBRA

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the COBRA premium in some cases. The premium reduction is available to certain individuals who experience a qualifying event that is an involuntary termination of employment during the period beginning September 1, 2008 and ending December 31, 2009. If you qualify for the premium reduction, you only pay 35% of the COBRA premium otherwise due to the plan. This premium reduction is available for up to nine months. If your COBRA continuation coverage lasts for more than nine months, you will have to pay the full amount to continue your COBRA continuation coverage. For additional information, request a copy of the "Summary of the COBRA Premium Reduction Provisions under ARRA" from your college/agency human resources office for more details, restrictions and obligations as well as the form necessary to establish eligibility.

If a Qualified Beneficiary is disabled according to Social Security or PERA and qualifies for 29 months of COBRA coverage, the monthly premium for the last 11 months of COBRA coverage will be the entire active employee premium plus a 50% administrative fee. If only the non-disabled family members elect the additional 11 months, the monthly premium will be the entire active employee premium plus a 2% administrative fee.

## 7. When and To Whom Does the Qualified Beneficiaries Pay?

Qualified Beneficiaries will be billed by HealthSmart Benefit Solutions and all payments must be sent directly to them. The first premium payment is due no later than 45 days after the Qualified Beneficiary is sent the COBRA confirmation notice.

Payment of the remaining monthly premiums are due on the first calendar day of each month. If the premium is not received by HealthSmart Benefit Solutions within 30 days of this due date, coverage will end on the final calendar day of the last month for which the COBRA premium was paid. All coverage canceled due to non-payment of COBRA premiums cannot be reinstated.

## 8. Will Evidence of Good Health Be Required?

No. A Qualified Beneficiary who elects COBRA coverage is not required to provide evidence of good health.

## 9. What Happens When COBRA Ends?

An individual who continues COBRA coverage through the entire period has the opportunity to convert COBRA coverage to an individual policy. This individual policy is limited to medical coverage only, and does not require evidence of good health. Conversion may be made during the month before the 18<sup>th</sup>, 29<sup>th</sup>, or 36<sup>th</sup> month COBRA coverage period ends. Individual conversion policies and rates are established by the medical carrier which underwrites the group plan for the SBCCOE and are not the same as coverage under COBRA.

Instead of selecting COBRA coverage, Qualified Beneficiaries who have been covered under the group coverage for at least three months immediately prior to termination of group coverage, may convert to an individual policy when regular group coverage ends (i.e., at the time a Qualifying Event occurs). To convert to an individual policy, the covered person must request conversion within 30 days after medical coverage under the SBCCOE Benefit Plan would end.

## 10. Questions About COBRA and Where Should The Form Be Sent?

Questions should be directed to the COBRA Coordinator at HealthSmart Benefit Solutions 1-800-423-4445. COBRA Continuation of Medical/Dental/Vision Coverage Election forms are available from your college/agency human resources office.

### Completed forms must be sent to:

HealthSmart Benefit Solutions  
10303 E. Dry Creek Road, Suite 200  
Englewood, CO 80112

## COBRA and the Trade Assistance Act

If you qualify for Trade Adjustment Assistance (TAA) as defined by the Trade Act of 2002, you will be provided with an additional 60-day enrollment period, with continuation coverage beginning on the date of such TAA approval.